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Development of an Academic-Service Alliance to address New Graduate Registered Nurses' Practice Readiness

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Abstract

New Graduate Registered Nurses' (NGRN) lack of practice readiness is a Problem of Practice (PoP) impacting hospitals. Stemming from the evolving complexity of today's healthcare environment and the generalist nature of the baccalaureate nursing program, the lack of NGRN practice readiness increases hospital-based orientation costs, patient safety risks, and NGRN attrition. There is currently no formal structure in which key stakeholders can address the NGRN lack of knowledge, skills and judgment and the associated implications for the safety and quality of patient care. This Organizational Improvement Plan (OIP) examines NGRN practice readiness within the organizational context of the Health Centre (HC), a Canadian academic health sciences center, and explores possible solutions. Nadler and Tushman's (1980) Congruence Model of Organizational Behavior is used to perform a critical analysis of the HC's current state and determine needed change. Consideration is given to the political, economic, social, cultural and historical influences shaping this PoP

The Change Leader (CL) draws on authentic leadership, collaboration theory, principles of influence and inclusion, and adaptive leadership theory to develop a comprehensive change plan. Viewing the disempowered position of nursing students, NGRN, and patients through a critical theory lens highlights the need to remove structural barriers and enable equitable participation of all stakeholders in the change process. The HC operates as a complex adaptive system (CAS) and, in light of complexity theory, the proposed emergent change is guided by broad, system-level goals. Three possible solutions to this PoP are reviewed. Based on Kotter's eight-stage process of major change, a plan to establish an Academic-Service Partnership (referred to as the

'Alliance') is described. Throughout the change plan attention is given to the empowerment of key stakeholders: nursing students, NGRN, and patients.

The evaluation component of the change plan incorporates a Return-on-Investment (ROI) methodology to identify both the monetary and intangible benefits of the proposed change. A multi-strategy communication plan designed to align with and support the corresponding stages of the planned change is outlined. This OIP proposes a model which provides the structure required to address NGRN practice readiness. In future, this solution has potential application for other healthcare professions and their transition into professional practice.

Keywords: New Graduate Registered Nurses, Practice readiness, Academic Service Partnership, Kotter's eight-stage process of major change, Critical Theory, Return-on-Investment (ROI) methodology

Executive Summary

Background and Problem of Practice

When New Graduate Registered Nurses (NGRN) transition to professional practice in a hospital setting, they are confronted with a complex and fast-paced environment. Unfortunately, many NGRN lack the knowledge, skills and judgment necessary to deliver safe, quality patient care in acute healthcare settings such as the Health Centre (HC), a pseudonym for an academic health sciences center in Ontario, Canada. The NGRN lack of practice readiness is a Problem of Practice (PoP) that has been attributed to many factors, including the generalist nature of the baccalaureate nursing program (Romyn et al., 2009) and the increasing complexity of acute hospital settings (Spiers et al., 2010). Both healthcare institutions and academic nursing programs have a role to play in addressing NGRN practice readiness (Guay, Bishop, & Espin, 2016; Wong et al., 2018). However, this issue is further complicated by the lack of existing infrastructure between the HC and the respective academic partners within which to address NGRN practice readiness. The need for an inter-organizational approach highlights the systems-level nature of this issue (Romyn et al., 2009). This Organizational Improvement Plan (OIP) examines the organizational context of this PoP, explores possible solutions, and details a staged approach to change.

This PoP is situated in the HC where the overarching mission is to deliver the best possible patient care. In Chapter 1, a political, economic, social, technological and environmental (PESTE) analysis is completed to determine the factors influencing the PoP and the organization. Using Weiner's (2009) theory of organizational readiness for change, the HC's notable strengths include this OIP's alignment with other planned change, existing corporate priorities, and organizational structure.

Leadership Vision

The development of this OIP is guided by critical theory. Use of this perspective highlights the vulnerable position of nursing students, NGRN, and in particular, the patients. The opportunity to include and empower these groups subsequently influences the selected leadership approach. A combined approach that applies authentic leadership, collaboration theory, inclusive leadership, and adaptive leadership is described. An authentic leadership approach describes the Change Leader's (CL's) innate leadership style, and is one which welcomes multiple perspectives (Avolio, Gardner, Walumbwa, Luthans, & May, 2004). Collaboration theory provides strategies to influence processes and structures (Huxam & Vangen, 2000; Vangen, 2003; Vangen & Huxham, 2008). Inclusive leadership principles guide the involvement of stakeholders and their perspectives (Wuffli, 2016). These selected theories provide direction for the leader and other key stakeholders: nursing students, NGRN, patients, and academic partners. Additionally, the HC has many characteristics of a complex adaptive system (CAS). The PoP can be considered an adaptive challenge as it is neither clear cut nor easy to identify, and thus requires collaboration to solve (Northouse, 2019). Consequently, both complexity theory and adaptive leadership will also be used to guide the development of this OIP.

Possible Solutions

Chapter 2 provides a critical organizational analysis. Nadler and Tushman's (1980) Congruence Model further demonstrates the gap between the NGRN and their task—providing safe, quality patient care. Throughout the analysis, the vulnerable position of nursing students, NGRN, and patients is highlighted. Three possible solutions to address the NGRN lack of practice readiness are identified. The solutions considered are to: (1) maintain the status quo; (2)

implement solutions reported in the literature; and (3) establish an approach that is inclusive of all key stakeholders. The recommended solution is the development of an Academic Service Alliance (Alliance) which will provide a venue for the HC and key stakeholders to "advance their mutual interests related to practice, education, and research" (Beal, 2012, p. 1).

Change Plan

The change plan described in Chapter 3 details the implementation of the Alliance to address NGRN practice readiness. Unlike the Academic-Service Partnerships (ASP) reported in the literature, the proposed final structure includes equitable roles for other key stakeholders e.g. nursing students, NGRN, Patient Advisors, and representatives from the healthcare provider and academic institutions. Kotter's (2012) eight-stage process of creating major change is used to create a phased approach to implementing the planned change. Evaluation of outcomes incorporates Return-on-Investment (ROI) methodology, an approach which seeks to capture both the monetary and the intangible benefits that will be achieved. The communication plan for each stage of the change is described.

Summary

Implementation of this OIP and the corresponding development of an Academic Service Alliance will establish the processes necessary to identify, prioritize, implement and evaluate a multipronged approach to address NGRN practice readiness. This model provides value to all key stakeholders and the initiatives evolving from the Alliance would support a curriculum that keeps pace with the evolving healthcare environment.

Acknowledgments

The attainment of a doctoral degree has been likened to a journey. For me, this learning journey began at a time when I was teaching in an undergraduate baccalaureate of nursing program. For, to teach is to learn; and it was in this capacity that I became aware of the challenges and angst New Graduate Registered Nurses (NGRN) encountered as they transitioned from the academic environment to the reality of professional practice. To the nursing students and NGRN who were the impetus for my doctoral studies and this resulting Organizational Improvement Plan (OIP), I thank you for sharing your experiences with me.

A journey is best when travelled with friends. To my colleagues and peers in the community leadership cohort, I thank you for your encouragement and comradery.

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Acronyms

Alliance (Academic Service Alliance)

ASP (Academic Service Partnership)

BScN (Baccalaureate of Science in Nursing)

CAS (Complex Adaptive System)

CASN (Canadian Association of Schools of Nursing)

CL (Change Leader)

CNO (College of Nurses of Ontario)

HC (Health Centre)

ICU (Intensive Care Unit)

MRP (Most Responsible Person)

NCLEX-RN® (National Council Licensure Examination for Registered Nurses)

NGRN (New Graduate Registered Nurses)

OIP (Organizational Improvement Plan)

ONA (Ontario Nurses' Association)

PESTE (Political, Economic, Social, Technological, and Environmental)

PoP (Problem of Practice)

RN (Registered Nurse)

ROI (Return-On-Investment)

Glossary of Terms

Term	Definition
Academic partners	The post-secondary institutions within the Health Centre's (HC) local geographic region that provide a nursing baccalaureate program and with whom the HC has established legal agreements supporting the clinical placement of nursing students.
Academic Service Alliance (Alliance)	An expanded academic service partnership which includes nursing student, New Graduate Registered Nurse (NGRN) and patient representation. These individuals have an equitable role in the collaboration and decision making undertaken by this group.
Academic Service Partnership (ASP)	A strategic, mutually beneficial relationship between educational institutions and healthcare employers that seeks to advance common goals related to nursing practice, research, and education (Beal, 2012; Nabavi, Vanaki, & Mohammadi, 2012)
Adaptive Leadership	Briefly, this is a leadership approach which focuses on the activities of the leader as they influence followers' adaptation to change within the context of challenges that require learning, innovation and behavior change (Northouse, 2019; Uhl-Bien, Marion, & McKelvey, 2007) and results in the organization becoming adaptive (Lichtenstein et al., 2006).
Attrition	Nurses' premature departure from the profession.
Complex Adaptive System (CAS)	A dynamic system of interconnected agents who interact and respond to their internal and external environment. The generated tensions result in emergent change (Lichtenstein et al., 2006; Plsek & Greenhalgh, 2001).
Critical theory	In simplest terms, this is a philosophical approach which seeks to liberate individuals through the exposure of conscious and unconscious constraints in order to enable their uncoerced participation in social interactions (Ray, 1992; Swartz, 2014; Wilson-Thomas, 1995).
New Graduate Registered Nurses (NGRN)	Individuals who have completed the education and exam requirements to be a Registered Nurse and are within one year, or less, of their graduation (Rush, Adamack, Gordon, Lilly, & Janke, 2013)

Patient Advisor	An individual who is a current or former patient or a family member of a patient who has experienced care at the Health Centre (HC) within the past two years. Their role is to share their experiences and perspectives at various decision-making tables within the HC.
Practice readiness	Registered Nurses' (RNs') possession of the knowledge, skills and judgement required to deliver safe, quality care within the area in which the RN is employed (Missen, Mckenna, & Beauchamp, 2016).
Preceptor	A Registered Nurse (RN) who provides individualized teaching and support in a clinical setting to a baccalaureate of nursing student or a new RN hire. This preceptored relationship, often referred to as a preceptored placement provides educational instruction and support to students and novices (Yonge, Olive, Billay, D., Myrick, F. & Luhanga, 2007).

Chapter 1: Introduction and Problem

New Graduate Registered Nurses' (NGRN) lack of practice readiness is a Problem of Practice (PoP) facing hospitals today. This issue impacts a leading academic health sciences centre located in a large urban area of Ontario, Canada and, at present, there is no existing structure through which to address this issue. In order to establish the organizational context of this particular PoP, Chapter 1 will explore the vision, mission, values and strategic goals of the organization. Along with a brief history of the organization, the broad social, cultural, economic, and political contexts of the organization will be described. Organizational readiness for change will be assessed using Weiner's (2009) theory of organizational readiness for change and identified change drivers. Select leadership approaches that inform the change vision will be examined. The discussion of the PoP along with the critical organizational analysis will establish the context for Chapter 2.

Organizational Context

The institution which is the focus of this Organizational Improvement Plan (OIP) is a large hospital corporation in Ontario, Canada and will be referred to as the 'Health Centre' (HC). The HC is comprised of interconnected individuals and groups which respond to internal and external pressures. The resulting interactivity and interdependency is characteristic of Complex Adaptive Systems (CAS) and generates emergent learning and adaptation (Begun, Zimmerman, & Dooley, 2003; Lichtenstein et al., 2006). Therefore, understanding the organization and the associated influences impacting this PoP establishes the context for the required change outlined in Chapter 2 and the change plan outlined in Chapter 3.

Organizational purpose. The primary purpose of the HC is to deliver acute hospital care and specialized health services for the city and the surrounding region. The HC provides

care for patients of all ages and is renowned for the provision of specialized services. The HC is recognized as an academic health sciences centre, a status achieved through affiliation with a faculty of medicine and at least one other health or professional school (e.g. nursing). The three main priorities of an academic health sciences centre such as the HC are patient care, well-trained specialized healthcare professionals, and research (National Task Force on the Future of Canada's Academic Health Sciences Centres, 2010). The HC's mission and vision reflect a commitment to patients, research and innovation which support the overarching goal to provide the best possible care for all patients. The determinants of best possible patient care, including quality, safety and experience, are largely influenced by the health professionals, including the Registered Nurses (RNs), who deliver the care.

One of the HC's corporate strategies targets the quality and quantity of learner experiences. Student placements are supported by affiliation agreements with more than one hundred academic institutions. Each year, the HC supports nearly five thousand student placements from a diverse array of academic programs. Approximately 2,000 of these placements are from nursing programs. Local university and college nursing programs, considered key academic partners, are given priority for available nursing student placements.

Another corporate strategy focuses on ongoing workforce development. Data from a recent nursing workforce analysis indicate that approximately one third of the entire HC workforce is comprised of nurses (n = 4239), of which more than two thirds are RNs (N=2984) (Health Centre, 2018). Each month, the HC hires an average of twenty new RNs to address both newly created positions and attrition. The ratio of new RN hires who are new graduates versus experienced staff is unknown. However, in the recent workforce analysis, the number of RNs with one year or less of service (n=424) likely includes a high percentage of NGRN (Health

Centre, 2018). Informal analysis suggests that NGRN represent a significant proportion of the HC's new hires, and, of these, many are graduates from the local community college or university programs. Thus, by offering learner placements, especially for nursing students, the HC is able to achieve workforce development goals.

Influencing factors. Organizations such as the HC are influenced by a variety of political, economic, social and cultural realities. These factors shape both the organization and the leadership.

***Political and economic factors*.** In Ontario, Canada, healthcare is publicly funded and represents 41% of total provincial government spending, of which hospital funding accounts for 36% (Financial Accountability Office of Ontario, 2019). In hospitals like the HC, more than 60% of the budget is spent on workforce compensation (Canadian Institute for Health, 2018). Although the HC supports student placements and orients new staff, the organization's mandate under the Canada Health Act is the provision of hospital care (Government of Canada, 1985), not education. The HC is funded by the Ministry of Health and Long-Term Care for services provided to patients and is accountable for the quality of those services (Ontario Ministry of Health and Long Term Care, 2018). In order to achieve the provincial government's balanced-budget targets, healthcare spending will need to be restrained with potential implications for healthcare access and quality (Financial Accountability Office of Ontario, 2019). The education activities undertaken by the HC are not linked to current funding models. This has potential, yet unknown, implications for hospitals and their employees, including RNs and NGRN.

Social and cultural factors. There is currently no standard definition of organizational culture. It is generally agreed that organizational culture is unique to each organization and refers to the pattern of shared values and assumptions created by a given group (Bellot, 2011).

In organizations, values, structure and processes interact to influence and shape culture (Elliott, 2015). Subcultures, or 'nested' cultures, may also exist within broader organizational culture (Bellot, 2011). This is evident at the HC where there is a large work force spread across several sites. There are slight variations in cultures at the individual hospital sites and, to a lesser extent, between departments within the hospitals. Through the orientation process, the more senior nurses assimilate new employees such as NGRN into the existing culture.

Many of the employee groups at the HC are unionized. The terms of RN employment are defined under the Ontario Nurses' Association (ONA) Central and Local Collective Agreements. Both agreements remain largely silent on the issue of the NGRN and practice readiness. Traditionally, hospitals have offered extended orientations to NGRN to support their transition to professional practice (Joswiak, 2018; Smyth, Pianta, & Perkins, 2018; Young, Stuenkel, & Bawel-Brinkley, 2008). At the HC, NGRN attend corporate nursing orientation, unit-based orientation, and then several weeks of one-to-one (also referred to as preceptored), unit-based training to support their transition to professional practice. Although the purpose of this orientation is to support the NGRN transition to professional practice, there is limited opportunity for them to determine their learning priorities or to provide feedback on this process. The need for and provision of this extensive orientation has a long history in the organization and is not challenged in the current culture.

Organizational structure and leadership approaches. The organizational structure of the HC reflects a traditional hierarchical structure. In collaboration with the Board of Directors, the Chief Executive Officer and senior leadership team establish the HC's strategic goals and priorities and then communicate these to the broader organization. Within the organization,

individuals are generally promoted to formal leadership roles based on their skills and behaviors, an approach which focuses on the leader rather than the follower (Northouse, 2019).

Inclusive leadership approaches which empower frontline staff are beginning to emerge at the HC through select initiatives. This leadership approach reflects "doing things with people, rather than to people" (Hollander, 2009, p. 3) and has the benefit of sharing decision making and promoting fairness. One example of this is a recently established enterprise-wide quality improvement process which enables front line staff to identify the need for and influence change within their respective programs. In this approach to quality improvement, leaders and their team members have equal voice in the identification of the problems to be addressed along with the possible solutions (Barnas, 2011).

The HC values the engagement and input of key stakeholders such as patients. Consequently, former patients and their family members are recruited to become Patient Advisors. In the role of Patient Advisors, individuals are provided opportunities to contribute their perspective to policy development and to various corporate initiatives. When designing new processes, patients' perspectives are also incorporated through an approach called experience-based co-design (Donetto, Tsianakas, & Robert, 2014). Using a series of tools and processes, this approach builds on patient experience and engages them in problem solving and solution design (Donetto et al., 2014).

Power differentials exist within the organization. The HC's leaders can exert their positional power through their formal positions and the associated control of rewards and resources. Nurses have access to information and decision-making that can wield power over patients (Henderson, 2003). However, the delivery of healthcare and the experience of patients can be enhanced when managers empower nurses (Mrayyan, 2004) and nurses advocate for and

empower patients (Newell & Jordan, 2015). Although these power imbalances still exist within the organization, the recent approaches implemented by the HC endeavour to be more inclusive and empower patients (through Patient Advisors and other initiatives such as electronic access to patient information) and frontline staff such as NGRN.

Organizational history. This HC originally began as several distinct hospitals. The existing corporation reflects an evolution that involved both mergers of the original hospitals as well as the development and expansion of new sites and services. Although each of the original hospitals provided a variety of general services, the mergers, along with the subsequent reorganization of programs, have resulted in site-based, specialized services.

Until the mid-1970's, nursing education used a hospital-based, apprenticeship model (Baker, 2014; Bramadat & Chalmers, 1989). Originally, two of the HC's hospitals offered nursing programs. In the 1970s, both of these programs were moved to the local community college. Although the HC no longer offers an accredited nursing program, there continues to be strong formal and informal connections with the local academic institutions that offer these programs. These relationships are a fundamental part of the organization being recognized as an academic health sciences centre. Likewise, as an academic health sciences centre, the HC's strategic goals continue to reflect the value of teaching and learning.

This section has established the organizational context of the NGRN practice readiness PoP at the HC. The organization's mission and strategic goals were identified. Social, cultural, political and economic factors which influence the organization were explored. Organizational structure and leadership approaches, along with a brief history of the organization have been reviewed. In this context, NGRN and patients wield limited power and are vulnerable stakeholders. The next section will further detail the HC's PoP.

Leadership Problem of Practice

The literature suggests that NGRN lack practice readiness. The associated deficits in knowledge, skills and judgment have implications for employers hiring NGRN. Currently, no infrastructure exists for academic institutions and healthcare employers to jointly address this issue. This section seeks to further define this PoP and articulate both the current and ideal state of NGRN practice readiness within a large academic health sciences centre such as the HC. Broader forces which influence this issue will be examined. Finally, this section will consider this writer's leadership position at the HC in relation to the specific PoP.

Practice readiness. The concept of NGRN practice readiness lacks standard definition and has been described as a 'nebulous construct' (El Haddad, 2016). In the literature, the approach to defining this construct varies. In some instances, contrast is used to define the concept. For example, Degrande, Liu, Greene, and Stankus (2018) identify that NRGN "through their educational preparation . . . have knowledge in managing entry-level, non-complex nursing situations . . . however, adult [Intensive Care Unit] ICU nursing practice requires in-depth knowledge of advanced assessment and technologies in managing life-threatening, complex nursing situations" (p. 72). In another example, Missen, Mckenna, and Beauchamp (2016) identify competent nurses as those with "the skills, experience and qualifications relevant to the area within which they are employed, [and who] demonstrate commitment to keeping those skills up-to-date, and deliver service that is capable, safe, knowledgeable, understanding, and completely focused on the needs of people in their care" (p. 144). It is implied that nurses without these skills lack competence.

In the literature, authors frequently attribute the lack of practice readiness to a gap between theory and practice (Romyn et al., 2009). However, other researchers have sought to

determine the specific skills which contribute to NGRN practice readiness. The results of several studies (Berkow, Virkstis, Stewart, & Conway, 2008; Casey et al., 2011; Casey, Fink, Krugman, & Propst, 2004; Hickey, 2009; Hopkins & Bromley, 2016; Missen, Mckenna, Beauchamp, & Larkins, 2016; Wolsky, 2014; Wright, 2014) have assessed the specific skills and attributes required for practice readiness and sought to determine possible alignment in the perspectives and expectations of nursing students, NGRN, faculty, and/or RNs who are staff or leaders in practice settings. This consensus approach remains problematic as it has been based on subjective perspectives rather than objective assessment. Despite the number of studies seeking to formulate such a list, no standard criteria for or definition of practice readiness has emerged.

Infrastructure. Currently, the HC and the local academic institutions which offer baccalaureate nursing degrees engage through a variety of formal committees and cross-appointed staff. Despite the existing collaborations, there is no existing infrastructure between the HC and the local academic partners in which to address NGRN practice readiness. The joint committees that currently exist between the HC and the academic partners focus on placement coordination, information sharing, and risk mitigation (e.g. preplacement e-learning requirements to address safety concerns). Although nursing students, NGRN and patients are key stakeholders in this process, none of these have representation or voice in the existing processes. Given the complexity of this PoP, if the HC addresses the NGRN practice readiness independently and in isolation from the respective academic partners and key stakeholders, the resulting structure and strategies risk not fully addressing elements of the educational process which may contribute to the current state.

Impact of the PoP. NGRN lack of practice readiness has a potential impact to patient safety. In their concept analysis, Mirza et al. (2019) found that practice readiness was related to the provision of safe care, performance confidence, and the ability to transition into the nursing role. By contrast, the assumption is that a lack of practice readiness can compromise patient safety. In one literature review examining the patient-safety knowledge and practices of NGRN, the authors concluded that the limited skills of NGRN may impact patient safety (Murray, Sundin, & Cope, 2018). Another study examined the work experience of NGRN in which participants revealed that they felt insecure and poorly prepared to deal with complex situations (Rhéaume, Clément, LeBel, & Robichaud, 2011). Similarly, in another literature review, eleven of the seventeen identified studies found that NGRN lack of experience was a barrier to interpreting signs of patient deterioration and responding appropriately (Purling & King, 2012). NGRN lack of experience has also been linked to adverse events (Ebright, Patricia, Urden, Patterson, & Chalko, 2004). Although the literature review by Murray et al. (2018) did not conclusively link practice readiness and patient safety, the other smaller studies by Purling and King (2012) and Rhéaume et al. (2011) suggest that a lack of practice readiness may be a potential risk to safe patient care. These concerns have also been echoed by the Institute of Medicine (2003). Ensuring that NGRN are practice ready and able to provide safe patient care is a priority for hospitals, including the HC.

Problem of Practice statement. The Problem of Practice (PoP) that will be addressed is the lack of New Graduate Registered Nurses' (NGRN) preparedness to deliver safe, quality patient care in acute healthcare settings such as the Health Centre (HC). Despite the rigor of the baccalaureate of nursing undergraduate education, the diversity of clinical practicums completed by students, and the Ontario requisites for registration as a nurse, many NGRN lack the

necessary knowledge, skills and judgment to deliver safe care in a complex and fast-paced environment. This lack of practice readiness results in NGRN angst, burnout, and, for some, a premature departure from the profession (Boychuk Duchscher, 2008). Furthermore, lack of preparedness may compromise patient safety (Ebright, Patricia et al., 2004; Murray et al., 2018; Purling & King, 2012). Currently, an extensive workplace orientation is required to support NGRN transition to practice and consumes significant HC time and financial resources. Both academic nursing programs and healthcare employers have a role to play in the delivery of nursing education and the NGRN transition to professional practice. What collaborative infrastructure between the HC, the academic partners, and the key stakeholders would provide a venue to engage in discourse and begin addressing the NGRN practice readiness gap?

Framing the Problem of Practice

The NGRN practice readiness gap exists within the broader context of the HC and the HC's local academic institutions. In order to fully comprehend the lack of NGRN practice readiness, the PoP must be situated within the relevant historical and structural context (Kellner, 2003; Popkewitz, 1980; Stevens, 1989). This section will consider the historical background, provide a political, economic, social, technological and environmental (PESTE) analysis, and identify a theoretical frame through which to view and understand the factors influencing this PoP.

Historical overview and literature review. In Canada, nursing education began as a hospital-based, apprenticeship model and continued in this format until the mid-1970s (Baker, 2014; Bramadat & Chalmers, 1989). The impetus to change this model began many years prior. In 1932, the Survey of Nursing Education in Canada (also known as the Weir Report) recommended that nurse preparation should be transferred from hospitals to the general

education system. This report also recommended that nursing education should be at the degree level and include both liberal arts and technical components (Pijl-Zieber, Grypma, & Barton, 2014). In Canada, the baccalaureate degree in nursing eventually became the entry-to-practice requirement in 2005 (Council of Ontario Universities, 2010). Thus, the responsibility of nursing education was shifted from hospitals to academic institutions.

This shift of nursing education from the hospitals to the academic institutions corresponded with the attempt to develop nursing as a science. Consequently, knowledge and science were regarded more favourably than bedside skills, and "knowing became more valuable than doing" (Wilson-Thomas, 1995, p. 569). Nursing education, like other forms of education, defines relationships and thus serves to perpetuate values, beliefs, and social order (Duffy & Scott, 1998; Wilson-Thomas, 1995).

