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Bridging Policy-Curriculum-Accommodations: A Nursing Education Initiative

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Abstract

Supporting student academic accommodations (AAs) is an increasingly prevalent challenge for post-secondary nursing instructors in Ontario, with the growing number of students in nursing programs with mental health or medical disabilities. Historically, nursing programs have denied access to potential students with disabilities; today, the rigorous nursing program structure and the lack of support for instructors remain realities, even with the Ontario Human Rights Code and administrators' policies. The nursing faculty team (NFT) at Top College (TC) (pseudonym) must uphold educational and clinical expectations while assuring student competencies and curriculum integrity. In this comprehensive dissertation-in-practice (DiP), I explore bridging gaps in policy, curriculum, and the growing complexity of AAs. This proposed initiative combines a universal design for learning (UDL) framework with a nursing solution (NS) (UDL-NS), which includes the creation of a nursing accommodation-accessibility decision tree tool. This DiP combines Shields's transformative, Heifetz's adaptive, and Ubuntu's socio-ethical leadership approaches to change. The implementation plan is guided by Deszca and Ingols' change path model (CPM), a communication plan with the alignment, voice, identification, and dialogue (AVID) framework, and a plan, do, study, act (PDSA) monitoring and evaluation plan. A knowledge mobilization plan further illustrates change implementation. The successful implementation will provide a systemic infrastructure for TC and, potentially, other nursing education programs.

Keywords: mental health, nursing, competencies, accommodation, universal design for learning, disability

Executive Summary

As post-secondary administrators create and maintain policies that uphold Ontario's human rights expectations of equitable student access to education (OHRC, 2014), the nursing profession is experiencing a rising enrolment of students with mental health or medical disabilities in post-secondary institutions (Epstein et al., 2021). Consequently, policy and academic accommodations (AAs) are familiar languages among the nursing faculty team (NFT) at Top College (TC), a pseudonym used to protect the institution's anonymity. Another familiar topic at TC is the increasingly urgent need to improve formal support for the nursing faculty, given their ongoing concerns about curriculum delivery and nursing competencies. Ultimately, in this comprehensive dissertation-in-practice (DiP), there is a plan to address my problem of practice (PoP): the lack of support for the NFT in addressing AAs.

Chapter 1 is about the leadership influence of nursing theorist Neuman (2011) and a description of the adult learning theory by Knowles (1984) aligning with TC's adult student profile. There is an outline of my scope of influence in the change process as a front-line clinical instructor and a non-management curriculum lead at TC. Following is a review of the three leadership positions: (a) socio-constructivism, recognizing all realities implicit in knowledge building during social interactions (Bruner, 1973), (b) teamwork, advocating for group collaboration (Rannikmäe et al., 2020), and (c) an ethical framework, aligning professional conduct and interpersonal relationships (CNO, 2023). There is an extensive analysis of the organizational context (Bolman & Deal, 2021) of TC to highlight the symbolic, Francophone-unique perspectives, and structural, political, and human resources frames operating within the organization. The PoP broadly draws on the history of AAs in nursing education. Framing the PoP with a PESTLE analysis (Thakur, 2021) permits determining the political, economic,

sociocultural, technological, legal, and environmental factors that influence the importance of the change initiative. After investigating guiding questions that emerge from the PoP, the chapter concludes by elaborating on current vs. future organizational change, describing how to identify priorities and lead the vision.

Chapter 2 describes the transformative goal (Shields, 2020) of this DiP by situating the PoP in the context of Heifetz et al. (2009a) adaptive leadership and Ubuntu's socio-ethical leadership (Laloo, 2022). Heifetz's view of leadership demonstrates practical ways to confront complex problems (Kuluski et al., 2021), such as AAs in nursing programs, while Ubuntu's leadership is an African-centred approach emphasizing collective engagement and participation in solution-oriented changes (Banda, 2019). Both approaches are symbiotic, offering leaders a means and an end, respectively. There is a description of the four overlapping phases, which are awakening, mobilization, acceleration, and institutionalization of Deszca and Ingols' change path model (CPM) (Deszca et al., 2020), that guide the change process for the duration of the DiP. Notably, the outcome of the organizational readiness to change assessment (ORCA) tool (Helfrich et al., 2009a) indicates organizational readiness for change at TC. Then is a discussion on how, through ethical leadership (Wood and Hilton, 2012), recognizing the way in which ethical issues (i.e., procedural justice, critique, local community, profession, and care) impact and influence social change to build communities. Chapter 2 concludes by elaborating on possible solutions focusing on a universal design for learning nursing solution (UDL-NS) for this program. This is through applying a proposed nursing accommodation-accessibility decision tree and contextualizing associated influential organizational change drivers.