Some have attributed the NGRN practice readiness gap to this transition of education from the hospitals to the academic institutions (Burns & Poster, 2008). Others have hypothesized that "this apparent delineation of educational responsibility is contributing to the problem, or possibly even driving it" (El Haddad, Moxham, & Broadbent, 2017. p. 273). As nursing education has shifted to the academic institutions, healthcare employers have continued to remain participants in nursing program delivery, primarily by providing the clinical placements which remain a critical and required component of the overall nursing curricula (Canadian Association of Schools of Nursing, 2014). In this current state, those organizations which provide healthcare services, such as hospitals, offer a diversity of experiential learning opportunities that allow nursing students to apply their knowledge and to develop and progress toward achievement of the requisite entry-to-practice competencies (College of Nurses of Ontario, 2019).

This historical transition of nursing education from hospitals to academic institutions created a chasm between these two types of organizations (Beal, 2012). More recently, interest in addressing workforce issues has led to an increased willingness to partner (Barger & Das, 2004). Benefits of partnerships between academic institutions and healthcare providers include access to resources (e.g. faculty, clinical placements), improved curriculum, and improved research opportunities; benefits which can help to bridge the gap between theory and practice (Sadeghnezhad, Heshmati Nabavi, Najafi, Kareshki, & Esmaily, 2018). In addition, evidence of a successful partnership to address NGRN practice readiness has been reported in the literature (Trepanier, Mainous, Africa, & Shinners, 2017).

PESTE analysis. A PESTE analysis can be used to identify additional contextual influences impacting a PoP (Cawsey, Deszca, & Ingols, 2016).

***Political*.** The Nursing Act 1991 (Government of Ontario, 1991a), under the Regulated Health Professions Act 1991 (Government of Ontario, 1991b) delegates responsibility to the College of Nurses of Ontario (CNO) to establish criteria for the registration of nurses and to outline scope of practice. The CNO subsequently delegates responsibility for academic program accreditation standards and program approval of the collaborative nursing programs to the Canadian Association of Schools of Nursing (CASN) (Kirby, 2007). The accreditation standards established by CASN (Canadian Association of Schools of Nursing, 2014) stipulate that "the curriculum prepares graduates with general, foundational knowledge in the humanities, sciences, and social sciences, necessary for professional nursing practice, and for preparing graduates to address current and emerging needs of society" (p. 23). Consequently, nursing baccalaureate programs design their curricula to prepare nurses to be generalists, not specialists. Thus, NGRN commence their professional practice with a diversity of skills that are transferable to a variety of

practice settings, but are not fully trained for any specific practice area, e.g. public health or acute care. Post-graduate continuing education programs offer additional specialization (e.g. perioperative nursing), but RN status is generally the admission requirement for these courses.

***Economic*.** Traditionally, hospitals have offered extended orientations to NGRN to support their transition to professional practice (Joswiak, 2018; Smyth et al., 2018; Young et al., 2008). This approach is not consistent across hospitals and the return on investment of this approach has not been fully evaluated. Historically, the provincial government has also provided funding to support NGRN transition to professional practice. HealthForceOntario provides funding, often referred to as the New Graduate Guarantee, to support new graduate transition through extended orientations (Health Workforce Planning Branch, 2018). The funding includes twelve weeks of paid orientation time for the new graduate and another eight weeks of funding for the employer to reinvest in existing frontline staff. In recent years, this funding has decreased and the criteria to receive funding have become more difficult to meet. Under the Canada Health Act, the HC is a facility which provides hospital care (Government of Canada, 1985) and is not funded for education. With tenuous funding available to support NGRN initiatives and ongoing provincial fiscal restraint in healthcare, extended orientations to support NGRN transition remain a costly choice for hospitals.

Social. Many NGRN are enculturated to the HC and professional practice through student placements. Not all unit cultures are welcoming and supportive of students and NGRN (Gillespie, Grubb, Brown, Boesch, & Ulrich, 2017). Nursing staff's actions, attitudes and willingness to teach can have a positive or negative impact on students' and NGRN's learning and confidence (Rush, Adamack, Gordon, & Janke, 2014; Webster, Bowron, Matthew-Maich, & Patterson, 2016). Consequently, the process of socialization that occurs during clinical

placements and the NGRN orientation to professional practice also has the potential to impact practice readiness.

Technological. Virtual care, robotics and use of big data are three examples of emerging technologies used in healthcare. Today's NGRN require expertise in both traditional nursing as well as new healthcare and information technology systems. Entry-to-practice competencies are intended to reflect the level of critical thinking and nursing knowledge required for advancing technology (Council of Ontario Universities, 2012); however, they fail to keep pace with the breadth and depth of new technology required for practice.

Environmental. The NGRN must be prepared to manage increasing patient acuity and complexity, decreasing length of patient stay, and advancing technology (Benner, 1982). The complexity of the work environment contributes to the practice readiness gap (Romyn et al., 2009). Although practice readiness is often described as an educational issue, it has also been recognized as "more of a larger systems level problem" (Romyn et al., 2009, p. 6). The current healthcare environment is complex and requires NGRN to be able to interact with a diversity of healthcare professionals, appreciate the myriad of policies and standards informing care delivery, and manage multiple stressors while delivering high quality care to patients and their families.

These political, social, economic, technological and environmental factors influence and contribute to this PoP.

Leadership Position and Lens Statement

The bulk of literature on practice readiness and academic-service partnerships focuses primarily on the academic institutions, the healthcare employers, and, to some extent, the nursing students and NGRN. Minimal attention has been given to the most vulnerable stakeholder in this PoP – the patient. For this OIP, it is important to select a theoretical frame that will provide a

lens that supports the perspectives of all stakeholders, especially those most vulnerable. While theories such as feminist or critical race theory, for example, view the world from gender and race perspectives respectively, a theory which offers a broader lens is needed.

Overarching theory. Critical theory originated from the philosophers at the Institute of Social Research in Germany, also known as the Frankfurt School, in the 1920s and 1930s (Boychuk Duchscher, 2000). A key tenet of this theory is the idea that by "explaining and critiquing the social order, critical science serves as a catalyst for enlightenment, empowerment, emancipation, and social transformation" (Browne, 2000, p. 39). For Habermas, one of the early theorists, the central aims of critical theory are to expose power relationships and act to bring about social change (Duffy & Scott, 1998). For this OIP, critical theory as an overarching theory is useful in elucidating the values and beliefs which inform and construct interactions between key stakeholders (Boychuk Duchscher, 2000).

Critical theory has been previously applied to examine forces influencing nursing (Boychuk Duchscher, 2000; Browne, 2001; Mosqueda-Diaz, Vilchez-Barboza, Valenzuela-Suazo, & Sanhueza-Alvarado, 2014; Wilson-Thomas, 1995) and their oppression as a group (Bent, 1993). Critical theory recognizes that oppression exists in every society and critique can reveal the structures and ideologies which perpetuate this current state (Browne, 2001). Use of critical theory in this OIP can support the identification of power imbalances and allow social change through empowerment. At present, nursing students, NGRN and patients are 'oppressed' and their voices silenced. This theoretical lens suggests that their 'voice' needs to be heard and acknowledged.

The process of nursing education results in many graduates feeling insecure and poorly prepared to deal with complex patient scenarios (Rhéaume et al., 2011) as well as lacking the

skills required to interpret and respond to deteriorating patients (Purling & King, 2012). Furthermore, literature also indicates that NGRN lack of experience is linked to adverse events (Ebright, Patricia et al., 2004) and increased risk of committing medication errors (Soletti, Bailey, Smith, & Hirvela, 2014). From this perspective, patients can be viewed as a vulnerable group. Thus, social critique reveals the power and control that nurses, including NGRN, wield over patients. Through the lens of critical theory, it is apparent that it is the patients who are disadvantaged. This critical theory lens thus offers a perspective which can act as a catalyst toward future change and empowerment of patients.

The role of critical leadership is to critique "hidden sources of coercion, power-over, and domination that are embedded in the everyday lived experience of the fact world" (Thompson, 1987, p. 34). The aim is to make constraints, assumptions and power relations transparent (Wilson-Thomas, 1995). The nursing students and NGRN are central to this PoP. Therefore, critical leadership is learner-centric and considers how decisions and change plans will advance the interests of these groups (Elliott, 2015).

Leadership lens. This writer, who is also the Change Leader (CL) of the proposed OIP, is a manager at the HC with oversight of student placements, academic relations, and corporate level nursing orientation. This manager role is positioned within the Quality Portfolio which includes leadership for quality improvement, Patient Advisors, nursing practice, and interprofessional staff education. For a diagrammatic representation of this organizational structure, refer to Appendix A.

The CL's formal role has limited positional power. Although the CL is an employee of the HC, the manager's role is jointly funded by the HC and the local academic partners. Thus, the shared funding of this writer's position enables a position of influence in the HC and with the

respective academic partners. The CL is familiar with the nursing undergraduate program, both as a former graduate and, more recently, as part-time, sessional faculty. Through both personal experience and mentoring of NGRN, the CL has first-hand experience with the challenges encountered during the transition to professional practice. These roles and relationships situate this CL in an ideal position to implement this OIP.

The CL views leadership as "the dynamic process of helping people together make sense of what is, imagine what could be, and act to shape the future" (Health Centre Leadership Development Program, 2017, p. 1). This definition informs and shapes the CL's leadership perspective and practices. Furthermore, this definition aligns closely Hollander's (2009) work on inclusive leadership as well as with that of Kotter (2012) who describes leading change. There are a number of leadership theories and approaches available. Personality traits, experience and professional development influence which one a leader will employ (Hollander, 2009). In particular, as an authentic leader, the CL will draw from inclusive leadership theory and incorporate principles of influence, collaboration theory and adaptive leadership.

Authentic leadership. Authentic leadership was introduced to the academic world by Luthans and Avolio (Avolio, Walumbwa, & Weber, 2009) and to the general populace by George (George, 2003). Authentic leadership theory arose out of transformational leadership and conceptualizes the leader as well as the followers and the context. According to George (2003), authentic leadership is "being yourself; being the person you were created to be" (Loc 227). Authentic leadership encompasses four constructs: balanced processing, internalized moral perspective, relational transparency, and self-awareness (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008). Simply stated, authentic leaders consider key information prior to

forming decisions, are guided by internal moral standards, demonstrate one's feelings and are cognizant of their own strengths and weaknesses (Avolio et al., 2009).

Authentic leaders are mindful of their own values and beliefs and act on them (Northouse, 2019). Based on this awareness, these leaders better appreciate how they influence others and adjust their interactions as required to lead and motivate others (Walumbwa, Christensen, & Hailey, 2011). Through balanced processing, authentic leaders collect, assess, and review available data prior to making decisions (Walumbwa et al., 2008). Therefore, a multiplicity of perspectives is welcome. This approach aligns well with what critical theory has previously highlighted: namely, the need to empower patients, nursing students, and NGRN. The characteristics of authentic leadership synthesize well with other selected approaches: inclusive leadership, principles of influence and collaboration theory.

***Collaboration theory*.** Developed by Huxam and Vangen, collaboration theory is based on social action research involving public and community inter-organizational collaborations (Huxam & Vangen, 2000). Addressing this PoP will require the CL to influence processes and structures both within the HC and with the external academic partners. In the latter setting, the CL does not have formal power or authority. Collaboration theory conceptualizes the activities of both the leaders and the participants involved in a partnership and focuses on the strategies required to influence others when direct authority is not an option (Vangen & Huxham, 2003). However, this theory does not address the specific processes required to implement and manage change**.** Overall, collaboration theory offers leaders two methods of influence which are oppositional to one another. The first, positive influence, includes embracing, engaging, empowering and mobilizing partners (Vangen & Huxham, 2003). The second, which this writer

choses to reject for its possible negative consequences overall, is termed ‘collaborative thuggery’ and involves manipulation, coercion and ‘playing the politics’ (Vangen & Huxham, 2003).

Inclusive leadership. Inclusive leadership, like collaboration theory, is an emerging theory. This OIP will utilize the work done in this area by authors Hollander (2009) and Wuffli (2016). Addressing the complex issue of NGRN practice readiness will require collaboration with academic partners. Thus, inclusive leadership theory will be one of the leadership approaches utilized in this OIP. Inclusion is achieved through dialogue with others i.e. connecting, listening, learning and educating, including dialogue with individuals and groups whose voices, such as those of patients, are not normally heard (Ryan, 1999). Inclusive leadership has been touted as a “superior way to align aspirations, solve problems, mobilize and motivate people, and ensure quality in decision-making and control” (Wuffli, 2016, p. 140).

Influence. The definition of leadership provided earlier refers to the concept of ‘people together’, one which embraces collaboration and inclusion. Principles of influence (Cialdini, 2001) will be used to guide the process of gathering group members together and establishing ongoing working relationships. Key principles of influence such as legitimate expertise, social proof (e.g. other successful academic-service partnerships), and voluntary commitments from partners and stakeholders can result in decisions that will benefit all (Cialdini, 2001), including the NGRN and the patients.

Adaptive leadership. The work on adaptive leadership has been largely credited to Heifetz (Northouse, 2019). Adaptive leadership theory focuses on how leaders lead people in the context of change (Northouse, 2019). Both collaboration theory and adaptive leadership involve the use of influence, irrespective of whether the focus is individuals or broader processes and structures. Although collaboration theory identifies strategies to support change, it lacks clear

processes. In contrast, adaptive leadership theory offers strategies and processes. Thus, both collaboration theory and adaptive leadership will be used to provide complementary approaches.

According to adaptive leadership theory, issues which are not clear cut, not easy to identify, and cannot be solved by leader's authority alone are labelled as adaptive challenges (Northouse, 2019). This approach highlights the importance of stakeholder engagement and use of influence, problem diagnosis and subsequent system mobilization to address the problem (Thygeson, Morrissey, & Ulstad, 2010).

Critical theory emphasizes the importance of achieving a rational, non-distorted consensus and problem solving through unconstrained dialogue and conversation (Duffy & Scott, 1998). These leadership theories and approaches presented above complement one another, reflect and value involvement of key stakeholders, and do so using informal power and influence. Therefore, these selected approaches and associated concepts align with the overarching goal to facilitate collaboration with academic partners, nursing students, NGRN and patients in order to address the NGRN practice readiness gap.

Guiding Questions Emerging from the Problem of Practice

The NGRN lack of practice readiness is a PoP that directly impacts the HC and the provision of safe, quality patient care. This PoP is confounded by the myriad of factors which contribute to and perpetuate both the development of the NGRN lack of practice readiness. The interconnectedness of the key stakeholders and the ever evolving landscape of healthcare create further complexity. Despite this interconnectedness, currently no infrastructure exists wherein stakeholders can collectively address this PoP. From this complexity, several questions emerge. Those which have been instrumental in guiding the development of this OIP will be reviewed.

The first question emerging from the POP asks, “As a leader with limited formal authority, how might this writer use their agency and voice to expose power imbalances and constraints preventing nursing students, NGRN and patients from fully participating in decisions and processes that shape the NGRN transition to professional practice?” Currently the HC has an established quality improvement process to support organizational excellence. This approach encourages the individuals most closely involved in operational issues to be those who are also involved in the processes of defining the problems and identifying potential solutions. In another parallel initiative, the HC has begun to integrate Patient Advisors in order to include their perspective in corporate initiatives. Patients, as recipients of the care delivered by NGRN, are key stakeholders and should therefore be included in this OIP and the resulting solution. Nursing students and NGRN, as potential future HC employees, are also key stakeholders. The resulting solution will need to offer more than a cursory consultation, but rather enable full, equitable participation and contributions of Patient Advisors along with nursing students and NGRN. Nursing students, NGRN and patients need to be seen as having the right to fully engage with leaders and educators (Kellner, 2003).

The second question guiding the development of the OIP is this: What approach to this PoP will support progressive social change to nursing education and enable NGRN to competently navigate the current complexities in acute healthcare competently? The local academic nursing programs are key stakeholders in this PoP. These academic partners are required to offer nursing curricula that meets accreditation standards (Canadian Association of Schools of Nursing, 2014), even though this may not ‘produce’ the graduate sought by employers such as the HC. The academic partners have different organizational structures, missions and cultures from the HC. For the HC, the development of practice-ready graduates is

becoming a greater priority in the current context of decreasing financial resources, increasing patient complexity and advancing healthcare technology. As these disparate organizations work together to identify and achieve common goals, there is a risk that NGRN will be viewed as a 'product'. Therefore, assumptions regarding whose interests are being served and who is constructing and maintaining barriers will need to be exposed (Thomas, 1995). Importantly, the identified solution needs to do more than simply advance these organizations' respective agendas. The overarching goal is to seek a solution which advances educational change and promotes the interests of patients, nursing students and NGRN.

The third guiding question asks, "What are the processes and structural elements of the current educational system which need to be addressed?" There are multiple initiatives reported in the literature seeking to decrease the gap between education and professional practice (e.g. through extended orientations, preceptor development, and expanded student placements). These approaches are commonly delineated according to the respective institutions: either by the academic program or healthcare employer. Identifying how relationships and processes have evolved historically is necessary to appreciating which elements can be modified and influenced (Popkewitz, 1980). Determining an approach to the development of a collaborative structure requires an understanding of which of the organizational components are subject to disruption or transformation. The success of this OIP will be dependent on the identification and removal of the instrumental structures which disempower the nursing students, NGRN and patients.

These questions posed above will shape the development of this OIP and the leadership-focused vision for change.

Leadership-Focused Vision for Change

In this section, the gap between the current and envisioned future state will be described along with priorities for change.

Current state. In Ontario, the baccalaureate of nursing programs produce generalists who are expected to achieve the established entry-to-practice competencies (College of Nurses of Ontario, 2019). Although the training prepares them with a breadth of knowledge, skills and judgment, NGRN are not able to function independently when they first enter practice in an acute health care setting (Romyn et al., 2009). The increasing complexity of healthcare environments coupled with the dwindling resources to support hospital-based orientation and training further contribute to the NGRN practice readiness gap (Spiers et al., 2010). While the programs are purported to graduate students who have achieved the entry-to-practice competencies, there is no formal summative assessment of the individual students with respect to this outcome. Despite successful completion of both a baccalaureate degree in nursing and the requisite registration exam, many NGRNs are unprepared to deliver acute nursing care in hospital-based employment. In the current state, NGRN require extensive orientation to acute hospital care which consumes significant HC human and financial resources. This lack of practice readiness disempowers the NGRN as they transition into professional practice.

The existing partnerships between the HC and the academic institutions are primarily focused on student placements. This is reflected in the affiliation agreements which exist between the HC and the academic partners and are limited to the provision of placement opportunities and associated liability and insurance coverage requirements. In its role as an academic health sciences centre, the HC provides a diversity of clinical placements for undergraduate baccalaureate nursing students. This diversity of experiences, however, results in

inconsistent opportunities for nursing students to attain the knowledge, skills and judgment necessary for competent practice in all clinical areas. Despite the provision of clinical placements, the opportunity for healthcare employers, such as the HC, to speak to the prioritization, ideal sequencing and use of available placements is extremely limited. An additional barrier is the lack of opportunity for NGRN, patients, the HC and other healthcare employers to provide input into the competencies required for NGRN who will eventually be employed in acute care settings.

Envisioned future state. The envisioned future state for the HC and the respective academic (nursing) institutions would be a collaborative partnership, often referred to as an Academic-Service Partnership (ASP) in the literature. The structure of this partnership will enable mutual decision-making regarding variables influencing competency attainment and development of joint initiatives aimed at improving and enhancing NGRN transition to professional practice.

NGRN will continue to require traditional nursing skills (e.g. wound dressings, physical assessment), but will also need to be adept at using new healthcare and information technology systems. Healthcare is evolving and will continue to do so. In an ideal state, both healthcare employers' and academic educators' collaborative efforts would support a curriculum that is evolving at a pace equal to or faster than that of changes occurring in the practice setting.

The patients, their families, nursing students and NGRN are key stakeholders. Inclusive leadership seeks to incorporate the interests of stakeholders such as patients and the NGRN (Hollander, 2009). In the envisioned future state of this partnership, no side will be privileged (Habermas, 1970, p. 371); the presence and voice of patients, nursing students and NGRN will be accorded equal status with the input from the academic partners and the HC. Studies indicate

that there is correlation between NGRN education and preparation for professional practice and patient outcomes (DeBourgh, 2012; Liao, Sun, Yu, & Li, 2016). Therefore, patients have a vested interest in ensuring that NGRN are prepared to deliver safe, quality care. The NGRN have been interviewed in research studies pertaining to the practice readiness gap (e.g. Ebright, Patricia, Urden, Patterson, & Chalko, 2004) and there are a multitude of studies examining possible approaches to address this gap (e.g. Draper et al., 2014; Tilley et al., 2007). None of the literature indicates that nursing students or NGRN have ever been included in the problem definition or identification of possible solutions. Allowing patients, nursing students and NGRN an opportunity to participate in the decision making process will empower them to influence their care and working environments respectively.

The literature suggests that there are multiple variables which contribute to NGRN lack of practice readiness. Correspondingly, the literature reports a variety of possible interventions. No single approach emerges from the literature as the remedy to resolve this practice readiness gap. Consequently, the vision of this OIP is not to propose a series of discreet solutions, but rather, to establish structures and processes between the key stakeholders (i.e. the HC, the academic partners, nursing students, NGRN, and patients) that will provide a venue to identify, explore, implement and evaluate potential solutions. In the literature, academic partnerships have effectively supported staff development, clinical education, evidence-based practice, sharing of resources, and programs to transition NGRN to the professional practice setting (De Geest et al., 2013; Jones-Bell et al., 2014; Nabavi et al., 2012). Consequently, an expanded partnership that also involves nursing students, NGRN and patients could provide the forum to identify system constraints as well as strategize and implement potential solutions to address NGRN practice readiness.

Priorities for change. The NGRN lack of practice readiness is a complex issue with literature suggesting multiple possible approaches. There is no evidence in the literature of a comprehensive approach that would eliminate this PoP. This lack of definitive solution further indicates the need to consider a systems-level, structural approach empowering all stakeholders. Given the ongoing fiscal constraints in healthcare, the HC, in conjunction with the local academic partners, must seek innovative approaches to better prepare NGRN. Thus, the priority for change will be engaging and empowering NGRN and patients in the co-creation of the structure and processes required to identify, prioritize, implement and evaluate possible solutions to this PoP.

Organizational Change Readiness

The discussion of the PoP has focused on the required change. The work of the CL involves managing both the change itself and the respective change conditions (Soparnot, 2011). Facilitating change requires consideration of the internal and external forces shaping the change as well as the context of the planned change. Understanding both the context and conditions of the change requires assessment of organizational change readiness. Weiner's (2009) theory of organizational readiness for change appreciates the broader organizational factors and will be used to assess the HC's readiness for change. Subsequently, change drivers influencing the change will be examined.

Theory of organizational readiness for change. While some change readiness scales assess individual attributes (e.g. Holt, Armenakis, Feild, & Harris, 2007), in this OIP it is important to appreciate the broader organizational factors. From a critical theory lens, understanding how the organizational systems interrelate informs practical actions (Popkewitz,

1980). Weiner's (2009) theory of organizational readiness for change (as depicted in Figure 1) will be used to assess the HC's motivation to address this PoP.

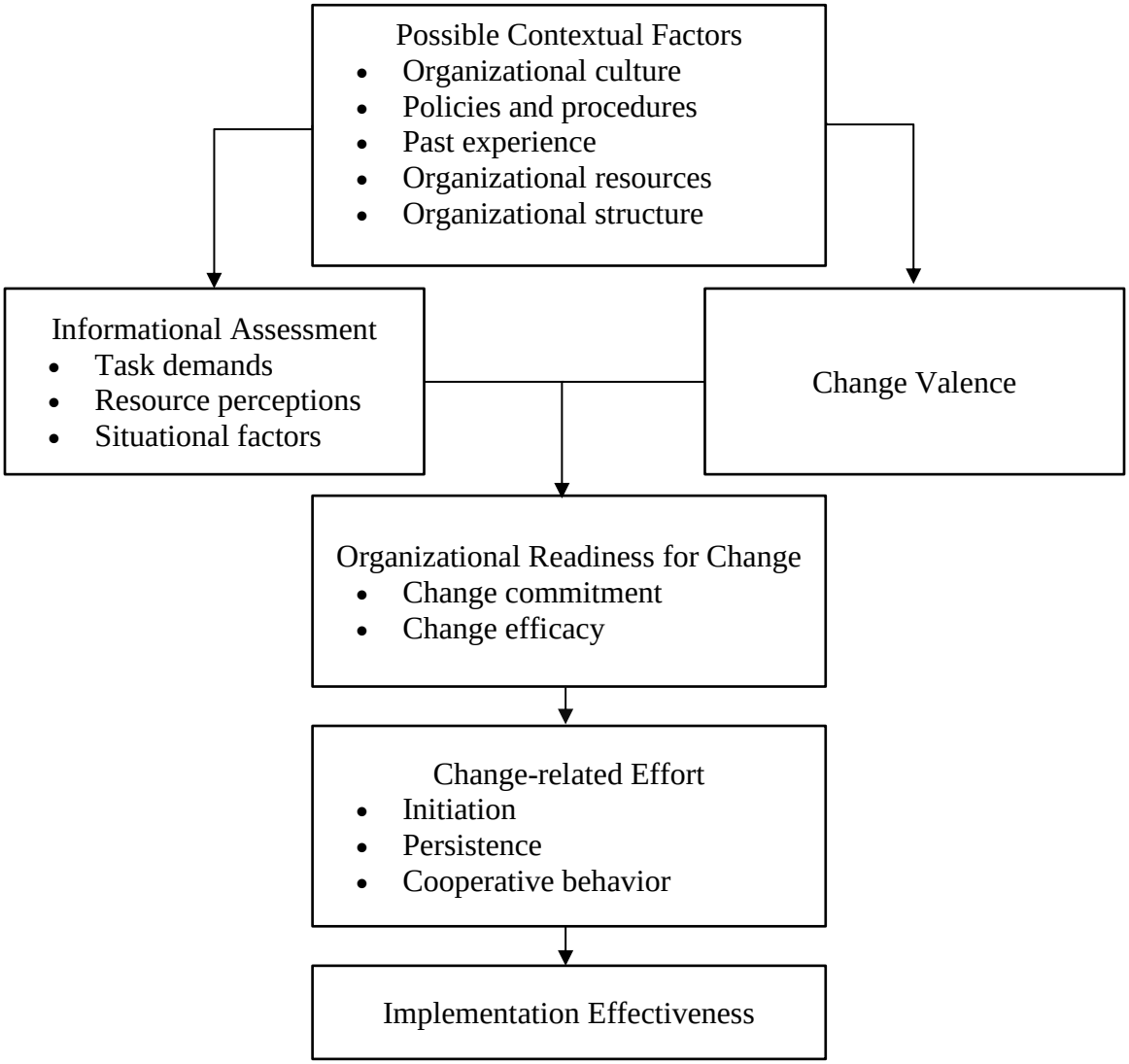


Figure 1. Determinants and outcomes of organizational readiness for change. Adapted from "A theory of organizational readiness for change," by B. J. Weiner, 2009, *Implementation Science, 4*(1), p. 70. Copyright 2009 Weiner; licensee BioMed Central Ltd.

According to Weiner (2009), there are two key determinants of organizational readiness: change commitment and change efficacy. Change commitment is defined as the "shared resolve" and change efficacy as the "shared beliefs in their collective capabilities to organize and

execute the courses of action involved in change implementation" (Weiner, 2009, p. 68). Both definitions reference the collective rather than the individual perspective. The value of the change, referred to as change valance, and the informational assessment (i.e. task demands, resource perceptions and situational factors) informs the subsequent commitment and efficacy (Weiner, 2009). Weiner (2009) also takes into account the contextual features (e.g. organizational resources) that other authors assess when considering change readiness (Cawsey et al., 2016), but acknowledges that it is the perceptions of these features that inform the collective members' assessment, not their presence alone. This theory postulates that this assessment subsequently results in the relative change effort and effectiveness (Weiner, 2009).

For this OIP, it is important to consider the possible contextual factors, and where feasible, identify the collective value assigned to these and the manner in which they inform the task demands, resource perceptions, and situational factors. Factors which contribute to the context of this change include the HC's values, culture, organizational structure, and current working relationships with the academic partners. Consideration of HC's past and present experience with change will also inform the members' perceptions and assessment of organizational change readiness.

As an organization, the HC emphasizes both strategy and innovation when addressing challenges that face the organization. The organization's values and current strategy identify the importance of both student placements and workforce development as mechanisms to support the HC's overarching mission. These contextual factors thus support the need to have NGRNs well prepared to deliver acute nursing care at the HC.

Organizational structure shapes perception of organizational readiness (Weiner, 2009). Within the HC, the organizational structure, and specifically the Quality Portfolio, is well aligned

to support an OIP which addresses NGRN practice readiness. The vice-president and directors within this portfolio support initiatives that will involve collaboration with the academic partners and decrease the practice readiness gap. More importantly, this leadership group is committed to empowering frontline staff such as the NGRN and Patient Advisors. Other leaders within this portfolio are responsible for initiatives which align with this PoP, i.e. the New Graduate Guarantee, corporate and nursing orientation, professional practice orientation, and Patient Advisors. This organizational structure therefore provides the structure and support necessary to implement this OIP. Furthermore, research suggests that alignment of leadership across hierarchical levels is also related to successful change implementation (O'Reilly, Caldwell, Chatman, Lapiz, & Self, 2010).

Working relationships is another contextual aspect to consider in this analysis. For the considered change, the key relationships to assess are those between the respective academic nursing programs and the HC. At the present state, the HC is engaged with academic partners in a variety of formal and informal initiatives. However, there is currently no structure which encompasses all the stakeholder groups identified in this OIP. Specifically, there is currently no environment in which the nursing students, NGRN and patients are empowered to participate as equals. The existing organizational working relationships suggest there is a foundation upon which to build future partnerships. The effort required to build such a partnership and the value of this to each of the other organizations is presently unknown.

Past and present experience with change can also shape perceptions of organizational readiness (Weiner, 2009). The HC has been involved in many change initiatives at all levels of the organization. In the past few years, one of the corporate change initiatives is the implementation of a continuous quality improvement process which enables front line staff

involvement in both problem definition and solution identification. This approach supports a culture of empowerment and inclusion. Similarly, the creation of the Patient Advisor role has increased the voice of patients across the organization. Consequently, involving key stakeholders and/or patients has been normalized as an approach to change. Thus, involving NGRN, nursing students and Patient Advisors in an OIP addressing NGRN practice readiness would be well received.

Organizational members perceive the organization's capability to implement change, also referred to as the change efficacy, by considering the required tasks, available resources and other situational factors (Weiner, 2009). Questions that inform this perspective include: what will it take to implement the change effectively; does the organization have the required resources; and can we implement the change given our current circumstances (Weiner, 2009)? The common adage that 'the only thing constant is change' captures the experience of leaders and staff at the HC. In healthcare, change is pervasive and there is a need to be cognizant of potential for change fatigue and the associated apathy and disengagement of staff (McMillan & Perron, 2013). Currently, the HC is in the early phase of implementing several large change initiatives that will impact resources, infrastructure and care delivery models. The question of leadership capacity for both ongoing and new change initiatives is being raised by senior executives and leaders alike. Preliminary discussion suggests that the ability to support additional change initiatives will depend on whether or not the associated work and outcomes will support key strategic priorities and build further capacity within the overall system. Given the competing priorities, there is a risk that members will perceive the HC as unable to support additional change initiatives such as this OIP. This OIP aligns with two of the key strategic priorities noted in Chapter 1: quality and quantity of learner experiences and ongoing workforce

development. Thus, clear articulation of the required resources and courses of action to address NGRN practice readiness will be essential to ensuring that stakeholders are able to see the alignment between available and required capabilities.

From a valence and efficacy perspective, the HC is change ready. There is value to the proposed change given the alignment with other corporate strategies. In the assessment of change readiness, identified areas of strength include organizational values, structure, and working relationships. In particular, this OIP will continue previous efforts to empower staff and patients. Given the ongoing change within the HC, there is a risk that change efficacy is deemed inadequate. Thus, identifying and clearly articulating the required tasks and resources will be essential to determining actual capacity.

Change drivers. The term 'change drivers' refers to those factors which facilitate change implementation within an organization (Whelan-Berry & Somerville, 2010). This concept of change drivers can be further differentiated into those factors which necessitate the change and those which enable the process for and adoption of change (Whelan-Berry & Somerville, 2010). A shift in the external environment or the marketplace is often the catalyst for change (Anderson & Ackerman Anderson, 2001). In the context of this OIP, and as previously discussed, the catalyst is multi-factorial and has evolved from the generalist-focused academic program for RNs, the increasingly complex healthcare environment, and the fiscal constraints limiting workplace training for NGRN.

The change required to address NGRN lack of practice readiness will require an appreciation of the forces necessitating change as well as those that will influence the process and adoption of change. These drivers can vary depending on the organization and the type of change (Parry, Kirsch, Carey, & Shaw, 2014; Whelan-Berry & Somerville, 2010). These

enablers include leadership, communication, stakeholder engagement, and alignment of organizational structure and processes.

Leadership. A key enabler of change is a clear, compelling vision that is mutually accepted by all stakeholders (Whelan-Berry & Somerville, 2010). In order for the change to be successful, commitment and support for the change plan must be evident across the organization and be demonstrated through leaders' active involvement and provision of necessary resources (O'Reilly et al., 2010; Whelan-Berry & Somerville, 2010).

Communication. Communication is an essential driver throughout planned change. Initially, communication is used to assist stakeholders to appreciate why the current state is no longer acceptable (Whelan-Berry & Somerville, 2010). Communication through information sharing and listening to stakeholders facilitates understanding and engagement.

Stakeholder engagement. Participation of key stakeholders in the change plan process facilitates an understanding of the needed change and the development of change champions (Whelan-Berry & Somerville, 2010). Including end users in problem solving has had a demonstrated impact on healthcare improvements (Donetto et al., 2014) and is an approach already adopted by the HC. For this OIP, this engagement will include Patient Advisors, nursing student and NGRN representation as well as the academic partners.

Alignment of organizational structure and processes. Factors which sustain planned change are organizational structures and processes which are aligned with the desired outcome (Whelan-Berry & Somerville, 2010). This includes human resources practices and organizational policies and process. Within the HC, the organizational structure currently aligns key leaders who are committed to this change plan. However, between the HC and the academic

partners there is an absence of formal structure and process to address NGRN practice readiness. Establishing this structure is a key focus of this OIP.

Change drivers are those "events, activities or behaviors" (Whelan-Berry & Somerville, 2010, p. 176) which can influence change. A changing healthcare environment has exacerbated the NGRN lack of practice readiness. As this PoP spearheads the need for change, the CL needs to be aware of those activities and behaviors that can influence the implementation and adoption of the change plan. Specifically, the CL needs to effectively utilize those forces within the organization which will create pressure for change (Cawsey et al., 2016). Based on the assessment of organizational readiness and change drivers, influences for change include the HC's leadership, existing communication platforms, culture of stakeholder engagement, and alignment of organizational structure and processes within the HC. Through identification of these change drivers, the CL can determine when and how to best apply these change drivers to support the success of the change plan.

Chapter summary. In this chapter, the NGRN lack of practice was introduced as a leadership PoP to be addressed. An organizational analysis of the HC reviewed the variables influencing this PoP and established the organizational readiness for change. Critical theory provides an overarching theoretical perspective and highlights the need to empower NGRN, nursing students, and patients in this process. The theories which inform and guide the leadership lens have been discussed. Finally, both the current and future envisioned states have been described. Establishing the PoP within the broader contextual factors sets the foundation for the next stage of the OIP, planning and development of the change plan, and which will be the focus of Chapter 2.

Chapter 2: Planning and Development

In the previous chapter, New Graduate Registered Nurses (NGRN) lack of practice readiness was introduced as a Problem of Practice (PoP) impacting the Health Centre (HC). To fully appreciate this PoP, the organizational context and change readiness was described. In this next chapter, the plan to address NGRN practice readiness will be explored through the leadership approach to change and the framework for leading change. Based on a critical organizational analysis, possible solutions will be explored. Finally, the ethical implications for the selected leadership and organizational change approach will be explored.

Leadership Approach to Change

This Organizational Improvement Plan (OIP) will utilize an array of leadership approaches to propel the required change including both authentic and adaptive leadership. Additionally, principles of inclusive leadership, influence and collaboration theory will inform the leadership practices.

Authentic leadership. Authentic leadership is this writer's preferred leadership style and consequently informs the approach to this OIP. Authentic leadership has been defined as "a pattern of leader behavior that draws upon and promotes both positive psychological capacities and a positive ethical climate, to foster greater self-awareness, an internalized moral perspective, balanced processing of information, and relational transparency" (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008, p. 94). These latter concepts are the four constructs which make up the basis of this leadership approach.

The first named construct of authentic leadership is self-awareness. This refers to the leader's insight into their internal strengths and weakness, and their overall impact on others (Gardner, Avolio, Luthans, May, & Walumbwa, 2005; Northouse, 2019). This self-awareness

leads to the second construct, an internalized moral perspective. As an authentic leader, reflections and actions will be in accordance with this writer's own identity, values, motives and goals (Gardner et al., 2005). The third construct, balanced processing, requires the writer to base decisions on objectively collected and interpreted information (Northouse, 2019). This is achieved through both the comprehensive collection of academic and grey literature used to inform this OIP and through the inclusion of stakeholders in the eventual change process. The final construct is relational transparency. Relational transparency occurs when leaders appropriately communicate their feelings and motives (Northouse, 2019). Thus, there is openness and self-disclosure with others involved (Gardner et al., 2005).

This authentic leadership approach focuses primarily on the characteristics of the leader (Northouse, 2019) and, to a lesser extent, their relationship with others. Thus, this approach is insufficient to guide this OIP and will be combined with adaptive leadership. In contrast, the focus of adaptive leadership is the process of mobilizing others both to respond to changes within the environment and to thrive (Heifetz, Grashow, & Linsky, 2009). This writer has only indirect authority. Thus, a leadership approach which focuses on engaging and influencing others will be required to implement this OIP.

Adaptive leadership. Adaptive leadership theory proposes that there are two types of problems: technical and adaptive. The technical challenges are those which both the problem and the solution are easy to identify (Thygeson et al., 2010). Adaptive challenges, however, are complex and characteristic of Complex Adaptive Systems (CAS) such as the HC (Plsek & Greenhalgh, 2001). The NGRN lack of practice readiness qualifies as an adaptive challenge based on three criteria outlined by Thygeson et al. (2010). First, problem definition and solution identification requires stakeholder involvement. Adaptive leaders recognize that "solutions to

adaptive challenges reside . . . in the collective intelligence of employees at all levels" (Heifetz et al., 2009, p. 124). For this OIP, the key stakeholders to include are the Patient Advisors, the nursing students and NGRN, and the academic partners. Second, implementation of the identified solutions will require change by the organization and the stakeholders. As will be discussed in the proposed solutions, maintaining the status quo is not a viable option and change is necessary. Finally, this change will require trade-offs and losses and therefore potential resistance to the change. Addressing this PoP will result in benefits for the NGRN and other stakeholders. However, the orientation of NGRN into the organization is based on long-standing traditions, and thus, resistance to change can be expected.

Adaptive challenges require adaptive leadership and will complement authentic leadership approaches in this OIP. Adaptive leadership is defined as "an interactive event in which knowledge, action preferences, and behaviors change, thereby provoking an organization to become more adaptive" (Lichtenstein et al., 2006, p. 1). This leadership approach can be conceptualized as a "generative dynamic" (Uhl-Bien, Marion, & McKelvey, 2007, p. 299) which supports a systems approach to change. Thus, as an adaptive leader, this writer is not the source of change, but rather, will be the one who enables the process of change (Lichtenstein et al., 2006). This writer, without direct authority, will need to influence others, as previously noted, but, more importantly, will need to influence and disrupt the systemic processes which disempower NGRN and patients and sustain the status quo.

There are six leadership behaviors that shape the work of adaptive leaders. These behaviors are not sequential and may overlap one another (Northouse, 2019). 'Get on the balcony' is one of these behaviors and identifies the need for leaders to take a systems view and appreciate the context for change (Heifetz & Laurie, 1997). By taking a broad view, this writer

is able to more fully appreciate the complexities of this PoP. This has been accomplished through the critical organizational analysis and the literature review. Another behavior is 'identifying the adaptive challenge'. This challenge has been identified in this OIP as the PoP and was articulated in the PoP statement in Chapter 1.

'Regulate distress' is a third behavior which recognizes the distress and uncertainty that change causes individuals. As an adaptive leader, there are three responsibilities: (1) creation of a holding environment, (2) provision of direction, protection, orientation, managing conflict, and shaping norms, and (3) regulation of personal distress (Heifetz & Laurie, 1997). A holding environment is one where the conditions are favourable for diverse groups to discuss, frame and debate the issue (Heifetz & Laurie, 1997). This is achieved by facilitating discussion and enabling participation of key stakeholders, i.e. nursing students, NGRN and Patient Advisors, and will be essential to achieving outcomes that will benefit all. This 'holding tank' of engagement has the potential for conflict. Used constructively, this conflict can drive innovative and creative solutions to address NGRN lack of practice readiness. This behavior aligns with an authentic leader who uses balanced processing and with principles of collaboration and inclusive leadership, all which are valued by this writer.

The work of an adaptive leader also includes providing direction, protection, orientation, managing conflict and shaping norms. 'Direction' will be provided by clearly identifying this PoP as HC's adaptive challenge and through the framing of the key questions and issues. Individuals working in their respective areas (e.g. managers) may not see the cumulative impact of the current model and why change is necessary. This leadership behavior helps others involved to appreciate the current reality and thus the needed change. This work aligns well with the first stage 'create a sense of urgency' in Kotter's model of change which will be discussed in

the next section. 'Protection' is provided through managing the rate of change. This OIP will feature small incremental change rather than radical change. 'Orientation' refers to clarifying key values which guide the change. Values which guide this OIP include safe, quality care for patients and inclusion of key stakeholders such as Patient Advisors. While many seek to avoid conflict, the adaptive leader uses conflict as an opportunity for creativity. The leader also needs to identify which organizational norms will endure and which to change. The current process of hiring and training NGRN at the HC has decades of history. Facilitating change will require a shifting of norms for many in the organization. The norm of didactic, classroom-based orientation may need to change whereas the value of safe patient care will remain central. The final task that pertains to regulating distress is the leader's role modeling of tolerance for uncertainty and a confidence in their ability to facilitate the envisioned change (Heifetz & Laurie, 1997). This will be evidenced as this writer demonstrates a willingness to embrace change and new solutions. This adaptive leadership behavior also pairs well with an authentic leader who demonstrates relational transparency, the open and honest communication of true feelings (Walumbwa et al., 2008).

There are three additional behaviors of adaptive leaders: (1) maintaining disciplined attention; (2) giving work back to people; and (3) providing safe opportunities for stakeholder perspectives to be shared (Heifetz & Laurie, 1997). From a critical theory lens, 'safe opportunities for stakeholder perspectives' would be further described as dialogue that is uncoerced, free of dominance by others, and empowering (Hart, 1990; Schlosberg, 1995; Thomas, 1995). For this OIP, these behaviors will involve listening to alternative points of view, enabling key stakeholders in the shared responsibility of identifying both the opportunities and

solutions, and ensuring all those with ideas are heard. These behaviors further ensure that principles of collaboration theory and inclusive leadership are aligned.

Influence, inclusive leadership and collaboration theory. Authentic and adaptive leadership have been identified as the two key approaches which will guide the implementation of this OIP. As noted in Chapter 1 and in this preceding discussion, the principles of influence along with collaborative theory and inclusive leadership will also support this writer's leadership. Principles of influence such as "legitimate expertise, genuine obligations, authentic similarities, real social proof, exclusive news, and freely made commitments" (Cialdini, 2001, p. 79) align with authentic leadership and support the adaptive work of engaging with key stakeholders and facilitating their full understanding of the PoP. Similar to adaptive leadership, inclusive leadership seeks to involve other stakeholders. This OIP will include nursing students, NGRN, academic partners, and Patient Advisors in the change process, from problem identification through solution implementation (Hollander, 2009). Finally, the context in which this writer seeks to implement this OIP is one in which they has little formal authority. Thus, collaboration theory will provide supplemental strategies on how to influence and mobilize others such as the academic partners (Vangen & Huxham, 2003).

This section has identified authentic and adaptive leadership approaches that will propel the changes required to solve the identified PoP. Select additional strategies will be drawn from the principles of influence, collaboration theory and inclusive leadership. The next section will describe the framework for leading this change process.

Framework for Leading the Change Process

At the HC, there is currently no organizational structure within which to address the NGRN lack of practice readiness gap. Today's educational model is not preparing workforce

ready graduates. The current processes disempower nursing students, NGRN and patients. With current funding constraints, the HC has limited resources to support the additional orientation and training required to fully prepare NGRN to deliver nursing care in the hospital. Given the limited HC's fiscal resources, the current model will soon be insufficient. The organization's need to adapt to this situation is thus considered proactive (Cawsey et al., 2016). This OIP aims to position the HC so that newly recruited NGRN are prepared for professional practice and able to keep pace with the evolving models of healthcare and the associated technology enhancements. Thus, the required change is not an isolated incremental change, but instead reflects a need for continuous change to ensure alignment between the capabilities of the NGRN and the hospital workforce requirements. Furthermore, as the stakeholders engage and bring about change, it is anticipated that this process may prompt additional constraints, barriers or domination by other parties and thus generate further dialogue and social change (Stevens, 1989). Overall, the planned change will be continuous and adaptive. This aligns with current change processes within the HC which are based on a continuous improvement model. There are three key characteristics of this model. Change is (1) continuous, with the pursuit of excellence ongoing; (2) incremental, not radical or transformative in nature; and (3) participative, requiring stakeholder involvement and intelligence (Singh & Singh, 2015).

Theories framing the change process. The literature offers several frameworks which outline the process (i.e. the 'how to') of change. In determining which process to use, this writer sought to select one which would support continuous, adaptive change and align with the overarching theoretical perspectives. Critical theory and adaptive leadership theory have both identified as lenses which inform this OIP. It has also been recognized that the HC represents a CAS. Thus, the selected change model must also meld with these perspectives.

In Chapter 1, it was identified that nurses and patients are oppressed groups. Although the nurses represent the largest occupational group in the healthcare system, they lack autonomy and control (Harden, 1996). This is especially true for NGRN who are nascent in both their profession and the workforce. Patients also experience a power imbalance within the health system and methods to involve and empower them need to be considered (Ocloo & Matthews, 2016). Thus, the selected change model also needs to support the empowerment of key stakeholders, especially the NGRN and the Patient Advisors.

The HC, as an organization, can be viewed as a CAS: 'Complex' due to the diversity of elements, 'Adaptive' due to its ability to change, and a 'System' due to its multitude of connections and interdependencies (Begun et al., 2003). When implementing change in a CAS, the following are key principles to consider: (a) use influence rather than control; (b) aim to link desired outcomes; (c) seek to facilitate evolution rather than impose process; (d) leverage stakeholder strengths; (e) be guided by broad, system-level goals; and (f) allow experimentation and learn from failure (Edson & McGee, 2016). These principles align well with the critical theory lens wherein the opposite approach, the compelling of a specific strategic direction, would only serve to replace one form of domination with another (Stevens, 1989).

CAS such as the HC are dynamic and have a certain amount of inherent unpredictability (Edson & McGee, 2016). Complexity theory is useful to appreciating the dynamics and interactions within CAS (Plsek & Wilson, 2001). Three concepts are foundational to complexity theory: "non-linear dynamics, chaos theory, and adaptation and evolution" (Schneider & Somers, 2006, p. 354). The 'non-linear dynamics' is the behavior that results from the complexity of subsystems (Plsek & Greenhalgh, 2001) and the interactions of "multiple interactive, interdependent, and interconnected sub-elements" (Waddock, Meszoely, Waddell, &

Dentoni, 2015, p. 996). As such, cause and effect are not directly related (Doğru, 2015). Chaos theory contributes two important concepts to this discussion of CAS. First, small, seemingly insignificant events can have big effects, and second, what appears to be random may have an underlying pattern (Begun et al., 2003; Fraser & Greenhalgh, 2001). Finally, 'adaptation and evolution' reference the idea that systems are evolving and emerging in response to other agents and their environment (Dooley, 1997).

The selected change model must support continuous adaptive change, provide an inclusive framework, and align with organizations which function as CAS. Prescriptive models which outline discreet phases of incremental change (e.g. Lewin's Stage Theory of Change) are best applied in linear organizations operating in stable environments (Doğru, 2015). These models are not suitable for managing change in complex adaptive systems and thus will be rejected for use in this OIP.

Kotter's eight-stage process of creating major change. Kotter's eight-stage process of creating major change (Kotter, 2012) will be used to implement this OIP. This model, developed by a Harvard Business School professor, John Kotter (Cawsey et al., 2016), will be briefly described. Additionally, the alignment with the aforementioned theories and criteria will be highlighted.

Establishing a sense of urgency. The first stage that Kotter (2012) identifies is establishing a sense of urgency. This can be achieved through creation of a crisis, setting stretch goals which require a change to business practices, or provision of accurate information which highlights the issues and the opportunities (Kotter, 2012). Creating a sense of urgency also requires decreasing complacency within the organization. In a CAS, motivation for change is accomplished through creating readiness for change and through overcoming resistance (Doğru,

2015). At the HC, drivers such as risks to patient safety due to NGRN lack of practice readiness and costs of training and orienting NGRN will be crucial to overcoming any complacency within the organization.

Creating the guiding coalition. The second stage of the process is to develop a guiding coalition. According to Kotter (2012), success of this team is dependent on having the right membership and should include the following essential characteristics: position power, expertise, credibility and leadership. In complex adaptive systems, top-down, prescriptive change is challenging to implement. Effective change is driven from the bottom up (Doğru, 2015). Thus membership of this coalition will need to encompass key stakeholders including nursing students, NGRN, the patient voice and academic partners. Enabling and empowering nursing student, NGRN and Patient Advisor representation in this coalition will require exposure of any structures and barriers preventing their full participation. This second phase of Kotter's eight-stage model supports further alignment between theoretical frames and the change process.

Developing a vision and strategy. Developing a vision and a strategy is the third phase of this process (Kotter, 2012). Similarly, effecting change in CAS also requires creating a clear vision of the future state (Doğru, 2015). While the first draft of the vision may come from a single individual, developing a clear, shared goal supports the solidification of teamwork within the guiding coalition (Kotter, 2012). The critical theory lens suggests that it is possible for these disparate stakeholders to all agree on 'what' is important, although their reasons 'why' may be quite different (Schlosberg, 1995). These first four stages represent what Kotter (2012) terms 'defrosting'. Generally speaking, this will require stakeholders to define an ideal structure to address NGRN practice readiness and to support the process of transition to professional practice.

Communicating the change vision. The final four stages of Kotter's (2012) model represent introduction of new practices. The fourth stage, communicating the change vision, is necessary to motivate and coordinate action that will lead to transformation (Kotter, 2012). In CAS, leadership requires influencing others in order to attain goals (Doğru, 2015). This influence is fostered through communicating a common understanding of the shared goals and direction. During this phase, communication is a two-way discussion. It is equally important to share information and to solicit and receive feedback from stakeholders on the change vision (Kotter, 2012).

Empowering broad-based action. Change requires the involvement of many people and, therefore, the fifth phase is empowering broad-based action (Kotter, 2012). Achieving change in CAS also requires empowering employees (Doğru, 2015). Empowering others requires aligning personnel, structures and processes to the stated change vision (Kotter, 2012).

Generating short-term wins. The sixth phase, generating short-term wins, assists the change effort to establish credibility and maintain momentum (Kotter, 2012). While these short-term results may provide milestones for the guiding coalition, they also offer encouragement and provide valuable feedback required to further refine the vision and strategy (Kotter, 2012). At this stage of change, solutions used to improve NGRN practice readiness should begin to show results.