Finally, Chapter 3 illustrates the connections between strategies, frameworks, leadership practices, and necessary analysis to validate the comprehensive implementation plan that

addresses the PoP. Additionally, are furnishing details pertaining to change participants, timelines, and actions. An alignment of goals and priorities with actions in relation to the projected one-year monitoring and evaluation plan, grounded in a plan, do, study, act (PDSA) monitoring and evaluation cycle (Deming, 1986/2018). The communication plan utilizes the internal alignment, voice, identification, and dialogue (AVID) communication framework (Ruck, 2020) to maintain continuity in exchange among implementers. The knowledge mobilization plan highlights an imminent need to better address AAs in nursing programs, given their historical outcome of excluding students with disabilities. Chapter 3 discusses the next steps and future considerations before providing a conclusion and my epilogue.

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First and foremost, my doctoral journey has included essential individuals from my family. My parents instilled in me the importance of continuous education. My husband Carl embraced the idea of solving imminent professional challenges. My daughter, Kiméa, has been my number-one go-to person for my IT concerns. Kiméa, my son, Leodril, and my daughter, Karlia, are my constant reminders to obtain gold medals and achieve goals. Thank you all for being part of my dream.

Further, with respect to ancestors and history, I must acknowledge in my native language, Haitian Creole, that I am a French-speaking settler and that the lands in which I live and have studied are the treaty and traditional territory of the Mississauga Anishinaabeg. I offer the following acknowledgement in my language:

“Nou kòmanse pa rekonèt tè sa a ak responsablite nou genyen pou pran swen l epi respekte tout sa Kreyasyon ofri nou pou n viv ladan l. Nan tout trete yo, tè sa sou li nap viv, travay ek ki sipòte tèt nou se peyi zansèt Michizaagig Anishinaabek la ke yo rele tou jodi a kòm Mississaugas nan kredi. Se yo mem gadyen legal peyi sa a. Nou rekonèt tou, ke peyi sa a rich nan listwa li ki te anvan arive Ewopeyen an. Depi arive Ewopeyen yo, peyi sa te toujou e yo kontinye rete lakay moun endijèn ak moun ki pa endijèn. Kòm yon kominote responsab, nou kwè ke tout moun se sakre, epi chak moun yo gen nou valè fondamantal ak diyite. Kolonyalis vin deplase e deposede pèp endijèn nan tè zansèt yo, epi li kontinye demanti dwa moun, diyite ak libète debaz yo. Nou pran angajman pou rekonsilyasyon, pou fè reparasyon epi ranpli obligasyon nou yo. Trete sa a gide nou aktivman pou nou kenbe relasyon mityèlman benefik, pou nou afime yon respè kolektif ak swen pou tè a, dlo, bèt yo, pou ke youn ak lòt asire yon bon lavi pou pwochen desandan nou yo ” (French Land Acknowledgement, n.d.).

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Acronyms

AAs	Academic accommodations
AVID	Alignment, voice, identification, and dialogue
CNO	College of Nurses of Ontario
CPM	Change path model
DEI	Diversity, equity, and inclusion
DiP	Dissertation-in-practice
ITM	Implementation team members
MHD	Mental health disabilities
NFT	Nursing faculty team
OD	Organizational department
OHRC	Ontario Human Rights Commission
ORCA	Organizational readiness to change assessment
PDSA	Plan, do, study, act
PESTLE	Political, economic, sociological, technological, legal, environmental
PoP	Problem of Practice
TC	Top College
UDL	Universal design for learning
UDL-NS	Universal design for learning—nursing solution

Definitions

Competency: A component of knowledge, skill, and/or judgment demonstrated by an individual for safe, ethical, and effective nursing practice (College of Nurses of Ontario, 2023).

Essential requirement: A task or activity expected to be performed in a particular way and might not be accommodated for a person with a disability without compromising the nature, purpose or function of the task (Roberts, 2012; Roberts et al., 2014).

Mental health disability: Temporary or permanent emotional, psychological, or mental health condition causing limitations in daily activities; for example, anxiety, depression, bipolar disorder, substance abuse, or anorexia (Condra et al., 2015; Philion et al., 2021).