Consolidating gains and producing more change. Kotter (2012) acknowledges the interconnectedness of elements within an organization and, consequently, endeavouring to change one thing usually involves changing many. Organizations which are CAS change continuously to adapt to their environment (Doğru, 2015). At this seventh stage, consolidating gains and producing more change, the short-term wins have created momentum and additional

change can be addressed. When solutions are implemented to address the PoP, the Change Leader (CL) will need to assess the impact across the HC and to the respective stakeholder groups. Communication is important throughout the change process. In this phase, it is crucial for leaders to help others understand how this ongoing change aligns with the overall strategy and vision (Kotter, 2012).

Anchoring new approaches in the culture. Corporate culture refers to the social forces which influence behavior in organizations (Kotter, 2012). When change is incompatible or not anchored into the organization's values and beliefs, there is a high likelihood that the change will not be sustained (Kotter, 2012). Thus, the eighth and final phase of this change process occurs when people's actions have changed and they're able to link the actions and desired outcomes together. In order to sustain solutions which improve the NGRN practice readiness, associated structures and processes will need to become part of standard work at the HC. The CL will need to exercise caution at this stage as a shift from process development to implementation of standardized processes risks creating new domination and disempowering individuals (Schlosberg, 1995).

Kotter' eight-stage process for leading change is a framework well suited for implementing this OIP. The process supports emergent change and aligns well with the dynamic nature of a CAS such as the HC (Burnes, 2009). Furthermore, the second phase, develop a guiding coalition, provides a means to empower those who are powerless in the current system: nursing students, NGRN and patients. Thus, this model aligns with the overarching theoretical frameworks which inform this OIP.

Critical Organizational Analysis

The previous section identified Kotter's eight-stage process as the one by which change will be managed in this OIP. Change, however, involves both process and content (Cawsey et al., 2016). To determine what needs to be changed, Nadler and Tushman's (1980) Congruence Model will be used to analyze the HC. This model will assist in determining gaps in the current state and identifying needed changes.

Congruence Model of Organizational Behavior. Building on systems theory, Nadler and Tushman (1980) proposed a model that conceptualizes the myriad of relationships that exist between individuals and groups within an organization. The complexity captured in this model is reflective of CAS such as the HC. The model reflects the interconnectedness and interdependencies within an organization and assumes that an organization as a system has these basic characteristics: internal interdependence, capacity for feedback, the need for equilibrium, equifinality, and ability to adapt (Nadler & Tushman, 1980). Events that occur in one part of an organization can have repercussions in others thus creating interdependences. The outputs from an organization can be used as feedback to correct errors and, consequently, change the organization. Overall, organizations seek to exist in a state of equilibrium. If events cause the organization to be out of balance, the organization will strive to bring itself back to balance. The concept termed equifinality suggests that there are multiple organizational configurations and structures that would enable it to achieve the same input-output conversion, i.e. there is no single best organizational structure. Finally, in order for the organization to survive, it must adapt and maintain a favorable balance of inputs and outputs within the environment in which exists.

Nadler and Tushman's (1980) Congruence Model views an organization as a system or process that transforms inputs into outputs (see Figure 2). Select components of this model and

the corresponding aspect at the HC, as it pertains to this PoP, will be explored in the following paragraphs. Many of the components which will be discussed were initially introduced in Chapter 1, 'Framing the PoP'. Finally, this model developed by Nadler and Tushman (1980) will be utilized to analyze where lack of congruence or 'fit' exists within the organization. This problem identification process will subsequently inform the possible solutions in the next section.

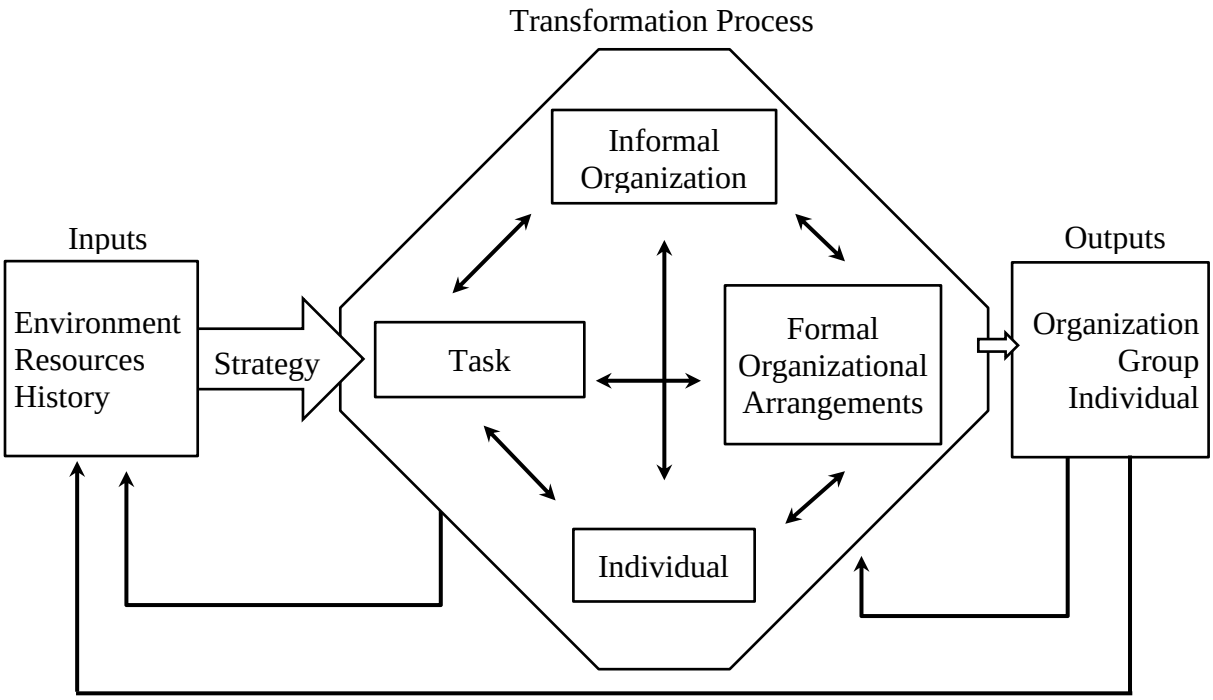


Figure 2. Congruence Model for organizational analysis. Model conceptualizing relationships within an organization such as the HC. Adapted from "A model for diagnosing organizational behavior" by Nadler, D. A., & Tushman, M. L., 1980, *Organizational Dynamics, 9*(2), p. 47.

Inputs. The material that an organization has to work with is referred to as the inputs (Nadler & Tushman, 1980). The types of input include the environment, the resources, and the history. The organization's strategy is also considered an input and is shaped by those inputs previously named. For each of these inputs, there are critical features, or lines of questioning, to guide the analysis.

Environment. One of the factors considered an input is the environment which encompasses "all factors outside the organization" (Nadler & Tushman, 1980, p. 39). This input referred to as the 'environment' by Nadler and Tushman (1980) includes all the factors discussed earlier in the Political, Economic, Social, Technological, and Environmental (PESTE) analysis. Examples of environmental factors include clients, government and regulatory bodies, and labour unions. The first critical feature for analysis focuses on the demands that the environment makes on the organization including the need for certain quality or quantity of products or services (Nadler & Tushman, 1980). As an academic health sciences centre, the main services expected of the HC are "(1) providing Canadians with timely access to advanced patient care services; (2) training the next generation of health care professionals; and (3) conducting leading-edge research and making it available to clinicians, administrators, policy makers and the public" (National Task Force on the Future of Canada's Academic Health Sciences Centres, 2010, p. i). Delivering the 'training' portion of the HC's mandate is achieved through collaborative partnerships with academic institutions. While the academic institutions are primarily responsible for education, the HC provides the clinical placements which support application of learning.

The second line of questions asks what constraints the environment places on the organization. Control is most often in the form of government legislation. The HC is a hospital organization within Ontario and thus subject to federal and provincial legislation. In addition to determining the mandate of hospitals, legislation also regulates the scope of practice for health professionals such as Registered Nurses (RNs). Hospitals historically have been responsible for delivering acute patient care. With recent changes in the provincial healthcare model, hospitals such as the HC are being asked to become part of a health team and collaborate with other

healthcare providers in order to coordinate the continuum of care for a population within a defined geographic region (Ontario Ministry of Health and Long-Term Care, 2019). The implications of this change are not yet fully realized by the HC.

Resources. In Nadler and Tushman's (1980) model, the input labelled resources are those assets accessible to the organization and would include the quality and availability of resources such as employees, technology, and capital. Non-tangible items such as reputation may also be considered a resource. One of the questions guiding the critical analysis seeks to determine the quality of the resources (Nadler & Tushman, 1980). Resources relevant to this OIP include the healthcare funding model and the availability of qualified RNs to fill vacancies. Healthcare in Ontario is publicly funded and the HC relies on the funding received from the provincial government. At a provincial level, health spending restraint continues (Financial Accountability Office of Ontario, 2019) which forces hospitals such as the HC to consider opportunities for efficiencies and cuts to spending. The HC also requires qualified RNs to fill ongoing vacancy needs. When NGRN are hired to fill RN vacancies, they require extensive orientation beyond what an experienced RN would require. Paying for extended orientations further depletes the limited financial resources. Thus, funding of the HC is a limited quantity resource and the quality of RNs available for employment is a possible concern.

The second critical feature for analysis considers whether the resources are fixed or flexible in their configuration (Nadler & Tushman, 1980). The provincial funding model which compensates the HC for services delivered and performance related metrics is fixed. Additionally, the HC has trimmed excess spending from the budget year after year. The HC leadership acknowledges that further budget cuts are not feasible and are seeking innovative ways to deliver care efficiently and effectively. Although the funding model would be

considered ‘fixed’, by contrast, the availability of qualified RNs is more flexible. When experienced RNs are not available, the HC can opt to hire the less practice ready NGRN. This approach, however, requires reallocating funding away from patient care in order to support the NGRN orientation and training.

History. According to Nadler and Tushman (1980), organizational history influences current performance. Two questions guide the analysis of the history inputs: (1) What have been the major phases of the organization’s development, and (2) What is the impact of previous strategic decisions, leadership actions, and core values (Nadler & Tushman, 1980)? These two questions will be explored in tandem. The HC was previously comprised of separate, independent hospitals. The historical mergers have resulted in each site providing highly specialized care. Thus, the HC’s recruitment needs include hiring qualified RNs capable of delivering specialized care e.g. neonatal intensive care, perioperative, and oncology. Historically, two of the hospitals that now form the HC once offered nursing education programs. When nursing education transitioned to higher education, the HC continued to collaborate with the academic institutions, particularly with respect to clinical placements. More recently, the HC partnered with the academic institutions to jointly fund this writer’s role which supports both student affairs and academic relations. Consequently, the impact of these historical actions for this PoP is twofold: (1) the HC continues to require RNs who are both qualified and specialized, and (2) the HC has a tenured relationship with local academic partners.

Strategy. Each organization determines how to configure and utilize resources to achieve the overall mission and purpose. This, according to Nadler and Tushman (1980) is the strategy input and is influenced by the other inputs. The HC’s mission, values and strategies were discussed in Chapter 1. The HC’s strategy includes plans for learners and human resources

however the majority of economic resources are directed toward the HC's mission, i.e. the delivery of patient care.

Key organizational components. Nadler and Tushman (1980) view organizational behavior as a series of complex patterns. The key components they identify in an organization are characterized as the task, the individual, the formal organizational arrangements and the informal organization (Nadler & Tushman, 1980). The nursing 'task' at the HC requires RNs who are able to deliver safe, quality patient care. The 'individual' of interest in this PoP is the NGRN who, as previously identified, lacks the requisite knowledge, skills and judgment. The HC's formal organizational arrangements currently provide extensive orientation and training for the NGRN. The informal organization component of the model identifies those less-structured arrangements within the HC such as additional orientation time and lighter assignments for NGRN.

Outputs. The outputs reflect the performance of an organization (Nadler & Tushman, 1980). Overall, the HC seeks to deliver the best possible patient care and thus, output can be measured against this objective. There are also unintended outputs. Literature indicates that a potential consequence of NGRN lack of practice readiness is unsafe patient care (Murray et al., 2018). Another potential output is NGRN prematurely leaving the HC and/or the profession due to exhaustion and burnout (Chachula, 2014; Guay et al., 2016). Neither of these are desirable outputs for the HC.

Congruence. The basic premise of Nadler and Tushman's (1980) Congruence Model of Organizational Behavior is that "for organizations to be effective, their subparts and components must be consistently structured and managed – they must approach a state of congruence" (Nadler & Tushman, 1980, pp. 35-36). Congruence refers to how well components 'fit' together.

It is assumed that "the degree to which the needs, demands, goals, objectives and/or structures of one component are consistent with the needs, demands, goals, objectives and/or structures of another component" (Nadler & Tushman, 1980, p. 45) determines the degree of congruence and thus the degree of 'fit'. Those parts of an organization which 'fit' well together will function effectively. Conversely, those that do not 'fit' well together will lead to dysfunction and poor organizational performance. By analyzing where there is no 'fit' or congruence, as it pertains to this PoP, it is possible to determine the gaps which exist. The 'fits' within the HC as they pertain to this PoP have been analyzed (see Table 1). From this analysis, it is apparent that the informal organizational arrangements (primarily extended orientations) have been shaped to create a 'fit' between the NGRN and the task of providing patient care. Given the increasing fiscal restraint in healthcare, the organizational performance is at risk if this gap is not addressed.

Table 1

Definition of Fits Applied to the HC

Fit	Issues	Summary HC data
Individual/Organization	How are the individual needs met by the organizational arrangements?	NGRN are provided with corporate orientation, unit-based training and mentorship
Individual/Task	Do individuals have skills and abilities to meet task demands?	No. NGRN lack knowledge, skills and judgment.
Individual/Informal Organization	How are individual needs met by the informal organization?	NGRN are provided extended unit-based orientation and lighter assignments to support their transition to professional practice. This informal arrangement results in increased workload for the other RN.

Task/Organization	Are organizational arrangements adequate to meet the demands of the task?	Not applicable to PoP
Task/Informal Organization	Does the informal organization structure facilitate task performance or not?	The extended orientation supports the NGRN transition to professional practice. This is a costly solution and not consistently available.
Organization/Informal Organization	Are the goals, rewards, and structures of the informal organization consistent with those of the formal organization?	Yes and no. Supporting extended orientation supports the HC's human resources plan. This additional orientation consumes financial resources.

Critical theory also argues the importance of analysing organization structures to examine the power relationships that maintain any unjust social systems (Duffy & Scott, 1998). Using Nadler and Tushman's (1980) Congruence Model, it is apparent that the current structure is aiming to achieve organizational financial and human resource strategies. The informal arrangements have been shaped to create a 'fit' in order to support the NGRN transition to professional practice. Unfortunately, this 'fit' disadvantages the NGRN and even the existing staff RNs.

The NGRN practice readiness gap has been described as a PoP that impacts the HC. In this section, Nadler and Tushman's (1980) Congruence Model illustrated that lack of 'fit' between the individual (NGRN) and the task (safe, quality patient care). Currently, one of the inputs (financial resources) has been shaped (redirected) to provide lengthy orientation support for NGRN. With ongoing fiscal constraints, organizational performance is at risk and a solution is required to address this lack of congruence.

Possible Solutions to Address the Problem of Practice

This section will discuss three possible solutions. For each solution proposed, the respective benefits and shortcomings will be examined. Resource requirements will also be reviewed. Based on this discussion, the ideal solution will be identified and set the context for the implementation and evaluation discussed in Chapter 3. A summary of the possible solutions is provided in Appendix B.

Possible solution 1: Maintain the status quo. To maintain the status quo is the first option to be explored. At present, when NGRN are hired by the HC they are offered formal in-class training followed by preceptored time in the clinical unit. The amount of clinical preceptored time varies from eight to twelve weeks depending on a number of variables. If the NGRN is hired under a provincial government initiative called the New Graduate Guarantee, they will receive the full 12 weeks of orientation (Health Workforce Planning Branch, 2018). The overall goal of this initiative is to support the transition of NGRN into professional practice (Guay et al., 2016). If this government funding is not available, the length of orientation is influenced by other variables such as available unit budget, staffing needs, perceived competence and readiness of the NGRN, and availability of preceptors.

Advantages and disadvantages. Maintaining the status quo offers limited advantages. This approach would not require any change management. There are potentially significant disadvantages to continuing with the current state. The literature indicates that the practice readiness gap causes angst for NGRNs, burnout, and even attrition (Boychuk Duchscher, 2008). Approximately 62% to 66% of NGRN in Ontario experience burnout as a result of the transition to professional practice (Guay et al., 2016). It has been reported at both the HC and in the literature that it is not unusual for NGRN to leave employment after the completion of hospital

orientation in order to pursue additional education or other employment (Greene, 2010). Although the New Graduate Guarantee provides funding to support a longer orientation, the experience is not all positive. Guay et al. (2016) studied the difficulties of NGRN transitioning to professional practice. One of the themes that emerged from this study included "experiencing fear" (Guay et al., 2016, p. 40) especially when encountering overwhelming workload and critically ill patients. Time-limited orientation may not provide the education and training required for NGRN to deliver safe, quality care. Medication errors, patient falls, near-miss situations, and adverse events have been disproportionately associated with inadequately prepared novice nurses (Hickerson, Taylor, & Terhaar, 2016).

The current delivery model of orientation is resource intensive. Greene (2010) reports that the estimated cost of nurse turnover in the United States ranges from $62,100 to $67,100 US per nurse. This estimate accounts for the cost of orientees', preceptors', and educators' time along with the associated costs of backfilling. Furthermore, it is anticipated that the volume of hiring will continue to increase as baby boomers retire (Greene, 2010). By 2022, it is anticipated that Canada will be short 60,000 RNs (Guay et al., 2016). Given the expense of the current model and the anticipated hiring volume, the current delivery model will be difficult to sustain. Furthermore, maintaining the status quo would perpetuate the disempowered, vulnerable position of nursing students, NGRN and patients.

Resource requirements. As this potential option is the current status quo, there would not be any new resource requirements. However, the financial cost of orientating NGRN is not insignificant. Based on the hourly wage and benefits paid to new RN hires in Ontario, the salary for an eight-week orientation is nearly $15,000 per NGRN (Ontario Nurses' Association, 2020). This does not consider the preceptor's time or the educator's time. Whenever possible, the HC

seeks to have the NGRN orientation time funded by the New Graduate Guarantee initiative. This funding, however, is becoming more difficult to obtain and requires that the organization meet qualifying criteria and strict timelines.

The status quo is not a viable long-term solution. Given the precarity of the funding, the cost of the orientation, and the volume of NGRN being hired, this model is not sustainable. Additionally, the current supports do not ensure that the NGRN is adequately prepared to deliver safe, quality care. Thus, maintaining the status quo is not an acceptable solution.

Possible solution 2: Implement solutions reported in the literature. The research literature reports a variety of possible solutions to address the NGRN lack of practice readiness and support NGRN transition to professional practice (Kaihlanen, Haavisto, Strandell-Laine, & Salminen, 2018). The proposed solutions can be generally separated into two categories. The first are those interventions which are trialed by the academic institution and seek to improve the NGRN practice readiness. The other broad category includes those solutions offered by those employing the NGRN. These solutions offered by healthcare institutions such as the HC aim to support the transition of the NGRN into professional practice (Burns & Poster, 2008). A sampling of solutions from both of these categories will be explored.

One approach that academic institutions have used is an increase in the amount of time that students spend in clinical placements. One academic institution sought to compare an 8-week clinical immersion model with a 16-week experience (Kumm, Godfrey, Richards, Hulen, & Ray, 2016). In the study, the preceptors evaluated the students' clinical knowledge, technical skills, critical thinking, communication, professionalism, management of responsibilities, and overall performance pre- and post-clinical experience. There was no statistical difference in the performance outcomes (Kumm et al., 2016). This study was limited by its non-equivalent

control group design, use of subjective evaluations and evaluator attrition. This outcome is in contrast with a scoping review of seventeen articles which found that longer clinical times in schools improved students' perception of practice readiness (Järvinen, Eklöf, & Salminen, 2018). This review did not include healthcare providers' perspectives on the students' practice readiness. Overall, the evidence is not clear on the optimal time students need to spend in clinical placements to achieve practice readiness.

In another study, the approach involved both academic and hospital partners. In this case report, a consortium of nursing schools in north Texas, US, in partnership with hospital staff, implemented a three-pronged educational intervention that contained the following: learning modules based on high-risk, high volume patient conditions; plans to distribute these learning modules; and training on competency development strategies for faculty and staff educators (Burns & Poster, 2008). The overall cost of developing the learning modules was $70,000 US, comparable with the estimated cost of training a new nurse ($45,000 - $70,000 US) (Burns & Poster, 2008). Due to the intellectual property of the developed learning modules, they were unable to broadly distribute the modules. Unfortunately, the effectiveness of the modules was not reported in the literature.

The literature is replete with articles which report clinically-based orientations offered by employers. Generally, there is variation in the recommended length of orientation (Baxter, 2010). One literature review aimed to establish an "evidence-based novice nurse preparation solution focused on the hospital-practice aspect that may help bridge the preparation–practice gap" (Hickerson et al., 2016, p. 18), but did not find a single, effective solution. Based on their findings, the strongest evidence suggested a hospital residency which would include clinical experience, classroom education, and hands-on skills training. Elsewhere, the ideal length of a

residency is reported to be nine months (Rush et al., 2013). The literature does not identify conclusively a single 'best' solution; both residency programs (up to 12 months long) and preceptored orientations are recommended (Hickerson et al., 2016). Despite this recommendation, there are pros and cons. Residency programs report improved nurse satisfaction and decreased turnover, but they are costly and resource intense for the hospital (Hickerson et al., 2016). Preceptored orientations, although less beneficial, are still associated with a decrease in near-miss and adverse events (Hickerson et al., 2016).

Another potential employer-based solution in the literature is a tiered skills acquisition model. While most orientations are based on a prescribed time length, this model offered a sequenced approach to learning from the simple to the complex. The NGRN moves through each phase based on their competency attainment. There were a number of positive outcomes from this approach including increased learning opportunities, decreased length of orientation time overall, increased nurse retention and decreased cost (Joswiak, 2018). Although this approach sounds promising, the study provided only relative change data. Unfortunately, this information is insufficient to allow comparison with HC's current orientation length, overall retention and cost.

Advantages and disadvantages. Overall, the most common recommendation in the literature is formal orientation followed by a nurse residency program with supports throughout the NGRN first year of practice (Theisen & Sandau, 2013). Employer-based transition programs do appear to support NGRN retention (Rush et al., 2013). While the tiered, competency-based approach to orientation suggests some potential, there is insufficient data to determine the effectiveness of this strategy. The literature also suggests that there is a role for academic institutions. Through strategies such as simulation-based learning, there is an opportunity for

educational programs to better prepare nursing students for high acuity patients as well as the uncertainty of the workplace (Theisen & Sandau, 2013). Unfortunately, for both recommendations, the quality of evidence is weak. An integrative review of the literature concluded:

> To date, no universally accepted solution exists, and the problem continues across most hospital settings. Even those studies appearing to report the answer are open to question. Many were idiosyncratic and pertain to only one setting. Others lacked rigor and involved only surveys, small samples, or descriptive designs. The strongest evidence suggests some form of on-the-job remediation, such as nurse residency or preceptor programs, as being the most efficient and effective solutions (Hickerson et al., 2016, p. 20).

Finally, this approach is less than ideal as it reflects a continued domination by the HC and the academic institutions, as the organizations act 'at' rather than 'with' the nursing students, NGRN and patients (Schlosberg, 1995).

Resource requirements. As noted above, the main recommendation from the literature appears to be a lengthy nurse residency program. The main resource requirement would be funding. The financial cost to the hospital for such a program is estimated to be between $45,000 and $75,000 per NGRN (Burns & Poster, 2008). This is costlier than the current HC model and lacks any supporting evidence which might indicate that this additional expense would result in improved outcomes to patient care. The expense for the lengthy nurse residency precludes this solution from being a viable option.

Possible solution 3: Establish a collaborative approach. The third solution proposes a collaborative approach to address NGRN practice readiness. A review of guidelines on

facilitating transition to professional nursing practice identified the importance of support in the final year of nursing education as well as during the transition to professional practice (van Rooyen, Jordan, ten Ham-Baloyi, & Caka, 2018). Whereas solutions reported have typically targeted either nursing students or NGRN, this recommendation suggests a combined approach. Similarly, Guay et al. (2016) identify that there is a role for both nursing schools and health care institutions to play in supporting the transition from student to independent professional practice as an RN. Therefore, this third solution proposes a partnership between the HC and the academic partners that would support a multi-pronged strategy to address NGRN practice readiness.

The partnerships described in the literature describe collaboration solely between healthcare employers and respective academic institutions. There is no role or voice for nursing students, NGRN, or patients. The legitimacy and arbitrariness of the current Academic-Service Partnership (ASP) structure has not been questioned. From a critical theory perspective, it's important to acknowledge that "the established order is only one possible way of constructing reality" (Thompson, 1987, p. 33). This third solution advocates for the empowerment and representation of all key stakeholders in this joint structure. To denote the difference between the ASPs reported in the literature, and the one proposed in this OIP with all key stakeholders involved, the term Academic-Service Alliance (Alliance) will be used for the latter.

In the literature, ASPs are "strategic relationships between educational and clinical practice settings that are established to advance their mutual interests related to practice, education, and research" (Beal, 2012, p. 1). These partnerships, often between universities and hospitals (Barger & Das, 2004), provide the opportunity to achieve mutual benefits and have served a variety of purposes including "synergy in training and empowerment of human

resources, education improvement, access to shared resources, facilitate production and application of beneficial knowledge into practice" (Sadeghnezhad et al., 2018, p. 68). Additionally, there are numerous reports of ASPs working collaboratively to address the NGRN practice readiness gap (e.g. Horns et al., 2007; McKillop, Doughty, Atherfold, & Shaw, 2016; Trepanier, Mainous, Africa, & Shinners, 2017; Van der Riet, Rossiter, Kirby, Dluzewska, & Harmon, 2015). Within the context of NGRN lack of practice readiness, the Alliance would provide the framework to identify potential strategies, trial and implement interventions, and evaluate the outcomes along the continuum from student to RN.

The majority of ASPs reporting strategies to address NGRN practice readiness are case-based with limited supporting data (Horns et al., 2007; Van et al., 2015). However, there is one report of an ASP-based approach which reports a 2% decrease in NGRN turnover resulting in an estimated savings of $600,000 US for the healthcare institution (Trepanier et al., 2017). In this case report, the hospital and the academic institution collaborated to identify competencies which students are expected to achieve during their final clinical placement and which support transition to professional practice. Other initiatives included in this collaboration were faculty-supported simulation-based training, preceptor training, gap assessments and a residency program (Trepanier et al., 2017). The outcomes of this collaboration had not yet been fully evaluated.

***Advantages and disadvantages*.** The creation of a collaborative model provides an innovative platform from which to address NGRN practice readiness. Unfortunately, there is no rigorous research to support this potential solution and formal evaluations of ASPs are generally lacking and of poor quality (De Geest et al., 2013). Nevertheless, a systematic literature review seeking to identify and describe their characteristics concluded that ASPs are "emerging as a

promising vehicle to enhance innovation in nursing and health care" (De Geest et al., 2013, p. 454).

The lack of research to inform potential and specific solutions is an existing limitation. Opportunities exist for further research on the topics of NGRN competencies (Theisen & Sandau, 2013) and strategies to address NGRN practice readiness. Both academic institutions and academic health sciences centres such as the HC have organizational missions focused on research. Thus, the collaborative effort of an Alliance provides the opportunity to advance the research in this field (Sadeghnezhad et al., 2018) and can also advance the respective missions of all organizations involved.

An ASP is dependent on the collaboration of both parties. Thus, development of the Alliance will require serious consideration of both barriers and facilitators. In the literature, the success of an ASP is supported by mutually beneficial goals and equitable sharing of resources (De Geest et al., 2013). The importance of a shared goal was noted by the consortium in north Texas, US. These authors report that the "commitment to quality education and safe patient care has been the binding force resulting in an exciting project with everyone working together as a cohesive team" (Burns & Poster, 2008, p. 72).

The development of the Alliance will require the removal of barriers and structures that currently impede the full participation of nursing students, NGRN, and Patient Advisors. If achieved, this solution will enable and empower these groups. However, when seeking to enable social reform there is the potential risk that the planned change will simply replace one form of domination with another (Duffy & Scott, 1998). Thus, this proposed solution will require mindful attention to who is benefiting or being empowered by the change.

Resource requirements. Resources required for the Alliance include time, human and financial resources. Four main stages of developing an ASP have been identified: (1) finding mutual benefits; (2) moving from being competitors to being collaborators; (3) joint practice; and (4) mutual beneficial outcomes (Nabavi et al., 2012). For this OIP, these four main stages will encompass: (1) identifying and agreeing to specific shared goals; (2) addressing potential areas of conflict and focusing on those of shared interest; (3) initiating joint initiatives such as simulation-based training; and (4) evaluating the outcomes to determine next steps. Development of the Alliance will require planning. In-kind contribution of human resources will be required to ensure appropriate representation from each participating institution during the planning and implementation of each phase. No additional financial resources are anticipated for the development of the Alliance at this stage. Once the Alliance has been developed, the group will focus on strategies to address the practice readiness of NGRN. The resource requirements for subsequently identified solutions will be determined by the nature and size of the planned strategy.

Three possible solutions have been proposed to address the lack of structure to address NGRN practice readiness. Maintaining the status quo or applying any of the solutions reported in the literature would consume valuable financial resources but would not deliver the desired outcomes. The development of the Alliance provides a platform on which to collaboratively strategize and address the NGRN. The development of the Alliance will not incur any additional financial burden, but will take time and energy to develop. The advantage of the Alliance is the opportunity to empower the nursing students, NGRN and Patient Advisors. Thus, the chosen solution is the development of the Alliance as a platform to develop, implement and evaluate a multi-pronged approach to NGRN practice readiness.

Change process for the selected solution. The change required to develop the Alliance will be achieved using Kotter's (2012) eight-stage process of major change. Select key phases of ASP development align well with the chosen change model (see Table 2) and will be discussed.

Table 2

Kotter's eight-stage process of major change aligned with process of forming Academic Service Partnerships (ASPs)

Eight-stage process of major change (Kotter, 2012)	Process of forming ASPs (Nabavi et al., 2012)
1. Establishing a sense of urgency	1. Finding mutual potential benefits
2. Creating the guiding coalition 3. Developing a vision and strategy	2. Moving from being competitors to collaborators 2.1. Coalition of all stakeholders, 2.2. Shared decision making 2.3. Shared structure
4. Communicating the change vision 5. Empowering broad-based action 6. Generating short-term wins	3. Joint practice
7. Consolidating gains and producing more change 8. Anchoring new approaches in the culture	4. Mutual beneficial outcomes

Nabavi et al. (2012) noted that the starting point for developing an ASP is finding mutual interests. Addressing NGRN practice readiness represents a major opportunity and thus aligns with Kotter's first stage, creating urgency. Strategies for increasing urgency would include highlighting the impact that lack of practice readiness has on patients (e.g. adverse events), on

NGRN (e.g. burnout, attrition), and the organization (e.g. cost). Kotter's (2012) second phase, creating a guiding coalition, would involve engaging with representatives from the respective academic partners and from the HC to form the Alliance. In order to maintain consistency with the guiding theoretical lens, it will be important to involve nursing students, NGRN and Patient Advisor representation in the guiding coalition along with the academic partners. In order to empower the representatives' participation in this Alliance, they need to be respected and be provided with the same rights of speech, decision making, and action (Schlosberg, 1995). This aligns with the second phase of creating an ASP, moving from being competitors to collaborators (Nabavi et al., 2012).

The third stage of Kotter's (2012) model focuses on the development of a vision and strategy for the guiding coalition. This parallels the sub-phases of 'moving from being competitors to collaborators', specifically concerning the shared decision making and shared structure. During this phase it will be important to solidify a shared vision which will inform the mandate of the Alliance.

The third phase of ASP development is referred to as 'joint practice' (Nabavi et al., 2012). At this point, which aligns well with Kotter's (2012) stages 4 through 6, communicating the change vision, empowering broad-based action, and generating short-term wins, the group will begin to identify and implement specific interventions to trial and evaluate. The sixth stage of Kotter's (2012) model, generating short-term wins, is a crucial time to validate, and if necessary refine, the vision. By this phase, there should be interventions that have been initiated allowing the Alliance / guiding coalition to evaluate the progress to date, to provide evidence for future interventions and to continue to build momentum.

Kotter's (2012) last stages, consolidating gains, producing more change and anchoring new approaches in the culture, align with the final phase of developing an ASP, mutual beneficial outcomes. At this point, one would expect that the Alliance is implementing strategies to address NGRN practice readiness and, based on outcomes, determining which approaches should become standard practice and which require revision and further evaluation.

Leadership Ethics and Organizational Change

The purpose of this OIP is to address the NGRN practice readiness gap. Leadership approaches to guide the implementation of this OIP were outlined in Chapter 1. Values guide the actions of leaders (Crossan, Mazutis, Seijts, & Gandz, 2013). Specifically, it is the "individual wills and individual needs" (Burnes & By, 2012, p. 239) of the leader which shape the leader's actions. This writer's preferred leadership style is authentic leadership. As an authentic leader, this writer seeks to operate from an internalized moral perspective that guides actions and decision making (Walumbwa et al., 2008). This section will therefore consider the ethical basis of the chosen leadership approach, the selected solution, and the organization.

Utilitarian lens. For this PoP, it will be important to approach the issues from a utilitarian lens, one that considers which solutions will bring the greatest utility or benefit to the most people (Donlevy & Walker, 2011). Consequential utilitarianism argues that the value of an action is determined by the consequences or outcome of that action rather than the intention associated with the action (Burnes & By, 2012). It follows then that an "action is ethically right if it maximises the beneficial consequences for everyone, including the instigator" (Burnes & By, 2012, p. 245). In this OIP, 'everyone' includes the key stakeholders i.e. the patients, the nursing students, the NGRN, the academic partners and the HC. Stakeholders can be influenced by the actions of the leader. However, stakeholders are also capable of identifying and ending

unethical practices (Burnes & By, 2012). By establishing the Alliance and guiding coalition, the stakeholders are well positioned to speak out against unethical behavior and to advocate for mutually beneficial outcomes.

Adaptive leadership will also be used to implement the selected solution. Adaptive leaders focus on helping groups solve complex problems (Heifetz et al., 2009). The use of adaptive leadership approaches, along with inclusive leadership, ensures that key stakeholders are involved in the problem and solution identification process. This further enables outcomes which will benefit the patients, nursing students, NGRN, the academic partners, and the HC.

Emergent approach to change. Kotter's eight-stage process of major change has been selected as the leadership approach to change for this OIP. This model has been characterized as an emergent approach to change. Emergent approaches are those which consider change to be a non-linear, continuous and unpredictable process (Burnes, 2009). In this context, organizations are considered power systems within which group conflict is necessary to protect or enhance interests (Burnes & By, 2012). Furthermore, the emergent approach has been accused of positioning leaders to use political process, power and manipulation to achieve their desired outcomes (Burnes & By, 2012). Although this is a potential weakness of this approach, whether or not this approach is ethical rests on whether these forces are used to promote self-interests or the greater good (Burnes & By, 2012). In this particular OIP, the development of the Alliance and guiding coalition will ensure that all stakeholders are empowered to participate and focused on achieving utilitarian outcomes. The vision for this OIP is that barriers will be identified and removed so that all stakeholders can contribute to the Alliance and achieve common goals.

Organizational and professional ethics. The ethics of an organization are shaped by its values, policies and procedures, and structure that guide and shape its actions and interactions

(Elliott, 2015). The HC as an academic health sciences centre has an ethical responsibility to deliver quality, safe patient care. Similarly, this writer and the NGRN, as regulated health professionals, are bound by the code of ethics for RNs (Canadian Nurses Association (CNA), 2017). This OIP seeks to support both the organization and the NGRN in meeting their ethical obligations. The academic institutions who will be partners in the Alliance and guiding coalition have an ethical responsibility to educate students. Specifically, they are required to "prepare graduates with general, foundational knowledge in the humanities, sciences, and social sciences, necessary for professional nursing practice, and for preparing graduates to address current and emerging needs of society" (Canadian Association of Schools of Nursing, 2014, p. 23). This latter obligation is somewhat dissonant with the other mentioned ethical responsibilities. Consequently, conflict between these competing priorities may arise. As previously identified, struggle is seen to be inherent in organizations. Maintaining a utilitarian lens will be crucial. Furthermore, adaptive leadership uses the interaction of conflict to foster adaptive change.

Chapter summary. This chapter has further expanded the OIP and the need for an organizational structure to address NGRN practice readiness. Authentic leadership and adaptive leadership approaches will form the foundation of the leadership approach, with principles of influence, inclusive leadership and collaboration theory selectively incorporated. The critical theory lens ensures ongoing consideration of those identified as vulnerable and disempowered by this PoP. Kotter's eight-stage process of major change has been identified as the leadership approach to change. Finally, Nadler and Tushman's (1980) Congruence Model of Organizational Behavior has been utilized to further explore this PoP. This chapter has further elaborated on the NGRN lack of practice readiness as it exists in the HC. Possible solutions were explored and the establishment of an Alliance has surfaced as the preferred solution.

Finally, ethical considerations and challenges were described. The next chapter will outline the plan to form the Alliance to address the PoP**.**

Chapter 3: Implementation, Evaluation, & Communication

Chapter 1 of this Organizational Improvement Plan (OIP) presented the New Graduate Registered Nurses' (NGRN) practice readiness as a Problem of Practice (PoP) within the Health Centre (HC) and outlined the corresponding organizational context. In the second chapter, leadership and change frameworks to address this PoP were identified. Establishment of an Academic-Service Alliance (the 'Alliance') was identified as the preferred solution. Building on this previous work, Chapter 3 will detail the change implementation plan using Kotter's (2012) eight-stage process of major change. Processes to monitor, evaluate and communicate the organizational change process will be considered along with next steps and future considerations.

When planning organizational change, the Change Leader (CL) must be attentive to the influence of the broader environment (Cawsey et al., 2016). In Chapter 1, NGRN lack of practice readiness was introduced as a PoP and situated within the context of the HC. The HC seeks to deliver safe, quality patient care. This OIP needs to ensure that the process of addressing NGRN practice readiness does not compromise the delivery of safe patient care. Overall, it is anticipated that the implementation of this OIP will serve to further advance the HC's mission. Two corporate strategies are particularly aligned to this OIP. One strategy is focused on the quality and quantity of learner placements. Solutions addressing this PoP have implications for learner placements and thus are well aligned with this strategic goal. As an academic health sciences centre, the HC has a long history of collaboration with academic partners. The other relevant corporate strategy is the focus on workforce development. This OIP seeks to enhance the ability of NGRN to provide safe, quality care and consequently will also advance the HC's workforce development goals. This writer, as CL, has responsibility within

the HC for both student affairs and academic relations and is thus well positioned to lead this change.

In developing this OIP, consistency has been sought with both the guiding theoretical framework, critical theory, and with the HC's values and key strategic goals. The process of implementing the OIP needs to also align with other processes of the HC. The HC recently implemented a quality improvement process which involves front-line staff in both the identification of problems vexing the organization as well as the opportunity to identify and implement solutions. This inclusive approach to problem solving has been broadened and now includes Patient Advisors and students. The HC recognizes the impact that collective efforts can have in achieving the organization's vision to deliver the best possible patient care. To align with the organizational culture, similar approaches need to be embedded in the OIP. Empowerment and involvement of key stakeholders such Patient Advisors, nursing students, NGRN is essential. Furthermore, a process by which these stakeholders can contribute to both problem identification and solution recommendations will be necessary.

In Chapter 2, this PoP was identified as an adaptive challenge: one which the problem definition and solution identification will require stakeholder involvement; the implementation of the identified solutions will require change by the organization and the stakeholders; and the change plan will require balancing competing priorities that may result in resistance (Thygeson et al., 2010). When implementing change in a Complex Adaptive System (CAS), there are key principles to consider. One principle suggests that change is to be guided by broad, system-level goals (Edson & McGee, 2016). This is partially achieved by aligning with the HC's strategic goals. Other principles to consider in the change plan are to: (a) use influence rather than control; (b) aim to link desired outcomes; (c) seek to facilitate evolution rather than impose

process; (d) leverage stakeholder strengths; and (e) allow experimentation and learn from failure (Edson & McGee, 2016). To support these principles, adaptive leadership will be used to guide the change plan.

Possible solutions to the PoP were outlined in Chapter 2. Based on an analysis of these, the preferred solution was deemed to be the development of an Alliance to enable broad stakeholder participation and to support a multi-pronged approach to address NGRN practice readiness. Preparing practice ready NGRN is the joint responsibility of both educational institutions and health care providers (Barger & Das, 2004). This collaboration, the Alliance, will provide the governance structure and associated processes to identify potential strategies, trial and implement interventions, and evaluate the outcomes along the continuum from student to Registered Nurse (RN). Development of this Alliance will be guided by Kotter's (2012) eight-stage process of major change.

Change Implementation Plan

The change implementation plan will begin by establishing the overarching goals and priorities. Subsequently, Kotter's (2012) eight-stage process of leading major change will be used to frame each step of the implementation plan. Consideration will also be given to the resources required to implement the change and the associated time frame. A summary of the change plan is presented in Appendix C.

Goals and priorities. The overarching goal for the planned change is to establish an Alliance to address NGRN practice readiness. This Alliance will enable representation from all key stakeholder groups including students enrolled in the baccalaureate of nursing program, NGRN employed by the HC, Patient Advisors, local academic partners and the HC. The Alliance will develop, execute and evaluate initiatives aimed at enhancing NGRN practice

readiness. The goals of the change plan can be broken down into short-, medium-, and long-term goals.

Short-term goals. The initial goal of the change management plan will be to establish the Alliance, its vision, membership and introduce at least one initiative to address NGRN practice readiness. The time frame for these goals to be achieved is within the first six months.

Medium-term goals. By eighteen months, at least one initiative will provide evidence of improved NGRN practice readiness. Additionally, at this milestone there will be at least two other initiatives underway. Successful change across organizations such as the HC and the academic partners can take years (Spencer & Winn, 2005). The desired outcomes are not expected to be realized until year two or beyond.

Long-term goals. The long-term goals will be ongoing strategy implementation that has measurable improvement for nursing students, NGRN, patients, the HC and the academic partners. For the HC, outcomes will include decreased length of NGRN orientation resulting in cost savings and increased NGRN retention. Stakeholder engagement will be required to determine the long-term goals of the patients, nursing students, NGRN and academic partners. Possible outcomes include improvement in NCLEX-RN® (National Council Licensure Examination for Registered Nurses[1]) pass rates and increased admission applications, both which would be valued by nursing students and the academic partners.

Managing the change. Kotter (2012) acknowledges that successful change management is driven by high-quality leadership and involves a multi-step process which creates motivation and energy. Kotter's (2012) eight-stage process of major change includes the following steps: (1) establishing a sense of urgency; (2) creating the guiding coalition; (3) developing a vision and a strategy; (4) communicating the change vision; (5) empowering broad-based action; (6)

[1] This exam is the entry-to-practice requisite examination for individuals seeking to practice as an RN in Canada

generating short-term wins; (7) consolidating gains and producing more change; and (8) anchoring new approaches in the culture. The first four stages of the process are essential to "defrost [the] hardened status quo" (Kotter, 2012, p. 24). The new desired state or practice is introduced during stages five through seven and then grounded in the culture during the last stage (Kotter, 2012). The change plan to implement the Alliance will adhere to these eight stages.

Establishing a sense of urgency. Kotter (1995) identifies that the first stage, and possibly the most crucial one of the change process, is to convince people of the need for change. The CL will meet with key HC and academic leadership one-on-one or in small groups to socialize the data and research which illustrate the NGRN lack of practice readiness. To create the sense of urgency it will be important to clearly articulate the impact of NGRN lack of practice readiness to the patients, the organization as well as to nursing students and NGRN. In order to involve NGRN, an invitation to participate will be shared in their offer of employment and again during their initial corporate orientation.

According to Kotter (2012), "outsiders can be helpful" (p. 52). Historically, nursing students, NGRN and patients have not been included in opportunities to influence change that impacts them. Presentations will be made to the nursing student and Patient Advisory councils. While the primary purpose of each of these meetings is to establish the need for change, there is also a secondary opportunity to identify barriers to their participation and to begin soliciting volunteers for a task force which will facilitate the change plan. It is anticipated that the planning and execution of this first stage will take approximately three months. The goal during this phase is to convince key stakeholders that the status quo is no longer acceptable.

During this initial stage, there are potential risks. Convincing people of the need for change is hard (Kotter, 1995). The NGRN lack of practice readiness does not directly impact the academic partners in the same manner it does the HC. Although academic partners may be willing to acknowledge the existence of this PoP, engaging them to become partners in the solution process may be more difficult. Kotter (2014) advises leaders to "speak to the genuine and fundamental human desire to contribute to some bigger cause, to take a community or an organization into a better future" (p. 11). Messaging to academic leaders will need to identify the potential value for their programs e.g. improved graduate outcomes such as increased pass rate on NCLEX-RN® exams, school reputation and increased applications for admissions. Furthermore, the PoP messaging will need to be focused on the potential value for the academic institutions to ensure that discussions are not perceived as a critique of their current programs. Kotter (1995) identifies the importance of stakeholder engagement and advises against rushing this phase.

If the academic partners remain unconvinced or reluctant to become involved, one option would be to initiate research to locally replicate assessment of NGRN practice readiness. This approach is not ideal as it would require time and financial resources, potentially delaying initiation of the change implementation plan. The premise of this change plan is the development of an Alliance that would address the PoP through the education continuum from applicant, to nursing student and eventually NRGN. In the event that both academic partners are unwilling to participate, another option is to focus the change plan on only the transition into professional practice. This approach is also not ideal as it does not address potential opportunities to build practice readiness prior to graduation. Transformation requires the "aggressive cooperation of many individuals" (Kotter, 1995, p. 60) including the academic

partners. Therefore, if the academic partners accept the status quo and are unwilling to engage, the change plan will require significant revision with a greater focus solely on the transition to professional practice. Merits of proceeding will be weighed against the potential costs and outcomes.

As previously noted, the remaining stakeholders – the nursing students, NGRN and Patient Advisors – are in vulnerable positions. The NGRN and nursing students may fear potential detrimental outcomes associated with participation such as termination of employment or removal from academic program, respectively. As the Patient Advisors are previous HC patients, their fear of reprisal may be somewhat less. Identifying and removing these barriers will be essential to the stakeholders' involvement.

Creating a guiding coalition. The second stage of the change process is to establish a working team that has sufficient power to act (Kotter, 2012). The CL will assemble an initial task force comprised of champions and volunteers identified during the prior phase, building urgency. To be effective, the collective membership of the task force needs to have the following key characteristics: position power, expertise, credibility and leadership (Kotter, 2012). This task force should include nursing practice leadership, a HC leader from human resources, both NGRN and Patient Advisor representation, and the CL from the HC. From the academic partners, nursing student representation along with faculty and senior leaders need to be included. On this task force, there is a need for both faculty and academic leadership representation. Faculty have a fulsome appreciation of the curriculum and placement processes while senior leadership bring a nuanced appreciation of available research funding, research-based evaluation, and innovative partnerships to support a broader institutional goal.

Ideally, this task force will be co-chaired by two individuals: one representing the HC or the academic partners[2] and the other a representative from either the nursing students, NGRN or Patient Advisors. Both the task force and the resulting Alliance will be accountable to the groups they represent, the Chief Nursing Executive of the HC and the leaders of the respective nursing programs. The formation of this Alliance will not require any changes to the existing organizational structure within the HC or the academic partners. To empower the involvement of all stakeholders, no one group should have more representatives than another. Decision-making will be based on the "synthesis of ideas, arguments, and positions generated from group discussion" (Schlosberg, 1995, p. 305). To ensure the success of this change, and despite representing various stakeholders, the Alliance needs to function as a team. Effective teamwork will require collaboration (Nabavi et al., 2012), willingness to share resources, an openness to new ideas (Barger & Das, 2004), an endorsement of common values, and effective communication (Granger et al., 2012). If teamwork is lacking in the task force or the resulting Alliance, the entire change effort will be undermined.

Developing a vision and a strategy. The initial work of the task force will be to determine the overarching vision and strategy for the Alliance. The vision that is established needs to articulate a picture of the desired future state (Kotter, 2012). Furthermore, this vision will serve to provide direction, motivate people and help to coordinate the action of the Alliance (Kotter, 2012). Strategy and structure have a reciprocal relationship and are closely correlated (Arora & Baronikian, 2013). In addition to developing the strategy, the task force will develop the structure and processes to deliver on the strategy. This will include key organizational aspects such as scope, guiding principles, membership, terms of reference, accountabilities and

[2] Although there are two academic partners, the university confers the Bachelor of Science in Nursing (BScN) degree for both institutions. It is anticipated that it will be the university which provides the co-chair. However, to recognize both institutions, a rotating chair model may evolve.

relationships to other existing working groups or committees. Each of these documents will be shared with the appropriate senior leaders and groups for sign-off and acceptance. Once this phase is complete, the Alliance will be an actual entity.

The literature provides case reports on existing strategies employed by other Academic Service Partnerships (ASPs) (Horns et al., 2007; Trepanier et al., 2017). It is anticipated that many of the initial strategies to pilot will be ones selected from the academic nursing and education literature. Alfredo Tan (n.d.), thought leader on innovation, has commented that "the truths of today will not be the truths of tomorrow". In essence, current educational approaches may be inadequate or even inappropriate to prepare the future NGRN. The task force will also need to consider strategies which provide opportunities to trial and evaluate innovative approaches such as using augmented or virtual reality teaching strategies. It is anticipated that this phase will take approximately two months. These proposed strategies will each go through a change plan as well. However, the remaining discussion will focus on the change plan to establish the Alliance and not these individual strategies. The work of the Alliance will need to focus on ensuring alignment between all resulting activities so that the goal of practice-ready NGRN can be realized.

The literature reflects the challenges of aligning disparate organizations (Evans & Baker, 2012). There is a risk that the Alliance will not be able to develop a unifying vision. Overcoming this risk will require strong communication, a systems perspective and a willingness on the part of all organizations to surrender autonomy (Evans & Baker, 2012). Success will be achieved when the organizations and stakeholders develop a commitment to the shared goal of preparing excellent, practice-ready nurses and recognize that all stakeholders have a crucial role in achieving this goal (Barger & Das, 2004).

Communicating the change vision. The establishment of the newly minted Alliance will be an ideal time to communicate the vision and identified high-level strategies of this collaboration. Kotter (2012) identified elements of effective communication including use of multiple forums, repetition, and use of examples. Communicating the vision will be focused on two broad activities: engaging senior leadership at partner organizations and showcasing existing activities (Pollack & Pollack, 2015). Once the Alliance is established, this group will lead the change plan and oversee strategy implementation. Nevertheless, support and buy-in across stakeholder groups as well as across the healthcare and the academic institutions will be necessary to achieve success, thus reinforcing the importance of communicating to leadership and staff.

Effective communication requires a myriad of platforms, both formal and informal (Springer, Clark, Strohfus, & Belcheir, 2012). Therefore, the Alliance will utilize the communication platforms within both the HC and the academic partners to highlight and share activities and progress. Achieving the overall goal of this OIP will require cooperation from more individuals than just the members of the Alliance. Inadequate communication has been associated with transformation efforts that fail (Kotter, 1995). Ensuring that the vision and strategies are broadly and consistently communicated is essential to gaining the support from across all stakeholder groups. A more fulsome communication plan is described later in this chapter.