Chapter 1: Problem Posing

The increased post-secondary enrollment of students with a mental health disability (MHD), such as anxiety and depression, poses challenges for students and educators alike. Students already experiencing daily challenges due to a pre-existing MHD face additional difficulties in learning course materials to achieve curriculum objectives in highly structured programs, including nursing programs (Brown et al., 2020). In Ontario's post-secondary institutions, students with MHDs rely on academic student centres to seek academic accommodations (AAs): educational supports sanctioned by medical professionals and mandated by the Ontario Human Rights Commission (OHRC, 2018). This mandated accessibility requirement generates a foundation for organizational policies supporting accommodation policy implementation (Evans et al., 2017). Notably, students requesting AAs often have complex mental health issues requiring ongoing support for their unique care needs (Brown et al., 2020), with treatment prevalence highest among female students (Linden et al., 2021). Meanwhile, according to recent Canadian survey data, just under nine percent of students with an MHD indicated that they currently receive any form of treatment (King et al., 2021). Furthermore, authors of studies examining nursing student anxiety determined that such programs are challenging for students with MHDs, interfering with learning and critical thinking (Brown et al., 2020). Consequently, nursing, a predominantly female profession, is not designed for students with MHDs and has added challenges to these students (Philion et al., 2021). Student requests for AAs are concurrent with social justice principles in education by removing equity barriers (OHRC, 2014); however, faculty members often lack the necessary support required to adequately support students with an MHD who experience difficulties with curricular outcomes (Neal-Boylan & Miller, 2017) and clinical placements (King, 2018) despite their AAs (Philion et

al., 2021). As a nursing faculty team (NFT) member, I seek to explore the link between faculty member compliance with accommodation policies posing potential practice risk gaps and student entitlement to sufficient AAs to achieve curriculum objectives (Volino et al., 2021). Ultimately, my problem of practice (PoP) aims to bridge gaps in policy, curriculum, and AA implementation in a comprehensive dissertation-in-practice (DiP). I begin by discussing my leadership position and lens. Before delving into my PoP, I share the organizational context in which I work. I then frame the PoP and formulate emerging guiding questions before concluding with a leadership-focused vision for change of Top College (TC), a pseudonym for my workplace.

Leadership Position and Lens

Below, I identify my leadership philosophy while outlining my personal position. I also describe my responsibilities within my scope of influence at TC. I also reflect on the importance of my position (Holmes, 2020) and explain how my leadership style is connected to theoretical perspectives.

Leadership Philosophy

My leadership philosophy is inspired by the late contemporary nurse theorist Neuman's (2011) approach to nursing, emphasizing how modelling behaviour is an essential component in nursing care's holistic approach (Ahmadi & Sadeghi, 2017; Wang et al., 2019). Additionally, I share Neuman's (2011) belief that an individual's mental health is insufficiently addressed in conventional nursing education programs. Neuman (2011) emphasizes the need to create more equitable learning models requires innovation as "It is important to state that neither was I knowledgeable about nursing models nor had a clear trend yet begun in nursing for developing models" (p. 332). My teaching philosophy regards all humans as capable of learning. Moreover, I believe learning is an evolutionary process corresponding to environmental contexts, including

stressors and guiding interventions (Montano, 2021). I view knowledge construction as a process that includes collecting data from multiple interdisciplinary perspectives with overlapping components including physiological, psychological, developmental, spiritual, and sociocultural variables (Vogel et al., 1999). As an educator, I emphasize the need for positive mental health and well-being of nursing students in a similar way to patients and clients (Mudd et al., 2020). This philosophy aligns with my identity as an educational leader seeking to create a lateral hierarchy (Azorín et al., 2020), meaning a substitution of a subordinating approach, which subsequently avoids authority power between educators and students. In this way, my leadership position and philosophical approach to teaching and learning are intertwined: I am committed to promoting a safer and healthier learning environment that supports faculty and students. The pursuit of equitable change (Shields & Hesbol, 2020) in education toward a greater social good.

My leadership is also influenced by adult learning theory, popularized by Knowles (1984) and its concept of andragogy, describing the art and science of helping adults learn. Adult learning theory focuses on adults as learners, whereas common pedagogical models fail to distinguish between child- and adult-specific learning frameworks. Consequently, andragogy is an important theoretical framework that supports appropriate contextualization of nuances in why and how adults learn, including their incentives to pursue learning (James & Bewsell, 2020). Knowles (1984) distinguished six components of andragogy: self-concept, experience, readiness, and orientation, motivation and need to know. In Appendix A, I illustrate these six adult learning theory assumptions (Knowles, 1984), which are crucial in understanding adult learner motivations (James & Bewsell, 2020). However, Ngozwana (2020) pointed out a potential issue with the self-concept assumption. More specifically, despite being adults, all learners, regardless of age, need an individual to guide the learning process. In my role as an

agent of change, I must consider adult learner preferences, as advocated by Christodoulakis et al. (2022). This includes being adaptable and open to various methods such as case study, simulation, role-playing, and self-evaluation.

Internal factors—such as dissatisfaction—and external factors, including curriculum concerns and practice gaps, can trigger adults to re-examine their learning needs, formulate goals, identify human and material resources, and evaluate those needs (Ngozwana, 2020). Consequently, in this DiP, I emphasize process frameworks over knowledge- and content-oriented learning models (Knowles, 1984). As a certified educator, I strive to better understand how to address AAs to increase my own efficacy as an adult educator. In my current leadership role, I intend to facilitate change and influence others using persuasive communication (Gallup, 2020) to set reasonable and attainable goals and outcomes (Christodoulakis et al., 2022) described in this DiP. Notably, management at TC has continuously supported my graduate studies and looks forward to contributing to my journey.

Leadership Influence

My interest in AAs stems from my position as an NFT member, in which I act as both a front-line clinical instructor and a non-manager curriculum lead. I also leverage previous professional experiences in my commitment to postmodern practices that emphasize the importance of collective action in encouraging knowledge sharing between staff (Lacan, 2019). My current role reflects my subject matter expertise, professional experience, and commitment to a team-based approach. I am leading the bridging program from the registered practical nursing diploma to a nursing degree at the bachelor level. In this position, I am a member of a nursing bachelor consulting committee that focuses on curriculum development. AAs are priorities that directly influence my PoP. In this role, I influence decision-making and interact with key internal

partners, including the post-secondary program manager, the nursing program manager, NFT members, the organizational development (OD) team, the program advisory committee, and the academic student centre team.

I have just divulged my appreciation for Neuman (2011), my passion as an adult educator, and my motivations toward effective change, which fuel my examination of a PoP. Still, I recognize the need to further elaborate on my leadership lens. Next, I discuss the ethical, socio-constructivist, and team-based leadership styles with which I identify.

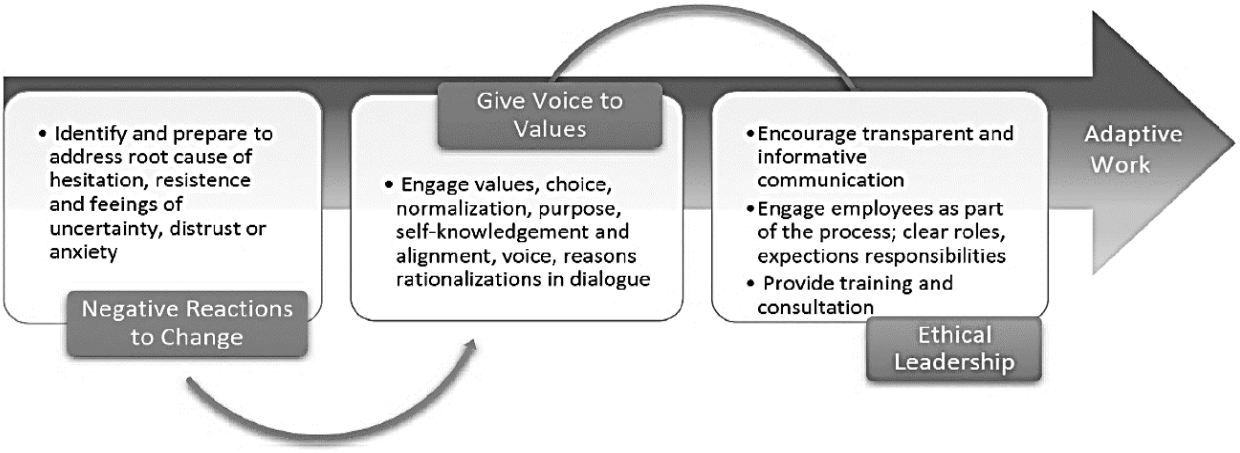
Ethical Leadership

Ethical leadership describes "the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement, and decision making" (Sağnak, 2017, p. 1103). In the context of this DiP, ethical leadership necessitates improving psychological safety (Newman et al., 2017), which O'donovan and Mcauliffe (2020) defined as supporting different opinions of organizations, teams, and individuals about professional responsibilities. The sensitivity and personal importance described in this DiP, given the inherent ethical concerns of issuing and accommodating AAs, require me to act as an ethical leader (Bush & Chen, 2020). As such, I ground myself in ongoing reflective processes tied to a wider literature review examining the historical application of AAs in formal nursing education (Mack et al., 2021) and the implications of the Accessibility for Ontarians with Disabilities Act (Evans et al., 2022). I then explore contemporary pedagogical frameworks, including universal design for learning (UDL) principles and adult learning theory in my desire to promote inclusivity, meet diversity needs, and establish more equitable education (Flood & Banks, 2021).