Empowering broad-based action. Kotter describes the next stage as "helping more people to become more powerful" (Kotter, 2012, p. 105). The overarching goal of the Alliance is to develop NGRN that have the requisite knowledge, skills and judgement to provide safe, quality patient care within a hospital. As the Alliance begins to execute the strategies and

initiates pilot projects, it will be important to ensure that the structures and processes align with and support the vision. Does the operating structure of the Alliance support a process which enables potential initiatives to be triaged and prioritized? How is the Alliance taking advantage of initiatives that may be 'low-hanging fruit', i.e. those that would be relatively easy to implement, trial, refine and provide early evidence of success?

Generating short-term wins. Successful change provides results that are "visible and unambiguous" (Kotter, 2012, p. 125). In large organizations such as the HC and the academic partners, this needs to occur within eighteen months (Kotter, 2012). By this stage, the Alliance will be able to report back to key stakeholders the development of the Alliance, the vision and strategic plan, the implementation of at least one pilot initiative, and preliminary results. These initial gains will provide the impetus to initiate additional strategies (Spencer & Winn, 2005). While this stage provides milestones to look forward to, more importantly, it can provide feedback about the validity of the vision that was initially developed (Kotter, 2012).

Consolidating gains and producing more change. Despite initial successes, it is important to maintain the progress of the change initiative. According to Kotter (2012) "Whenever you let up before the job is done, critical momentum can be lost and regression may follow. Until changed practices attain a new equilibrium and have been driven into the culture, they can be very fragile" (p. 133). At this stage, the Alliance will be continuing to identify new strategies to implement and evaluate. For initiatives which have proven success, the Alliance will need to focus on spread and dissemination of the new approach. By this stage, the Alliance will also need to begin incorporating long-term evaluation measures that are relevant for all stakeholders e.g. decreased orientation time of NGRN, decreased attrition, increased NCLEX-RN® pass rates of students.

Anchoring new approaches in the culture. In the final phase of the change process, the Alliance will need to ensure that the Alliance itself and the associated processes and structure are well established as part of the organizations' respective cultures. There are a number of mechanisms the Alliance might use to formalize this structure and ensure its sustainability. Possible approaches include (1) a formal agreement or memorandum of understanding expressing ongoing commitment to the Alliance between the organizations; (2) an endowed chair position for a faculty member with the university who would support the ongoing functions of the Alliance; (3) identified sources of sustainable funding to support ongoing research; or (4) development of roles within each organization that incorporate responsibilities of the Alliance. From a critical theory perspective, any approach needs to be considered carefully. The transition from a process of stakeholder empowerment to a structure approach may introduce new forms of power and domination (Schlosberg, 1995).

Other Supports and Resources. In order to implement this OIP, resources will be required from both the HC and the academic partners. The primary resource necessary to ensure the success of this change is human capital, particularly time to participate in Alliance meetings, time to support strategy initiatives and time for evaluation. The majority of leaders who will form the Alliance already have extremely full workloads. Stage one, creating urgency, will need to ensure that stakeholders see the value of this initiative so that leaders are willing to reprioritize their workload and commit to this OIP.

Supplemental resources may be obtained by engaging with students and faculty from other academic programs. For example, partnership with students completing research programs could provide research opportunities for these learners while their research, in return, would support the evaluation of existing strategies or the determination of future ones. Collaboration

with programs developing simulation modalities such as virtual and augmented reality could support innovative approaches to the professional practice development of nurses. Access to and inclusion of these resources will require the Alliance to ensure that assessment of potential strategies considers potential resources beyond the HC and the immediate nursing programs.

In this section of Chapter 3, the change plan has been situated within the context of the broader organization. The plan for change has been outlined using Kotter's (2012) eight-stage process for leading change. Consideration of potential risks and limitations has been integrated in this plan. The resource requirements and short-, mid-, and long-term goals were identified. The remaining sections of Chapter 3 will outline processes to monitor, evaluate and communicate the organizational change process. The resulting Alliance will be well-positioned to implement strategies to address NGRN practice readiness.

Change Process Monitoring and Evaluation

The plan to address NGRN practice readiness has been outlined using Kotter's eight-stage process for leading change. Potential risks and limitations have been identified. Risk can be mitigated by ensuring that there are processes in place to monitor the change process and evaluate expected outcomes. Monitoring and evaluating are critical aspects of a change plan and, to stakeholders, serve to communicate the importance of the change (Whelan-Berry & Somerville, 2010). Although evaluation is typically conceptualized as a post-change activity (Phillips & Phillips, 2007), the full benefits of evaluation are realized if these processes are initiated at the beginning and continued throughout the change implementation (Cawsey et al., 2016). Establishing measures to monitor and evaluate change clarifies and defines the need for change, assesses progress to inform midcourse corrections, and determines the outcomes

achieved (Cawsey et al., 2016). This section will outline the tools and measures that will monitor the change process, evaluate the outcomes, and inform refinements to the change plan.

Monitoring the change process. Kotter (2012) outlines a staged, sequential approach to change, with each stage building upon the previous one. Successful change, however, is not accomplished by skipping steps and should not be assessed by the speed at which each stage is completed (Smith, 2011). The process of change will be monitored by comparing the progress of this OIP against Kotter's eight-stage process (Spencer & Winn, 2005). In the implementation plan that has been established, and as outlined in Appendix C, the Most Responsible Person (MRP) for each stage is identified. The respective MRPs will monitor the change process at each stage to ensure that deliverables are achieved, pitfalls are avoided, and, where necessary, the change plan is adjusted.

In each stage of the change process, the MRP needs to monitor for issues that may lead to change failure. Change implementation requires a considerable length of time (Kotter, 1995). Although there may be a desire to rush through the change stages, being ahead of schedule, provided a realistic schedule has been established, may be an early flag that an important step has been missed or an unnecessary risk assumed. Kotter (1995) has provided more specific warning signs which align with each stage of the change process. Refer to Appendix D for an overview of the change monitoring activities.

There are specific pitfalls the MRPs will monitor for during the change process. In the first stage, establishing a sense of urgency, Kotter (1995) indicates that approximately seventy-five percent of leadership needs to acknowledge the PoP and be unaccepting of the current state. Furthermore, a critical mass of leadership will need to be engaged and aligned across all hierarchical levels in order to achieve implementation success (O'Reilly et al., 2010). This target

of seventy-five percent is not expected to reflect all of the HC and the respective academic partners' many employees. The MRP's objective will be to ensure that at least two influential leaders from each stakeholder group are engaged and committed.

At the second stage, development of the guiding coalition, there is risk of failure if the resulting group does not have sufficient power and authority (Kotter, 1995). As the resulting task force and, eventually, the Alliance form, the MRP for this phase will monitor to ensure that the team has adequate formal and informal influence across stakeholder groups in order to drive initiatives forward. Ideally, the task force will be comprised of individuals with formal authority in the institutions they represent. Where formal authority is lacking, the MRP may need to seek executive sponsors who can champion this cause and use their influence to obtain resources and remove barriers (Arora & Baronikian, 2013). Alternatively, letters indicating executive leadership support or memorandums of understanding can support those without formal leadership positions.

The next two stages, creating and then communicating the vision, are closely linked. As the Alliance creates the vision, they will be monitoring to ensure that it is well defined and compelling. Without a clear vision, the resulting strategies may lack direction and cohesion (Kotter, 1995) and risk not addressing NGRN practice readiness. Once the vision is developed, it needs to be broadly communicated to all stakeholders. At this stage, the MRP will monitor to ensure that messaging meets two key criteria: quality and quantity (Kotter, 1995). This ensures further engagement across all stakeholder groups.

The fifth stage is empowering broad-based action. At this stage, the MRP will determine which obstacles have been removed and which additional ones still need to be addressed (Kotter, 1995). The following questions can help to guide this analysis: Is the structure of the Alliance

supporting the vision? Are the processes which have been established to identify initiatives to address NGRN practice readiness and then subsequently, to prioritize, pilot and evaluate them, barrier free? If not, how can obstacles be removed or minimized? What actions might be taken to empower more individuals to bring forward additional ideas? The MRPs, which at this stage will be the Alliance team members, may not be able to remove all impediments identified, but will, at minimum, need to focus energy on removing the largest ones.

At the next stage, termed creating short-term wins, clear, unambiguous results need to be identified and communicated to stakeholders and senior leadership (Kotter, 1995). The risk at this stage is to identify only process results e.g. creation of the Alliance or establishment of the vision. Although these are important change process milestones, the MRP needs to be able to present outcomes from at least one pilot initiative. The tools that will be used to assess these outcomes will be presented later in this chapter. The outcomes and 'wins' from this stage set the foundation for the next stage i.e. consolidating gains and producing more change. The risk at this stage is to declare victory and success too soon (Kotter, 1995). While there is value in celebrating any achievements, the Alliance needs to ensure that it remains focused on using this success to gain more momentum and establish additional initiatives. For example, how might outcomes from a successful pilot launch a larger trial, secure research funding or even establish new permanent processes within the respective institutions?

The final phase of the overall change plan will focus on anchoring the change within the cultures of the respective organizations. At this stage there are two factors that are important to monitor and which will help to galvanize the change. First, the Alliance needs to demonstrate to stakeholders how the initiatives are supporting NGRN practice readiness. The connection between initiatives, outcomes, and vision needs to be explicit (Kotter, 1995). The second factor

to address is sustainability (Kotter, 1995). There are frequent changes to senior leadership across all stakeholder organizations. Thus, the work of the Alliance needs to be strategically linked to roles and not to individuals. This will ensure that the work continues and momentum is maintained in the event that key individuals leave the institutions. As part of the monitoring process, the Alliance will communicate with any new leaders to engage their support.

Kotter (1995) identified key issues which require monitoring at each stage of the change process. This list is not intended to be comprehensive, but does identify critical issues that the respective MRPs will be required to attend to. The initiatives that are implemented by the Alliance, however, will require a formal tool to evaluate outcomes. For the individual initiatives, the Return-On-Investment (ROI) methodology will be used.

Assessing outcomes using Return-On-Investment (ROI) methodology. Initiatives seeking to impact learning have frequently been evaluated according to Kirkpatrick's four-level model (Kirkpatrick, 1996). The four levels, termed reaction, learning, behavior and results, seek to assess outcomes of educational initiatives (Kirkpatrick, 1996). The first level of the model is reaction and the outcome of interest is the learners' feelings towards the educational initiative (Kirkpatrick, 1996). The second level, learning, seeks to determine the extent to which the individuals' knowledge, skills or judgment have improved whereas the third level, behavior, assesses the application of learning and behavior changes in the workplace (Kirkpatrick, 1996). The fourth level, results, seeks to determine the business impact of the learning on organizational variables such as productivity (Kirkpatrick, 1996). The difficulty and complexity of assessing learning outcomes increases with each level. Consequently, educational initiatives have typically been assessed at the level of reaction or learning.

These levels identified by Kirkpatrick (1996), i.e. reaction, learning, behavior, and results, all have merit. The Alliance, however, needs to be able to demonstrate to all stakeholders the value for the resources invested (e.g. human capital, time, any financial expenditures) in initiatives and to do so in terms which resonate with senior leadership (Phillips & Phillips, 2007). This will be achieved using ROI methodology. This approach builds on Kirkpatrick's (1996) earlier work and can be used across all project types (Buzachero, Phillips, Phillips, & Phillips, 2013). In addition to applying Kirkpatrick's levels, it also assesses the monetary benefits realized by the initiative (Phillips, 2012). Thus, it is an ideal framework to evaluate the initiatives implemented by the Alliance.

Building on Fitzpatrick's (1996) four levels, the ROI methodology considers two additional metrics, the ROI and the intangible benefits. The ROI is a financial metric which compares the monetary benefits of the investment in learning, performance improvement or human resource programs to the investment itself (Phillips, 2012). In this context, "value is defined by outcome versus activity" (Buzachero et al., 2013, p. 9). Additionally, this framework considers the intangible benefits such as "increased job satisfaction, increased organizational commitment, improved teamwork, improved customer service, reduced complaints, reduced conflicts" (Phillips & Phillips, 2007, p. 28). In the context of NGRN practice readiness, intangibles may include variables such as improved patient experience and increased NGRN resilience.

The ROI methodology is a process that will be incorporated from the initial planning of a potential initiative, will support data collection during implementation, and will be used to guide data analysis and eventual communication of results (Phillips & Phillips, 2007). When this approach is integrated through the full cycle of the initiatives, the ROI methodology can help to

determine which initiatives to undertake. Given the resource restrictions in healthcare today, this approach ensures that available resources are directed to those initiatives which will have the greatest return (Buzachero et al., 2013). This full process is outlined in Figure 3.

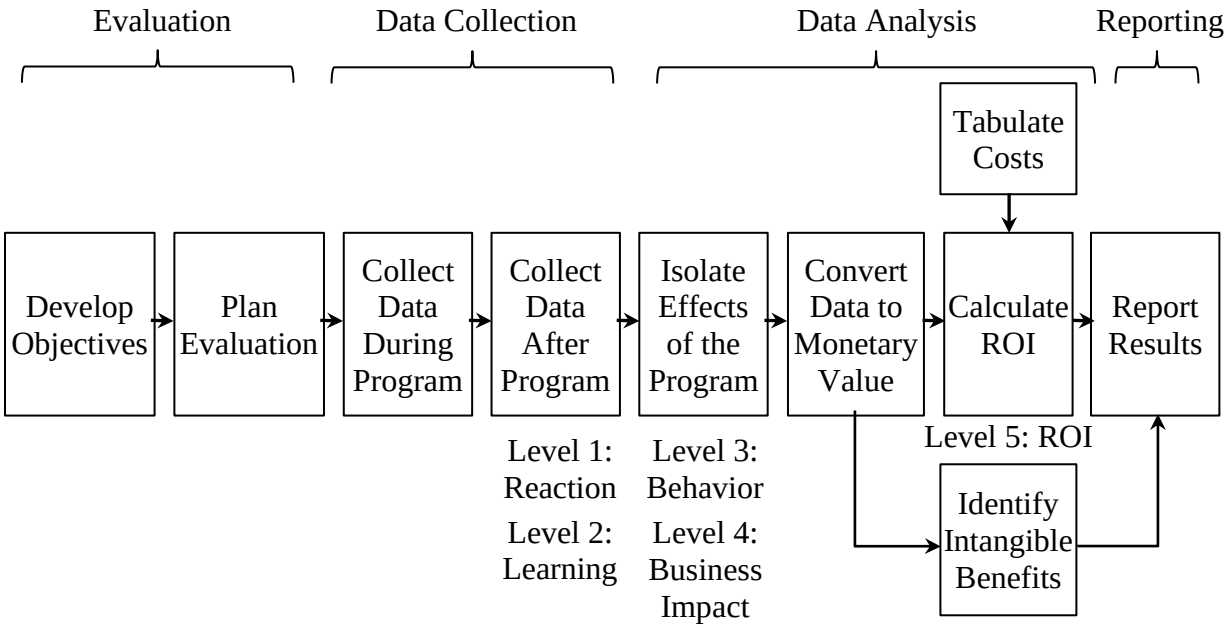


Figure 3. The ROI process model. Model adapted from "The ROI Methodology," by Phillips, P. P., & Phillips, J. J., 2007, *The value of learning: How organizations capture value and ROI and translate them into support, improvement, and funds*, p. 20. Copyright 2007 by John Wiley & Sons, Inc.

In order for this ROI methodology approach to be valued by the stakeholders, it will need to meet certain criteria. The first criteria is that the use of ROI needs to be balanced with other measures, e.g. inclusion of both financial and non-financial, qualitative and quantitative data (Buzachero et al., 2013). The data used for evaluation needs to be accurate, reliable and reasonably available (Buzachero et al., 2013). The ideal data will provide information for adjustments to the change plan while also demonstrating alignment with the overall vision of the Alliance. Finally, the data should represent the different stakeholder perspectives (Buzachero et al., 2013). As members of the Alliance, the NGRN, nursing student and Patient Advisor

representatives will contribute to the identification of these metrics. Examples of potential data are listed in Table 3. Note that some data may address more than one criterion.

Table 3

Examples of Data Sources to Meet Identified Criteria

Criteria	Example Data
Balanced data	Financial: Cost of initiative Non-financial: Learners reaction to initiative
Credible	NGRN attrition
Readily available	Length of NGRN orientation pre- and post-initiative
Represent tactical and strategic issues	Length of NGRN orientation pre- and post-initiative NGRN attrition
Represent different perspectives	Patient experience pre- and post-initiative

Environmental monitoring. The monitoring and evaluation of this OIP primarily focuses on the macro process of change and the micro outcomes resulting from initiatives that are undertaken. This plan is being implemented in the context of the HC which, as identified in earlier chapters, is a CAS. This complexity can create a phenomenon known as emergence (Diment, Yu, & Garrety, 2009). Emergence refers to the manner in which interactions or activities at one level of a system cause changes elsewhere (Diment et al., 2009). As this OIP is implemented, the Alliance needs to consider the immediate outcomes of distinct initiatives for which the outcomes are observable and measureable. However, there needs to also be an ongoing environmental scan to determine what, if any, are the broader ranging impacts to the associated education and healthcare systems.

Consider this hypothetical example: If the Alliance were extremely successful in developing practice-ready NGRN, the HC could become the employer of choice. This would undoubtedly benefit the patient care delivered within the HC. If, however, this resulted in an inability for other healthcare employers such as long-term care facilities to attract and retain qualified nursing staff, there would be potential negative consequences for the HC. Low staffing in long-term care facilities would decrease the HC's ability to move hospitalized patients to alternate-level of care settings and result in overcrowding in the hospital. Furthermore, a staffing crisis in long-term care has the potential to degrade quality of care in those settings and increase the hospitalization rate of long-term care residents. Overall, this unintended outcome would have a negative impact on the delivery of healthcare in the region. Therefore, in the monitoring and evaluation processes, the Alliance needs to appreciate the HC and the academic partners and their roles in the broader CAS. Consequently, it will be imperative to periodically perform environmental scans to monitor for both positive and potentially detrimental impacts to the broader healthcare and educational systems.

Even more broadly, ongoing changes within the healthcare and education sectors need to be monitored. The future of healthcare will include diverse innovations in information and technology systems, care delivery models (e.g. telehealth and telemedicine), and equipment systems (Gilmartin, 2001). The pace and scale of changes are rapidly increasing (Smith, 2011). Consequently, the ideal state for NGRN practice readiness will continue to evolve. Therefore, prioritization for initiatives and overall direction needs to consider alignment with the evolving nature of healthcare.

Refining the change plan. One of the purposes of monitoring and evaluating is to identify the need for course correction. The three aforementioned processes for evaluating and

monitoring change will inform change plan refinements. The change process itself will be monitored for the eight major mistakes that Kotter (1996) suggests can lead to failure. Through awareness and early identification of these potential mistakes, the associated issues can be avoided or, at least, mitigated (Kotter, 2012). The use of the ROI methodology will support a feedback cycle (Phillips & Phillips, 2007). The data which emerges from this process can be used to determine which initiatives will be prioritized. For those initiatives which are implemented, the resulting ROI data will identify which are effective and should be sustained and which do not support the overall vision of the Alliance. The environmental scanning will provide valuable information regarding the future of healthcare and any unintended consequences resulting from the individual initiatives. This information will provide general direction for the Alliance. The cumulative total of information gathered from these three processes will provide valuable feedback to inform both specific initiatives developed by the Alliance as well as the overall direction of the Alliance.

Monitoring and evaluating the change process is essential to defining the need for change, assessing progress, informing midcourse corrections, and identifying the outcomes achieved. This section has described the process and tools that will be utilized to monitor the change process and evaluate the outcomes of specific initiatives. These will support a feedback process to ensure correction or risk mitigation as well as future direction.

Plan to Communicate the Need for Change and the Change Process

A change plan to implement the Alliance has been established using Kotter's (2012) eight-stage process of major change. Effective communication is an essential element of any successful change (Barrett, 2002) and should be provided throughout the change process (Whelan-Berry & Somerville, 2010). Kotter (1995) similarly notes the importance of "credible

communication, and a lot of it" (p. 63). A detailed communication plan for this OIP is outlined below. This plan aligns with the phases of Kotter's model and considers the perspectives of various stakeholders.

Framing the change plan. The plan to implement an Alliance involves the following key stakeholders: NGRN and nursing students, Patient Advisors, academic partners and the HC. Response and reaction can vary amongst stakeholder groups leading some to perceive proposed change as a disaster while others view it as an opportunity (Lewis, 2007). Effective communication during change, however, can decrease the resistance to change and lead to more productive change efforts (Husain, 2013). Lewis (2007) proposes four communication strategy dimensions to consider when developing stakeholder messaging: (1) positive versus balanced message; (2) dissemination focus versus input focus; (3) discrepancy versus efficacy focus; and (4) target message versus blanket message. Each of these dimensions will be discussed and applied to the stakeholders impacted by this change plan. This discussion has been summarized in Table 4.

Table 4

Communication Strategy Focus According to Stakeholder Group

Focus: Stakeholder:	Positive vs. balanced	Dissemination vs. input	Discrepancy vs. efficacy	Target vs. blanket
NGRN & nursing student representatives	Positive	Input	Discrepancy	Target
Patient Advisor	Positive	Input	Discrepancy	Blanket
Academic partners	Positive	Input	Both	Target
HC nursing staff	Positive	Dissemination	Discrepancy	Blanket

HC leaders	Positive	Dissemination	Both	Target

Positive versus balanced message. This dimension considers whether the communication should focus on the positive aspects of the change or balanced with the negative aspects of the process (Lewis, 2007). Overall, the development of an Alliance and the improved NGRN practice readiness that will be realized with the implementation of this OIP offers a positive message. There are no negative consequences (e.g. layoffs) in the proposed change. Thus, the messaging will be positive across all stakeholder groups.

Dissemination focus versus input focus. Communication, by definition, is the "transmission of information from one entity to another" (Hogard & Ellis, 2006, p. 174) and includes both sharing and receiving information. In the dissemination versus input focus, a determination is whether the emphasis should be the distribution or solicitation of information (Lewis, 2007). The input focus engages and empowers stakeholders to contribute their perspective and participate in decision making (Lewis, 2007). In the literature, ASP are typically a joint collaboration between healthcare employers and academic institutions. The Alliance proposed by this OIP seeks to be inclusive of NGRN, nursing students and Patient Advisors. Therefore, for these groups, an input focus will be important. For those stakeholders who are less involved in the Alliance, i.e. HC nursing staff and leaders, sharing information will be the primary focus.

Discrepancy focus versus efficacy focus. The two dimensions of this focus contrast motivating through need for change (i.e. discrepancy) or supporting the idea that the resources exist to achieve the change (i.e. efficacy) (Lewis, 2007). To gain support from both the academic partners and the HC leaders, communication geared to these stakeholders will need to

address both foci. For the other stakeholders, and to create a sense of urgency, the focus of communication will address the reasons for change e.g. potential risk for NGRN burnout, unsafe patient care. Although messaging to patients will highlight the discrepancy, it will need to be balanced with a positive focus e.g. need for NGRN to be prepared for the evolving healthcare landscape due to new technologies.

Target message versus blanket message. This last dimension addresses the degree to which communication needs to be customized and targeted (Lewis, 2007). For stakeholders such as the HC nursing staff who will have a more peripheral role in the change plan, a blanket message would be appropriate. However, for key stakeholders, targeted messages will detail the benefits to them and opportunities for active participation. In high-performing companies, there is alignment between the company's strategic objectives and the communication objectives (Barrett, 2002). Therefore, for the HC leaders, messaging will link the change plan to key organizational strategies (i.e. learner experience and workforce development) and the expected benefits. For the academic partners, communication will focus on the anticipated benefit to their respective organizations i.e. improved NCLEX-RN® results and program reputation. Messaging to nursing students and NGRN will seek to engage their participation in trial initiatives arising from the Alliance. Although there is both blanket and tailored communication, it will be crucial to ensure that the messaging is consistent.

Communication plan. The communication plan outlines the messaging, timing and media to be used during the change process. For effective communication, the plan incorporates the following best practices:

- Messaging will be repeated (Klein, 1996; Kotter, 1995)
- A variety of media will be incorporated (Barrett, 2002; Klein, 1996)

- Face-to-face communication will be offered when possible (Klein, 1996)
- Tailored, relevant messaging will be delivered when appropriate (Barrett, 2002; Klein, 1996)

Alignment of communication plan. A communication plan should align with the corresponding stages of the planned change (Klein, 1996). The plan to address NGRN practice readiness through the development of an Alliance has been outlined according to Kotter's (2012) eight-stage process for major change. Kotter (2012) categorizes these eight stages into three broader stages, as depicted in Table 5. Corresponding communication objectives have been developed to guide the associated information requirements. Each stage, with its corresponding objectives, requires different communication activities (Klein, 1996).

Table 5

Communication Objectives Aligned with Change Stages

Kotter's 8-stage process (Kotter, 2012)	Kotter's Broad Stages (Kotter, 2012)	Communication Objectives (Klein, 1996)
Establishing a sense of urgency Creating the guiding coalition Develop vision and strategy Communicating the change vision	Defrost the status quo	Justify the change Ready the organization for change Challenge the status quo
Empowering broad-based change Generating short-term wins. Consolidating gains and producing more change	Introduce new practices	Inform stakeholders re: process and progress Develop and maintain momentum
Anchoring new approaches in culture	Ground the changes in the culture	Institutionalize the change Publicize the success of the change

Defrost the status quo. Kotter's (2012) first broad stage is described as defrosting the status quo. A primary goal of this first stage is to build awareness of the need for change. Justifying this change requires the CL to communicate both the current PoP as well as the opportunity to address NGRN practice readiness through the development of the Alliance. The majority of this communication will be face-to-face meetings or presentations to the respective stakeholders. This approach provides a forum for two-way communication and allows opportunity to address questions or provide clarification (Klein, 1996; Whelan-Berry & Somerville, 2010). These forums also provide the CL an opportunity to solicit input into the process and encourage individuals to participate on the task force.