As an ethical leader, I create an "ethical space of engagement" (Ermine, 2007, p. 1) in which two opposing worldviews can engage during informal and formal team meetings; these debates are important because they ultimately contribute new dialogue and insights. In the context of this DiP, this ethical space discourages policies and AAs from opposing current nursing curriculum objectives at TC through a process of ethical engagement. In Figure 1, I describe this theoretical perspective and present a framework for ethical engagement in change.

Figure 1

Process for Ethical Engagement in Change



Note. This figure is adapted from Kolga (2021).

Utilizing an ethical leadership approach, I also inspire the NFT to re-examine their beliefs by providing evidence that alleviates professional concerns and makes space for negotiations during group discussions (Epstein et al., 2020). As an ethical leader, I expect ambivalent reactions from individuals or teams during the ethical engagement process (Ermine, 2007).

Socio-Constructivist Leadership

According to Mohajan and Mohajan (2022), constructivism is a theoretical paradigm that describes how learning experiences provide positive outcomes, such as knowledge acquisition and decision-making skills. Bruner (1973) expanded on that definition by including the influence of social interaction on learning. Therefore, "While constructivism is seen as acting at a personal level, not imposed by others, in a social constructivist environment, the personal level learning is collaborative" (Rannikmäe et al., 2020, p. 265). In this paper, I refer to socio-constructivism to denote this leadership principle.

With my specialization in mental health, I intend to leverage the trust within the relationships I built throughout my employment at TC to address AAs with a socio-constructivist approach (Mohajan and Mohajan, 2022). Given the historical disfavourment of nursing students with MHDs (Englund & Lancaster, 2022), I believe that acknowledging any underlying mental health component contributing to AA requests is crucial. Also, I align with Volino et al.'s (2021) recommendation that education be made more equitable. As a Caribbean scholar, I support the growing influence of transforming education systems for inclusion in the Caribbean (Blackman et al., 2019) and abroad. As a result, my ontological position embraces the concept of multiple realities, even when these realities, such as the dichotomy between policy and curriculum, seemingly conflict (Mohajan & Mohajan, 2022). Additionally, I recognize that researchers act under specific conditions—both known and unknown—that are in constant evolution (Charmaz, 2014). This necessitates networking (Van Bruggen, 2019) as an essential component in enhancing outcomes through the investigation of accommodation policies across various educational institutions (Deszca et al., 2020). To this end, not only do I participate in TC's internal committees and external professional groups, such as the Registered Nurse Association

of Ontario, but I also belong to two professional governing bodies: the College of Nurses of Ontario (CNO) and the Ontario College of Teachers. To address AAs, both regulated professions require in-depth socio-constructivist approaches. Mohajan et Mohajan (2022) discussed how the socio-constructivist approach is grounded in theories on research, learning, and peer teaching. Therefore, my practice supports (a) the creation of knowledge resulting from engaged learners, (b) the evolution of knowledge through experiences, (c) the interaction among learners, (d) the facilitation of learning through scaffolded activities and assessment, and (e) the negotiation of meaning, and planned collaboration (Barak, 2017). Inevitably, health and education significantly impact individual well-being (Woloshyn et al., 2019). Consequently, AAs must be considered through an intersectional lens in theory and practice (Barak, 2017) to enhance learning outcomes.

Team-Based Leadership

A team is composed of specific individuals with the influence of an identified leader working interdependently to achieve common goals (Northouse, 2021), such as the NFT with AAs. The collaboration among NFT members is an example of team-based leadership, which has long been my preferred leadership style. Indeed, my nursing training was grounded on the belief that a team-based approach is best for the continuation of care at all organizational levels (Wang et al., 2019). As a team-based leader, I demonstrate my engagement in achieving common goals by encouraging staff participation in the change process (Nagda, 2019).