Introduce new practices. During the stage 'introducing new practices', the focus is on reporting information on progress and initial outcomes (Klein, 1996). At this stage, the communication is integrated into the existing process for the respective stakeholders (Barrett, 2002). Ongoing change plan activities will be focused on the Alliance and select initiatives with nursing students or NGRN. Consequently, much of the HC workforce will not be directly involved. Therefore, there is a risk for rumours and uncertainty to spread. Blanket messaging needs to be shared with HC staff through the existing electronic platforms to provide information regarding Alliance activities, any changes that may impact them, and how they can become involved (Klein, 1996).

Ground the changes in the culture. This final stage is an opportunity to solidify both the establishment of the Alliance and celebrate the progress achieved (Klein, 1996). During this stage, the majority of communication processes will have been established. The Alliance will include representatives from each of the key stakeholder groups. One role of each representative will be to communicate information and progress back to their respective councils. At this stage

of the plan, there will be ROI evaluation data to share with senior leadership of the HC and the academic institutions. A summary of these stages and the associated communication activities is presented in Table 6.

Table 6

Summary of Communication Plan

Stakeholder Group:	Defrost the status quo	Introduce new practices	Ground the changes in the culture
NGRN & nursing student representatives	Presentation to nursing student council Invite NGRN to attend presentation	Quarterly reports from Alliance to student council	Nursing student representative on Alliance establishes ongoing formal process to report back to council
Patient Advisor	Presentation to Patient Advisory Council	Quarterly reports from Alliance to Patient Advisory council	Patient representative on Alliance establishes ongoing formal process to report back to council
Academic partners	One-to-one meetings with key leaders	Utilize existing communication channels of academic partners to provide updates to faculty and leaders	Academic partner representatives establish ongoing formal process to report back to academic leadership
HC nursing staff	Presentation to corporate nursing	Bi-annual report to corporate nursing	Updates on Alliance initiatives are standing

	council	council and annual presentation on outcomes Presentation at rounds	item on council agenda and incorporated in council's dashboard of metrics
HC leaders	Presentation at key leadership meetings One-to-one meetings with select individuals	Utilize existing HC communication media (e.g. quarterly emails to leaders) for updates	Quarterly report on ROI evaluation measures
ALL	Utilize existing HC communication media (intranet) to invite participation in initiative	On HC intranet, narrative stories focusing on pilot initiatives in progress and outcomes realized, and how interested individuals may participate	Bi-annual interest stories on HC intranet to highlight progress and outcomes

This change plan has detailed the overarching objectives and associated activities at each stage of the change process. The broad goal of this OIP is to establish an Alliance which will provide the framework to explore innovative solutions to the NGRN practice readiness gap. This framework will support ongoing initiatives. A similar, but scaled down, approach to communication will need to be undertaken with each pilot initiative. At times, it may be warranted to link the communication for specific initiatives to the broader change communication. For example, a successful innovative approach that addresses the PoP would warrant a narrative story on the HC intranet or on social media. Overall, the communication plan will ensure that key stakeholders are informed and positioned to support this OIP.

Next Steps and Future Considerations

This OIP has described a change plan to establish the Alliance and the processes to begin to address NGRN practice readiness. Although some change has a distinct beginning and end, this is not the case here. The launch of the Alliance is simply the beginning of ongoing change. Kotter (2012) noted that the rate of change in organizations is not going to slow. The future of healthcare will include innovations in technology systems, telehealth, virtual medicine, electronic patient records, and other sophisticated technologies which will impact clinical decision making and disease treatment (Gilmartin, 2001). In its current state, it is unlikely that the academic programs will be able to address the depth and breadth of knowledge required for NGRN to deliver safe, quality care. There is a very real possibility that the gap between the academic programs and healthcare delivery will continue to widen. There will be no single, definitive solution. Even approaches identified, trialed and successfully implemented by the Alliance may eventually become inadequate or outdated. Consequently, the Alliance will need to continue to pursue new approaches to supporting NGRN practice readiness and their transition to professional practice.

This OIP advocates for the empowerment of key stakeholders and their participation in the Alliance. For some of these individuals, the exposure of dominant, distorted power relations will be a positive, affirming experience. For others, it can be painful and disorienting as assumptions and values are questioned and challenged (Thompson, 1987). Therefore, the ongoing success of the Alliance will require vigilance, mutual respect, and a commitment to open, transparent communication between all stakeholders.

Healthcare today requires collaboration with an interprofessional team. Both nursing students and NGRN will interact with a diversity of other healthcare professionals. It is

anticipated that some of the initiatives trialed and implemented by the Alliance will likely involve other members of the interprofessional team. This OIP has focused solely on the baccalaureate of nursing programs and the individuals transitioning to RN status. Lessons learned from the Alliance may similarly inform the empowerment, education and transition of Registered Practical Nurses and Nurse Practitioners. Even more broadly, there may be opportunity to apply successful initiatives from the Alliance experience to other healthcare professions beyond nursing e.g. respiratory therapy, physiotherapy, etc.

There are key factors, drawn from Kotter's (2012) work which will support the Alliance's ongoing ability to support NGRN practice readiness. These factors are: (1) a persistent sense of urgency, (2) teamwork, and (3) a motivating vision. As change in healthcare continues, there will be no occasion for complacency on the part of the Alliance. Rather, the sense of urgency will need to remain elevated at all times (Kotter, 2012). The initial success of this Alliance is dependent on the contribution of all stakeholders; it is imperative to sustain effective, ongoing collaborative efforts. Finally, the Alliance requires "a clearly stated, believed in, understood, and meaningful vision statement" (Barrett, 2002, p. 225) to keep the Alliance focused and moving forward.

Kotter (2012) acknowledges the importance of leadership and lifelong learning. As healthcare professionals, RNs are required to engage in lifelong learning. Inclusion of nursing students and NGRN in the Alliance provides opportunities for them to influence strategies that will support the development of the knowledge, skills and judgment of the colleagues. For those individuals directly involved in the Alliance, it also provides them opportunities to further develop their leadership skills. Their participation in the Alliance will offer a paradigm shift; an opportunity to be engaged in social interaction free of domination and an experience that "holds

the seeds of enlightenment and the potential for the construction of a more fully human world" (Thompson, 1987, p. 35).

Chapter summary. Building on previous chapters, this final section has outlined a comprehensive change plan. The fundamental goal of this plan is to establish an Alliance that will provide the structure and processes to address NGRN practice readiness. This change process will be implemented following Kotter's (2012) eight-stage process of major change. The processes to monitor and evaluate the change were described. Using ROI methodology will enable the outcomes to be translated into monetary benefits. Successful change requires an effective communication plan. The communication plan considers various stakeholder approaches and the guiding objectives for each phase of the change process. Finally, next steps and future considerations were addressed. Overall, through the development of the Alliance, this OIP seeks to make a measurable impact on the transition NGRN into professional practice and their ability to deliver safe, quality care to patients in the acute care setting. Moreover, the empowerment of nursing students and NGRN in the Alliance gives nurses a voice in the construction of their future.

References

Anderson, D., & Ackerman Anderson, L. S. (2001). *Beyond change management: Advanced strategies for today's transformational leaders*. San Francisco, CA: Jossey-Bass/Pfeiffer.

Arora, M., & Baronikian, H. (2013). *Leadership in project management* (2nd ed.). Toronto, ON: Leadership Publishing House.

Avolio, B. J., Gardner, W. L., Walumbwa, F. O., Luthans, F., & May, D. R. (2004). Unlocking the mask: A look at the process by which authentic leaders impact follower attitudes and behaviors. *Leadership Quarterly*, *15*(6), 801–823. https://doi.org/10.1016/j.leaqua.2004.09.003

Avolio, B. J., Walumbwa, F. O., & Weber, T. J. (2009). Leadership: Current theories, fesearch, and future directions. *Annual Review of Psychology, 60*(1), 421–449. https://doi.org/10.1146/annurev.psych.60.110707.163621

Baker, C. (2014). Future directions for nursing education. *Nursing Leadership (Toronto, Ont.)*, *27*(2), 35–39. https://doi.org/10.129271/cjnl.2014.23838

Barger, S. E., & Das, E. (2004). An academic-service partnership: Ideas that work. *Journal of Professional Nursing*, *20*(2), 97–102. https://doi.org/10.1016/j.profnurs.2004.02.005

Barnas, K. (2011). Thedacare's business performance system: Sustaining continuous daily improvement through hospital management in a lean environment. *Joint Commission Journal on Quality and Patient Safety*, *37*(9), 387–399.

Barrett, D. J. (2002). Change communication: Using strategic employee communication to facilitate major change. *Corporate Communications, 7*(4), 219–231. https://doi.org/10.1108/13563280210449804

Baxter, P. E. (2010). Providing orientation programs to new graduate nurses. *Journal for Nurses*

in Staff Development, *26*(4), E12–E17. https://doi.org/10.1097/NND.0b013e3181d80319

Beal, J. A. (2012). Academic-Service Partnerships in Nursing: An Integrative Review. *Nursing Research and Practice*, *2012*, 1–9. https://doi.org/10.1155/2012/501564

Begun, J. W., Zimmerman, B., & Dooley, K. (2003). Health care organizations as complex adaptive systems. In S. M. Mick & M. Wyttenbach (Eds.), *Advances in health care organization theory* (1st ed., pp. 253–288). San Francisco, CA: Jossey-Bass. https://doi.org/10.1177/009430610403300325

Bellot, J. (2011). Defining and assessing organizational culture. *Nursing Forum*, *46*(1), 29–37.

Benner, P. (1982). From novice to expert. *The American Journal of Nursing*, *82*(3), 402–407. https://doi.org/10.1097/01.EDE.0000023965.92535.C0

Bent, K. N. (1993). Perspectives on critical and feminist theory in developing nursing praxis. *Journal of Professional Nursing*, *9*(5), 296–303. https://doi.org/10.1016/8755-7223(93)90056-I

Berkow, S., Virkstis, K., Stewart, J., & Conway, L. (2008). Assessing new graduate nurse performance. *JONA: The Journal of Nursing Administration*, *38*(11), 468–474.

Boychuk Duchscher, J. E. (2000). Bending a habit: critical social theory as a framework for humanistic nursing education. *Nurse Education Today*, *20*(6), 453–462. https://doi.org/10.1054/nedt.2000.0492

Boychuk Duchscher, J. E. (2008). A process of becoming: The stages of new nursing graduate professional role transition. *Journal of Continuing Education in Nursing*, *39*(10), 441–450. https://doi.org/10.3928/00220124-20081001-03

Bramadat, I., & Chalmers, K. (1989). Nursing education in Canada: Historical progress, contemporary issues. *Journal of Advanced Nursing*, *14*, 719–726.

Browne, A. J. (2000). The potential contributions of critical social theory to nursing science. *Canadian Journal of Nursing Research*, *32*(2), 35–55. Retrieved from http://cyber.usask.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=107148271&site=ehost-live

Browne, A. J. (2001). The influence of liberal political ideology on nursing science. *Nursing Inquiry*, *8*(2), 118–129. https://doi.org/10.1046/j.1440-1800.2001.00095.x

Burnes, B. (2009). Reflections: Ethics and organizational change – Time for a return to Lewinian values. *Journal of Change Management*, *9*(4), 359–381. https://doi.org/10.1080/14697010903360558

Burnes, B., & By, R. T. (2012). Leadership and change: The case for greater ethical lacrity. *Journal of Business Ethics*, *108*(2), 239–252. https://doi.org/10.1007/s10551-011-1088-2

Burns, P., & Poster, E. C. (2008). Competency development in new registered nurse graduates: Closing the gap between education and practice. *Journal of Continuing Education in Nursing*, *39*(2), 67–73. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18323143

Buzachero, V. V., Phillips, J. J., Phillips, P. P., & Phillips, Z. L. (2013). *Measuring return on investment in healthcare*. New York, NY: McGraw-Hill Education.

Canadian Association of Schools of Nursing. (2014). *CASN Accreditation Program Standards*. Ottawa, ON. Retrieved from http://www.casn.ca/wp-content/uploads/2014/12/2014-FINAL-EN-Accred-standards-March-311.pdf

Canadian Institute for Health. (2018). *National health expenditure trends, 1975 to 2018*. Ottawa, ON: CIHI. Retrieved from www.cihi.ca

Canadian Nurses Association (CNA). (2017). *Code of Ethics for Registered Nurses*. Ottawa, ON: Canadian Nurses Association. Retrieved from https://www.cna-aiic.ca/~/media/cna/page-

content/pdf-en/code-of-ethics-2017-edition-secure-interactive.pdf?la=en%0Ahttps://cna-aiic.ca/~/media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive.pdf?la=en

Casey, K., Fink, R., Jaynes, C., Campbell, L., Cook, P., & Wilson, V. (2011). Readiness for practice: The senior practicum experience. *Journal of Nursing Education*, *50*(11), 646–652. https://doi.org/10.3928/01484834-20110817-03

Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The graduate nurse experience. *JONA: The Journal of Nursing Administration*, *34*(6), 303–311. Retrieved from https://www.uchealth.org/wp-content/uploads/2016/10/PROF-JONA-Grad-Nurse-Exp-2004.pdf

Cawsey, T. F., Deszca, G., & Ingols, C. (2016). *Organizational change: An action-oriented toolkit* (3rd ed.). Thousand Oaks, CA: Sage Publications Inc.

Chachula, K. M. (2014). *Letting go: How newly-graduated Registered Nurses in western Canada decide to exit the nursing profession*. (Masters thesis, University of Alberta, Edmonton, Alberta).

Cialdini, R. B. (2001). Harnessing the science of persuasion. *Harvard Business Review*, *79*(9), 72–79. Retrieved from http://www.alvarezporter.com/wp-content/uploads/Cialdini-Influence-1.pdf

College of Nurses of Ontario. (2019). *Entry-to-practice competencies for Registered Nurses (Pub. No. 41037)*. Toronto, ON. Retrieved from https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf

Council of Ontario Universities. (2010). *Position paper on graduate education in Ontario (Report No. 837)*. Toronto, ON. Retrieved from https://cou.ca/wp-

content/uploads/2015/05/COU-Position-Paper-on-Collaborative-Nursing-Programs-in-Ontario.pdf

Crossan, M., Mazutis, D., Seijts, G., & Gandz, J. (2013). Developing leadership character in business programs. *Academy of Management Learning & Education*, *12*(2), 285–305. https://doi.org/10.1163/9789004242166_069

De Geest, S., Dobbels, F., Schönfeld, S., Duerinckx, N., Sveinbjarnardottir, E. K., & Denhaerynck, K. (2013). Academic service partnerships: What do we learn from around the globe? A systematic literature review. *Nursing Outlook*, *61*(6), 447–457. https://doi.org/10.1016/j.outlook.2013.02.001

DeBourgh, G. A. (2012). Synergy for patient safety and quality: Academic and service partnerships to promote effective nurse education and clinical practice. *Journal of Professional Nursing*, *28*(1), 48–61. https://doi.org/10.1016/j.profnurs.2011.06.003

Diment, K., Yu, P., & Garrety, K. (2009). Complex adaptive systems as a model for evaluating organisational change caused by the introduction of health information systems. In V. Sintchenko & P. Croll (Eds.), *HIC 2009: Proceedings; Frontiers of Health Informatics - Redefining Healthcare, National Convention Centre Canberra, 19-21 August 2009* (pp. 165–169). Brunswick East, Vic., Australia: Health Informatics Society of Australia (HISA). Retrieved from http://www.uow.edu.au/~kd21/uploads/Diment-complexity.pdf

Doğru, Ç. (2015). Leading and managing organizational change in chaos and complexity. In Ş. Ş. Erçetin & S. Banerjee (Eds.), *Chaos, Complexity and Leadership 2013* (pp. 497–507). Switzerland: Springer International Publishing. https://doi.org/10.1007/978-3-319-09710-7_44

Donetto, S., Tsianakas, V., & Robert, G. (2014). *Using experience-based co-design to improve*

the quality of healthcare: Mapping where we are now and establishing future directions. London, UK: King's College London. Retrieved from http://79.125.112.176/nursing/research/nnru/publications/Reports/EBCD-Where-are-we-now-Report.pdf

Donlevy, K. J., & Walker, K. D. (2011). Ethical schools of thought. In *Working through ethics in education and leadership: Theory, analysis, plays, cases, poems, prose, and speeches* (pp. 21–32). Rotterdam: Sense Publishers.

Dooley, K. J. (1997). A complex adaptive systems model of organization change. *Nonlinear Dynamics, Psychology, and Life Sciences*, *1*(1), 69–97. https://doi.org/10.1023/A:1022375910940

Draper, J., Beretta, R., Kenward, L., McDonagh, L., Messenger, J., & Rounce, J. (2014). "Ready to hit the ground running": Alumni and employer accounts of a unique part-time distance learning pre-registration nurse education programme. *Nurse Education Today*, *34*(10), 1305–1310. https://doi.org/10.1016/j.nedt.2014.06.007

Duffy, K., & Scott, P. A. (1998). Viewing an old issue through a new lens: A critical theory insight into the education-practice gap. *Nurse Education Today*, *18*(3), 183–189. https://doi.org/10.1016/S0260-6917(98)80077-4

Ebright, Patricia, R., Urden, L., Patterson, E., & Chalko, B. (2004). Themes surrounding novice nurse near-miss and adverse-event situations. *JONA*, *34*(11), 531–538.

Edson, R., & McGee, S. (2016). Governing the education extended enterprise as a complex adaptive system. *European Journal of Education*, *51*(4), 431–436. https://doi.org/10.1111/ejed.12194

El Haddad, M. (2016). *Grounded theory examination of the perspective of practice and*

education sectors regarding graduate registered nurse practice readiness in the Australian context. (Doctoral dissertation, University of Wollongong, Wollongong, Australia). Retrieved from http://ro.uow.edu.au/theses/4723

El Haddad, M., Moxham, L., & Broadbent, M. (2017). Graduate nurse practice readiness: A conceptual understanding of an age old debate. *Collegian*, *24*(4), 391–396. https://doi.org/10.1016/j.colegn.2016.08.004

Elliott, G. (2015). Critical practice leadership in post-compulsory education. *Educational Management Administration and Leadership*, *43*(2), 308–322. https://doi.org/10.1177/1741143213494891

Evans, J. M., & Baker, G. R. (2012). Shared mental models of integrated care: Aligning multiple stakeholder perspectives. *Journal of Health, Organisation and Management*, *26*(6), 713–736. https://doi.org/10.1108/14777261211276989

Financial Accountability Office of Ontario. (2019). *Ontario health sector: 2019 updated assessment of Ontario health spending*. Toronto, ON. Retrieved from https://www.fao-on.org/web/default/files/publications/Health Sector march 2019/Health Update 2019.pdf

Fraser, S. W., & Greenhalgh, T. (2001). Complexity science: Coping with complexity: educating for capability. *BMJ*, *323*(7316), 799–803. https://doi.org/10.1136/bmj.323.7316.799

Gardner, W. L., Avolio, B. J., Luthans, F., May, D. R., & Walumbwa, F. (2005). "Can you see the real me?" A self-based model of authentic leader and follower development. *Leadership Quarterly*, *16*(3), 343–372. https://doi.org/10.1016/j.leaqua.2005.03.003

George, B. (2003). *Authentic leadership: Rediscovering the secrets to creating lasting value*. San Francisco, CA: Jossey-Bass.

Gillespie, G. L., Grubb, P. L., Brown, K., Boesch, M. C., & Ulrich, D. L. (2017). "Nurses eat

their young": A novel bullying educational program for student nurses. *Journal of Nursing Education and Practice, 7*(7), 11. https://doi.org/10.5430/jnep.v7n7p11

Gilmartin, M. J. (2001). Humanism in health care service: The role of stakeholder management. *Nurs Admin Q, 25*(3), 24–36.

Granger, B. B., Prvu-Bettger, J., Aucoin, J., Fuchs, M. A., Mitchell, P. H., Holditch-Davis, D., … Gilliss, C. L. (2012). An Academic-Health Service Partnership in Nursing: Lessons From the Field. *Journal of Nursing Scholarship*, *44*(1), 71–79. https://doi.org/10.1111/j.1547-5069.2011.01432.x

Greene, M. A. (2010). Paying for nursing orientation. *Journal for Nurses in Professional Development*, *26*(6), E3–E7. https://doi.org/10.1097/NND.0b013e3181fc0459

Guay, J., Bishop, S. E., & Espin, S. (2016). New graduate RNs' perceptions of transitioning to professional practice after completing Ontario's new graduate guarantee orientation program. *The Journal of Continuing Education in Nursing*, *47*(1), 37–44. https://doi.org/10.3928/00220124-20151230-10

Habermas, J. (1970). Towards a theory of communicative competence. *Inquiry*, *13*(1–4), 360–375. https://doi.org/10.1080/00201747008601597

Harden, J. (1996). Enlightenment, empowerment and emancipation: the case for critical pedagogy in nurse education. *Nurse Education Today, 16*, 32–37.

Hart, M. (1990). Critical theory and beyond: Further perspectives on emancipatory education. *Adult Education Quarterly*, *40*(3), 125–138.

Health Centre. (2018). *Nursing workforce analysis*. Large Urban Centre, ON.

Health Centre Leadership Development Program. (2017). *Reimagining leadership in a complex system*. Blue Dot Strategy.

Health Workforce Planning Branch. (2018). *2018/19 Guidelines for participation in the Nursing Graduate Guarantee*. Toronto, ON. Retrieved from http://www.healthforceontario.ca/UserFiles/file/NGG/NGG Guidelines - EN.pdf

Heifetz, R. A., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership*. Boston, MA: Harvard Business Press.

Heifetz, R. A., & Laurie, D. L. (1997). The work of leadership. *Harvard Business Review*, *January-February*, 124–134.

Henderson, S. (2003). Power imbalance between nurses and patients: A potential inhibitor of partnership in care. *Journal of Clinical Nursinglinical Nursing*, *12*(4), 501–508.

Hickerson, K. A., Taylor, L. A., & Terhaar, M. F. (2016). The preparation–practice gap: An integrative literature review. *The Journal of Continuing Education in Nursing*, *47*(1), 17–23. https://doi.org/10.3928/00220124-20151230-06

Hickey, M. T. (2009). Preceptor perceptions of new graduate nurse readiness for practice. *Journal for Nurses in Staff Development*, *25*(1), 35–41.

Hogard, E., & Ellis, R. (2006). Evaluation and communication: Using a communication audit to evaluate organizational communication. *Evaluation Review*, *30*(2), 171–187. https://doi.org/10.1177/0193841X05278789

Hollander, E. P. (2009). *Inclusive leadership: The essential leader-follower relationship*. New York, NY: Routledge. https://doi.org/10.4324/9780203809914

Holt, D. T., Armenakis, A. A., Feild, H. S., & Harris, S. G. (2007). Readiness for organizational change: The systematic development of a scale. *Journal of Applied Behavioral Science*, *43*(2), 232–255. https://doi.org/10.1177/0021886306295295

Hopkins, J. L., & Bromley, G. E. (2016). Preparing new graduates for interprofessional

teamwork: Effectiveness of a nurse residency program. *Journal of Continuing Education in Nursing*, *47*(3), 140–148. https://doi.org/10.3928/00220124-20160218-10

Horns, P. N., Czaplijski, T. J., Engelke, M. K., Marshburn, D., McAuliffe, M., & Baker, S. (2007). Leading through collaboration: A regional academic/service partnership that works. *Nursing Outlook*, *55*(2), 74–78. https://doi.org/10.1016/j.outlook.2007.01.002

Husain, Z. (2013). Effective communication brings successful organizational change. *The Business and Management Review*, *3*(2), 43–50.

Huxam, C., & Vangen, S. (2000). Leadership in the shaping and implementation of collaboration agendas: How things happen in a (not quite) joined-up world. *The Academy of Management Journal*, *43*(6), 1159–1175.

Institute of Medicine. (2003). *Health professions education: A bridge to quality*. Washington, D.C.: Author.

Järvinen, T., Eklöf, N., & Salminen, L. (2018). Factors related to nursing students' readiness to enter working life – A scoping literature review. *Nurse Education in Practice*, *29*(January), 191–199. https://doi.org/10.1016/j.nepr.2018.01.010

Jones-Bell, J., Karshmer, J., Berman, A., Prion, S., Van, P., Wallace, J., & West, N. (2014). Collaborative academic-practice transition program for new graduate RNs in community settings: Lessons learned. *Journal of Continuing Education in Nursing*, *45*(6), 259–264. https://doi.org/10.3928/00220124-20140402-01

Joswiak, M. E. (2018). Transforming orientation through a tiered skills acquisition model. *Journal for Nurses in Professional Development*, *34*(3), 118–122. https://doi.org/10.1097/NND.0000000000000439

Kaihlanen, A. M., Haavisto, E., Strandell-Laine, C., & Salminen, L. (2018). Facilitating the

transition from a nursing student to a Registered Nurse in the final clinical practicum: A scoping literature review. *Scandinavian Journal of Caring Sciences*, *32*(2), 466–477. https://doi.org/10.1111/scs.12494

Kellner, D. (2003). Toward a critical theory of education. *Democracy and Nature*, *9*(1), 51–64. https://doi.org/10.1080/1085566032000074940

Kirby, D. (2007). Change and challenge: Ontario's collaborative baccalaureate nursing programs. *Education, 37*(2), 29–46.

Kirkpatrick, D. (1996). Great ideas revisited. *Training & Development*, *50*(1), 54–59.

Klein, S. M. (1996). A management communication strategy for change. *Journal of Organizational Change Management*, *9*(2), 32–46. https://doi.org/10.1108/09534819610113720

Kotter, J. P. (1995). Leading change: Why transformation efforts fail. *Harvard Business Review*, *73*(3), 59–67. Retrieved from papers2://publication/uuid/6EE98667-4405-4C5C-8A06-A412F725809E

Kotter, J. P. (2012). *Leading change*. Boston, MA: Harvard Business Review Press.

Kotter, J. P. (2014). Seizing opportunities and dodging threats with a dual operating system. *Strategy and Leadership*, *42*(6), 10–12. https://doi.org/10.1108/SL-10-2014-0079

Kumm, S., Godfrey, N., Richards, V., Hulen, J., & Ray, K. (2016). Senior student nurse proficiency: A comparative study of two clinical immersion models. *Nurse Education Today*, *44*, 146–150. https://doi.org/10.1016/j.nedt.2016.05.023

Lewis, L. K. (2007). An organizational stakeholder model of change implementation communication. *Communication Theory*, *17*(2), 176–204. https://doi.org/10.1111/j.1468-2885.2007.00291.x

Liao, L. M., Sun, X. Y., Yu, H., & Li, J. W. (2016). The association of nurse educational preparation and patient outcomes: Systematic review and meta-analysis. *Nurse Education Today*, *42*(32), 9–16. https://doi.org/10.1016/j.nedt.2016.03.029

Lichtenstein, B. B., Uhl-bien, M., Marion, R., Seers, A., Douglas, J., & Schreiber, C. (2006). Complexity leadership theory: An interactive perspective on leading in complex adaptive systems. *Emergence: Complexity and Organization*, *8*(4), 2–12.

McKillop, A., Doughty, L., Atherfold, C., & Shaw, K. (2016). Reaching their potential: Perceived impact of a collaborative academic-clinical partnership programme for early career nurses in New Zealand. *Nurse Education Today*, *36*, 145–151. https://doi.org/10.1016/j.nedt.2015.09.005

McMillan, K., & Perron, A. (2013). Nurses amidst change: The concept of change fatigue offers an alternative perspective on organizational change. *Policy, Politics, & Nursing Practice*, *14*(1), 26–32. https://doi.org/10.1177/1527154413481811

Mirza, N., Manankil-Rankin, L., Prentice, D., Hagerman, L.-A., & Draenos, C. (2019). Practice readiness of new nursing graduates: A concept analysis. *Nurse Education in Practice*, *37*(April), 68–74. https://doi.org/10.1016/j.nepr.2019.04.009

Missen, K., Mckenna, L., & Beauchamp, A. (2016). Registered nurses' perceptions of new nursing graduates' clinical competence: A systematic integrative review. *Nursing and Health Sciences*, *18*(2), 143–153. https://doi.org/10.1111/nhs.12249

Missen, K., Mckenna, L., Beauchamp, A., & Larkins, J. (2016). Qualified nurses' perceptions of nursing graduates' abilities vary according to specific demographic and clinical characteristics. A descriptive quantitative study. *Nurse Education Today, 45*, 108–113. https://doi.org/10.1016/j.nedt.2016.07.001

Mosqueda-Diaz, A., Vilchez-Barboza, V., Valenzuela-Suazo, S., & Sanhueza-Alvarado, O. (2014). Critical theory and its contribution to the nursing discipline. *Invest Educ Enferm*, *32*(2), 356–363.

Mrayyan, M. T. (2004). Nurses' autonomy: Influence of nurse managers' actions. *Journal of Advanced Nursing*, *45*(3), 326–336. https://doi.org/10.1046/j.1365-2648.2003.02893.x

Murray, M., Sundin, D., & Cope, V. (2018). New graduate registered nurses' knowledge of patient safety and practice: A literature review. *Journal of Clinical Nursing*, *27*(1–2), 31–47. https://doi.org/10.1111/jocn.13785

Nabavi, F. H., Vanaki, Z., & Mohammadi, E. (2012). Systematic review: Process of forming academic service partnerships to reform clinical education. *Western Journal of Nursing Research*, *34*(1), 118–141. https://doi.org/10.1177/0193945910394380

Nadler, D. A., & Tushman, M. L. (1980). A model for diagnosing organizational behavior. *Organizational Dynamics*, *9*(2), 35–51.

National Task Force on the Future of Canada's Academic Health Sciences Centres. (2010). *Three missions... one future: Optimizing the performance of Canada's academic health sciences centres*. Retrieved from http://www.healthcarecan.ca/wp-content/uploads/2014/07/AHSCNTFFinalReportMay312010.pdf

Newell, S., & Jordan, Z. (2015). The patient experience of patient-centered communication with nurses in the hospital setting: A qualitative systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports*, *13*(1), 76–87. https://doi.org/10.11124/jbisrir-2015-1072

Northouse, P. G. (2019). *Leadership: Theory and practice* (8th ed.). Thousand Oaks, CA: Sage Publications Inc.

O'Reilly, C. A., Caldwell, D. F., Chatman, J. A., Lapiz, M., & Self, W. (2010). How leadership matters: The effects of leaders' alignment on strategy implementation. *Leadership Quarterly, 21*(1), 104–113. https://doi.org/10.1016/j.leaqua.2009.10.008

Ocloo, J., & Matthews, R. (2016). From tokenism to empowerment: Progressing patient and public involvement in healthcare improvement. *BMJ Quality and Safety, 25*(8), 626–632. https://doi.org/10.1136/bmjqs-2015-004839

Ontario Ministry of Health and Long-Term Care. (2019). *Ontario health teams: Guidance for health care providers and organizations*. Toronto, ON. Retrieved from http://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf

Ontario Ministry of Health and Long Term Care. (2018). *Bundled care (Integrated funding models)*. Toronto, ON. Retrieved from http://health.gov.on.ca/en/pro/programs/ecfa/funding/ifm/default.aspx

Ontario Nurses' Association. (2020). *Collective agreement: Hospital central agreement*. Toronto, ON. Retrieved from https://www.ona.org/wp-content/uploads/ona_hospitalcentralagreement_march312020.pdf

Parry, W., Kirsch, C., Carey, P., & Shaw, D. (2014). Empirical development of a model of performance drivers in organizational change projects. *Journal of Change Management, 14*(1), 99–125. https://doi.org/10.1080/14697017.2012.745894

Phillips, P. P. (2012). *The bottomline on ROI* (2nd ed.). United States: HRDQ.

Phillips, P. P., & Phillips, J. J. (2007). *The value of learning: How organizations capture value and ROI and translate them into support, improvement, and funds*. San Francisco, CA: John Wiley & Sons, Inc.

Pijl-Zieber, E. M., Grypma, S., & Barton, S. (2014). Baccalaureate nursing education: Has it

delivered? A retrospective critique. *Nursing Leadership (Toronto, Ont.)*, *27*(2), 27–34. https://doi.org/10.12927/cjnl.2014.23839

Plsek, P. E., & Greenhalgh, T. (2001). Complexity science: The challenge of complexity in health care. *BMJ*, *323*(7313), 625–628. https://doi.org/10.1136/bmj.323.7313.625

Plsek, P. E., & Wilson, T. (2001). Complexity, leadership, and management in healthcare organisations. *BMJ (Clinical Research Ed.)*, *323*(7315), 746–749. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11576986%0Ahttp://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC1121291

Pollack, J., & Pollack, R. (2015). Using Kotter's eight stage process to manage an organisational change program: Presentation and practice. *Systemic Practice and Action Research*, *28*(1), 51–66. https://doi.org/10.1007/s11213-014-9317-0

Popkewitz, T. S. (1980). Paradigms in educational science: Different meanings and purpose to theory. *The Journal of Education*, *162*(1), 28–46.

Purling, A., & King, L. (2012). A literature review: Graduate nurses' preparedness for recognising and responding to the deteriorating patient. *Journal of Clinical Nursing*, *21*(23–24), 3451–3465. https://doi.org/10.1111/j.1365-2702.2012.04348.x

Ray, M. A. (1992). Critical theory as a framework to enhance nursing science. *Nursing Science Quarterly*, *5*(3), 98–101.

Rhéaume, A., Clément, L., LeBel, N., & Robichaud, K. (2011). Workplace experiences of new graduate nurses. *Nursing Leadership*, *24*(2), 80–89.

Romyn, D. M., Linton, N., Giblin, C., Hendrickson, B., Houger Limacher, L., Murray, C., … Zimmel, C. M. (2009). Successful transition of the new graduate nurse. *International Journal of Nursing Education Scholarship*, *6*(1), 1–17.

https://doi.org/10.1016/j.ijnurstu.2008.11.006

Rush, K. L., Adamack, M., Gordon, J., & Janke, R. (2014). New graduate nurse transition programs: Relationships with bullying and access to support. *Contemporary Nurse*, *48*(2), 219–228. https://doi.org/doi:10.5172/conu.2014.48.2.219

Rush, K. L., Adamack, M., Gordon, J., Lilly, M., & Janke, R. (2013). Best practices of formal new graduate nurse transition programs: An integrative review. *International Journal of Nursing Studies*, *50*(3), 345–356. https://doi.org/10.1016/j.ijnurstu.2012.06.009

Ryan, J. (1999). Inclusive leadership for ethnically diverse schools: Initiating and sustaining dialogue. In *Annual Meeting of the American Educational Research Association* (pp. 1–29). Montreal, Canada.

Sadeghnezhad, M., Heshmati Nabavi, F., Najafi, F., Kareshki, H., & Esmaily, H. (2018). Mutual benefits in academic-service partnership: An integrative review. *Nurse Education Today*, *68*, 78–85. https://doi.org/10.1016/j.nedt.2018.05.019

Schlosberg, D. (1995). Communicative action in practice: Intersubjectivity and new social movements. *Political Studies*, *43*(2), 291–311. https://doi.org/10.1111/j.1467-9248.1995.tb01713.x

Schneider, M., & Somers, M. (2006). Organizations as complex adaptive systems: Implications of Complexity Theory for leadership research. *Leadership Quarterly*, *17*(4), 351–365. https://doi.org/10.1016/j.leaqua.2006.04.006

Singh, J., & Singh, H. (2015). Continuous improvement philosophy – literature review and directions. *Benchmarking*, *22*(1), 75–119. https://doi.org/10.1108/BIJ-06-2012-0038

Smith, I. (2011). Organisational quality and organisational change: Interconnecting paths to effectiveness. *Library Management*, *32*(1/2), 111–128.

https://doi.org/10.1108/01435121111102629

Smyth, W., Pianta, P., & Perkins, R. (2018). New nurses' positive evaluation of transition-to-practice programs. *The Journal of Continuing Education in Nursing, 49*(11), 500–506. https://doi.org/10.3928/00220124-20181017-06

Soletti, L., Bailey, A., Smith, M., & Hirvela, M. (2014). Novice nurses, night shifts, and medication errors. *Nevada RNformation*, *23*(4), 18.

Soparnot, R. (2011). The concept of organizational change capacity. *Journal of Organizational Change Management*, *24*(5), 640–661. https://doi.org/10.1108/09534811111158903

Spencer, M. H., & Winn, B. A. (2005). Evaluating the success of strategic change against Kotter's eight steps. *Planning for Higher Education*, *33*(2), 15–22.

Spiers, J. A., Kabotoff, W., Richard, E., Williams, B., McIlwraith, D., Fisk, A., … Scully, A. (2010). Do learning approaches influence practice-readiness? *Alberta RN*, *66*(2), 20–23. https://doi.org/10.2202/1548-923X.1802

Springer, P. J., Clark, C. M., Strohfus, P., & Belcheir, M. (2012). Using transformational change to improve organizational culture and climate in a school of nursing. *Journal of Nursing Education, 51*(2), 81–88. https://doi.org/10.3928/01484834-20111230-02

Stevens, P. E. (1989). A critical social reconceptualization of environment in nursing: Implications for methodology. *Advances in Nursing*, *12*(4), 56–68.

Swartz, M. K. (2014). Critical theory as a framework for academic nursing practice. *Journal of Nursing Education, 53*(5), 271–276. https://doi.org/10.3928/01484834-20140408-01

Theisen, J. L., & Sandau, K. E. (2013). Competency of new graduate nurses: A review of their weaknesses and strategies for success. *The Journal of Continuing Education in Nursing, 44*(9), 406–414. https://doi.org/10.3928/00220124-20130617-38

Thomas, L. W. (1995). A critical feminist perspective of the health belief model: Implications for nursing theory, research, practice, and education. *Journal of Professional Nursing*, *11*(4), 246–252. https://doi.org/10.1016/S8755-7223(95)80027-1

Thompson, J. L. (1987). Critical scholarship: The critique of domination in nursing. *Advances in Nursing Science*, *10*(1), 27–38. https://doi.org/10.1097/00012272-198710000-00008

Thygeson, M., Morrissey, L., & Ulstad, V. (2010). Adaptive leadership and the practice of medicine: A complexity-based approach to reframing the doctor-patient relationship. *Journal of Evaluation in Clinical Practice*, *16*(5), 1009–1015. https://doi.org/10.1111/j.1365-2753.2010.01533.x

Tilley, D. S., Allen, P., Collins, C., Bridges, R. A., Francis, P., & Green, A. (2007). Promoting clinical competence: Using scaffolded instruction for practice-Based learning. *Journal of Professional Nursing*, *23*(5), 285–289. https://doi.org/10.1016/j.profnurs.2007.01.013

Trepanier, S., Mainous, R., Africa, L., & Shinners, J. (2017). Nursing academic–practice partnership: The effectiveness of implementing an early residency program for nursing students. *Nurse Leader*, *15*(1), 35–39. https://doi.org/10.1016/j.mnl.2016.07.010

Uhl-Bien, M., Marion, R., & McKelvey, B. (2007). Complexity leadership theory: Shifting leadership from the industrial age to the knowledge era. *Leadership Quarterly*, *18*(4), 298–318. https://doi.org/10.1016/j.leaqua.2007.04.002

Van der Riet, P., Rossiter, R., Kirby, D., Dluzewska, T., & Harmon, C. (2015). Piloting a stress management and mindfulness program for undergraduate nursing students: Student feedback and lessons learned. *Nurse Education Today*, *35*(1), 44–49. https://doi.org/10.1016/j.nedt.2014.05.003

Van, P., Berman, A., Karshmer, J., Prion, S., West, N., & Wallace, J. (2015). Academic-practice

partnerships for unemployed new graduates in California. *Journal of Professional Nursing*, *31*(4), 351–358. https://doi.org/10.1016/j.profnurs.2015.02.005

van Rooyen, D. R. M., Jordan, P. J., ten Ham-Baloyi, W., & Caka, E. M. (2018). A comprehensive literature review of guidelines facilitating transition of newly graduated nurses to professional nurses. *Nurse Education in Practice*, *30*, 35–41. https://doi.org/10.1016/j.nepr.2018.02.010

Vangen, S. (2003). Collaboration theory for collaboration practice: transfer design principles. In C. M. Scott & W. E. Thurston (Eds.), *Collaboration in context* (pp. 149–159). Calgary, Alberta: Health Promotion Research Group, University of Calgary. Retrieved from http://oro.open.ac.uk/23959/1/Collaboration in Context.pdf

Vangen, S., & Huxham, C. (2003). Enacting leadership for collaborative advantage: Dilemmas of ideology and pragmatism in the activities of partnership. *British Academy of Management*, *14*, S61–S76.

Vangen, S., & Huxham, C. (2008). The Journal of Applied Behavioral Science. *The Journal of Applied Behavioral Science*, *39*(3), 490–504. https://doi.org/10.1177/0021886303253179

Waddock, S., Meszoely, G. M., Waddell, S., & Dentoni, D. (2015). The complexity of wicked problems in large scale change. *Journal of Organizational Change Management*, *28*(6), 993–1012. https://doi.org/10.1108/JOCM-08-2014-0146

Walumbwa, F. O., Avolio, B. J., Gardner, W. L., Wernsing, T. S., & Peterson, S. J. (2008). Authentic leadership: Development and validation of a theory-based measure. *Journal of Management*, *34*(1), 89–126. https://doi.org/10.1177/0149206307308913

Walumbwa, F. O., Christensen, A. L., & Hailey, F. (2011). Authentic leadership and the knowledge economy: Sustaining motivation and trust among knowledge workers.

Organizational Dynamics, *40*(2), 110–118. https://doi.org/10.1016/j.orgdyn.2011.01.005

Webster, A., Bowron, C., Matthew-Maich, N., & Patterson, P. (2016). The effect of nursing staff on student learning in the clinical setting. *Nursing Standard*, *30*(40), 40–47. https://doi.org/10.7748/ns.30.40.40.s44

Weiner, B. J. (2009). A theory of organizational readiness for change. *Implementation Science*, *4*(1), 67–75. https://doi.org/10.1186/1748-5908-4-67

Whelan-Berry, K. S., & Somerville, K. A. (2010). Linking change drivers and the organizational change process: A review and synthesis. *Journal of Change Management*, *10*(2), 175–193. https://doi.org/10.1080/14697011003795651

Wilson-Thomas, L. (1995). Applying critical social theory in nursing education to bridge the gap between theory, research and practice. *Joumal of Advanced Nursing Journal of Advanced Nursing*, *21*(3), 568–575.

Wolsky, K. L. (2014). *Establishment of a standard definition of practice readiness: Academia's vs practices' registered nurses perceptions related to new graduate nurse competencies within Alberta, Canada*. (Doctoral dissesrtation, Capella University). https://doi.org/UMI Number: 3631522

Wong, S. W. J., Che, W. S. W., Cheng, M. T. C., Cheung, C. K., Cheung, T. Y. J., Lee, K. Y., … Yip, S. L. (2018). Challenges of fresh nursing graduates during their transition period. *Journal of Nursing Education and Practice*, *8*(6), 30–37. https://doi.org/10.5430/jnep.v8n6p30

Wright, A. P. (2014). *Preparedness to practice as perceived by the graduate nurse, nursing faculty and hospital leadership*. (Doctoral dissertation, Texas Women's University). https://doi.org/UMI Number: 3624015

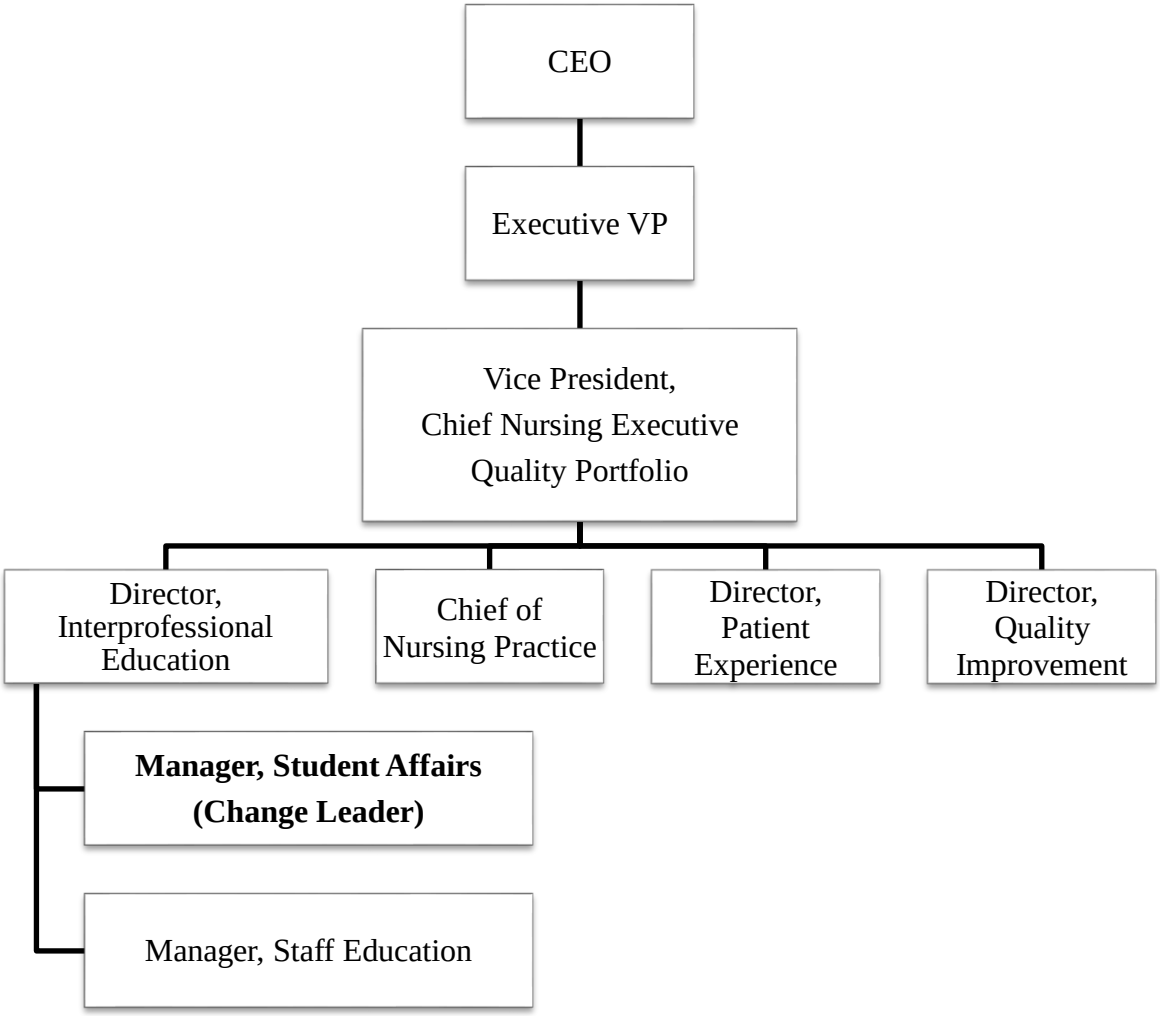
Wuffli, P. A. (2016). *Inclusive Leadership: A framework for the global era*. Switzerland: Springer International Publishing.

Yonge, Olive, Billay, D., Myrick, F. & Luhanga, F. (2007). Preceptorship and mentorship: Not merely a matter of semantics. *International Journal of Nursing Education Scholarship*, *4*(1), 1–13. https://doi.org/10.2202/1548-923x.1384

Young, M. E., Stuenkel, D. L., & Bawel-Brinkley, K. (2008). Strategies for easing the role transformation of graduate nurses. *Journal for Nurses in Staff Development*, *24*(3), 105–110. https://doi.org/10.1097/01.NND.0000300878.95436.98

Appendices

Appendix A: Position of Change Leader (CL) within Organizational Structure



Appendix B: Overview of Possible Solutions to Address PoP

Possible solution	Advantages	Disadvantages	Resource requirements
Possible solution 1: Maintain the status quo:			
• NGRN receive formal in-class orientation and preceptored shifts on the unit	• No change management required	• NGRN angst, burnout, attrition • Potential patient safety issues • Orientation is costly and resource intensive • Patients, nursing students & NGRN remain disempowered	• Financial funding for cost of orientation
Possible solution 2: Implement solutions reported in the literature			
• Interventions implemented by an academic institution or healthcare provider to increase NGRN practice readiness	• Variety of approaches reported in the literature • Limited evidence suggesting employer-based initiatives increase NGRN retention	• Inconsistent evidence • Quality of evidence is weak • No established best practice • Continued domination by the HC & the academic partners	• Most promising approaches require significant financial funding

Possible solution 3: Establish a collaborative approach

• There is a role for both academic institutions and healthcare providers to play • Develop an ASP	• Select evidence suggesting this may be an effective approach • Innovative approach • Mutually beneficial goals • Equitable sharing of resources • Nursing students, NGRN & patients empowered	• Lack of research to inform specific and potential strategies	• Human and financial resources • May be supported with 'in kind' contributions

Appendix C: Overview of Implementation Plan Using Kotter's Eight-stage Process

Kotter's (2012) Change Framework	Action	MRP	Time Line (Month No.)
Establishing a sense of urgency	Impact of current state and value of proposed ideal state communicated to key stakeholders Volunteers for task force solicited	Change Leader	0 - 3
Creating the guiding coalition	Task force assembled and initial meeting held	Change Leader	4
Develop vision and strategy	Vision and initial strategies for Alliance developed Further development of the Alliance: as scope, guiding principles, membership, terms of reference, accountabilities and relationships to other existing working groups or committees	Change Leader & Task Force	5 - 6
Communicating the change vision	Communicate the vision and strategies developed by the Alliance Promote the current activities of the Alliance	Alliance Members	7 - 12
Empowering broad-based change	Alliance continues to execute on the identified strategies Alliance ensures that the structure of the partnership supports ongoing submission of ideas for future strategies.	Alliance Members	13 - 17
Generating short-term wins.	Results of at least one pilot initiative are disseminated to key stakeholders Additional strategies are initiated or underway	Alliance Members	18
Consolidating gains and producing more change	Disseminate and build capacity for successful strategies Evaluate long-term impact of initiatives e.g.	Alliance Members	24 & onwards

	e.g. decreased orientation time of NGRN, increased retention, increased NCLEX pass rates of students.		
Anchoring new approaches in culture	Formalize the role of the Alliance within the cultures of the HC and the academic partners respectively	Alliance Members	24 & onwards

Appendix D: Overview of Change Plan Monitoring Activities

Kotter's (2012) Change Framework	Monitoring Activity
Establishing a sense of urgency	Ensure at least two influential leaders from each stakeholder group are engaged and committed
Creating the guiding coalition	Ensure the team has adequate formal and informal influence across stakeholder groups • Do team members have formal authority in the institutions they representative? • Where formal authority is lacking, is there executive sponsors who will champion this cause and use their influence to obtain resources and remove barriers?
Develop vision and strategy	Ensure the vision is well defined and compelling
Communicating the change vision	Does the messaging meet key criteria: quality and quantity
Empowering broad-based change	Determine which obstacles have been removed and which additional ones need to be addressed • Is the structure of the Alliance supporting the vision? • Are the established processes free of all barriers? • If not, how can obstacles be removed or minimized? • What actions might be taken to empower more individuals to bring forward additional ideas?
Generating short-term wins.	Be prepared to present outcomes from at least one pilot initiative
Consolidating gains and producing more change	Alliance needs to ensure that it remains focused and momentum is sustained • Are additional initiatives being identified and trialed?

Anchoring new approaches in culture	Ensure that the Alliance and associated activities are embedded in structure and processes of the organizations: • Is there explicit linkage between the initiatives, the outcomes and the vision? • Is the Alliance membership and roles linked to roles (not individuals) • Which new leaders within the organization need to be aware of the work of the Alliance?