More broadly, a combination of team-based elements (Van Diggele, 2020), including knowledge of adult learning theory, leadership qualities, subject matter expertise, and communication style, contributed to my appointment as a curriculum lead in my NFT role. Notably, the distributed leadership approach applied at TC necessitates the sharing of influence by team members according to complex issues, aligning with my socio-constructivist lens in

viewing knowledge acquisition as a gradual knowledge achieved through collaboration (Burgess et al., 2014). More specifically, I value human relations, the development of trust, and collaborative effort; in team meetings, I create group dynamics that promote idea exchanges (Mohajan & Mohajan, 2022). I am also a proponent of hybrid communication, which offers the flexibility of traditional in-person interactions with contemporary virtual communications to connect internal partners and external community members (Barley et al., 2017). Hybrid communication also supports cognitive diversity, which "bring[s] together a range of different styles of thinking among group members. Factors that could lead to diverse thinking could include but are not limited to, different perspectives, abilities, knowledge, attitudes, information styles, and demographic characteristics, or any combination of these" (Trepanier, 2023, p. 248). I understand my responsibility to promote leadership behaviour that supports group navigation of team-based problem-solving (Banda, 2019) and applying appropriate interventions. Discourse in hybrid environments supports a team approach in ensuring all stakeholders have an equal participation opportunity.

Above, I presented my leadership philosophies and emphasized supporting student mental health in nursing education programs. Further, I have acknowledged the influence of ethical leadership on my behaviour within my current role at TC. I also identified how a socio-constructivist approach helps to build knowledge and described my team leadership style. Next, I situate these observations while providing an overview of TC's organizational context.

Organizational Context

In this section, I describe TC's organizational context and provide insight into the symbolic, structural, political, and human resources frames (Bolman & Deal, 2021) that affect my DiP.

Symbolic Frame

The symbolic frame supports apt descriptions of organizational cultures, including how workplaces celebrate and recognize employees' achievements and their capacities to stimulate employee performance (Bolman & Deal, 2021). TC (2023) is a mid-size, publicly funded Ontario-based Francophone Community College for Applied Arts and Technology with fewer than 10,000 students, which offers over 100 post-secondary education and apprenticeship programs, including nearly 50 unique French-language programs and other services. Under the Canadian French Language Services Act and the Franco-Ontarian flag, TC (2023) has a designated status and a specific mandate to preserve French-language healthcare service accessibility, promote French heritage, and maintain personal and professional connections to French communities. Notably, Ontario's large geographic area and minority Francophone population require TC to make additional efforts with all levels of government to build strong relationships with policymakers and develop strategic alliances with other Francophone groups. Although the provincial government funds TC, the survival of the nursing program—and employment of nursing staff—is conditional on student enrollment. This contributes to mutual dependence between TC, the provincial government, and Francophone communities.

Consequently, addressing AAs is a sustainability strategy that will maintain student enrolment and increase retention. McGregor and Hunter (2021) emphasized that post-secondary institutions are experiencing decreased enrollment of domestic students with a substantially increased enrollment of international students. This is especially evident in the nursing program (Epstein et al., 2021). The high nursing student enrollment from French-speaking countries represents an average total admittance of approximately 30 percent (TC, 2023). The percentage of international students contributes to TC's (2023) operational stability and aligns with its

mission, vision, and values. Nevertheless, internal data indicates an overwhelming solicitation of AAs from domestic students when compared to international student peers (TC, 2023). However, McGregor and Hunter (2021) discussed potential accessibility barriers for international students, including financial and knowledge barriers, which should not be left unconsidered. The absence of specifics can mask the appropriate identification of students requiring this support.

TC's (2023) organizational culture includes empowerment and celebration through certificates or pins when staff complete educational initiatives and achieve success indicators. All while considering culture, accessibility, and sustainability, which are key features of AAs and associated policies. Ultimately, TC's (2023) symbolic frame recognizes staff commitment as a significant contributor, while its educational focus, identity, and heritage give TC a distinct positionality and unique perspective.

Structural Frame

The structural frame relates to an organization's primary mission, vision, values, objectives, and strategies (Bolman & Deal, 2021). TC's (2023) leadership has established a quinquennial revision cycle of its mission, vision, and values; this process is set to repeat within 1 to 2 years. This review aims to offer improved and more sustainable educational training for Ontario's Francophone communities. TC's (2023) vision is to be a community model of educational training and personalized services, while its values include openness to innovative approaches. TC's (2023) mission, vision, and values are visible on all official documents and websites and are approved by a Board of Governors. Consequently, there is a deliberate focus on quality as validated in the strategic plan, annual report, activity plan, strategic mandate agreement, policies and directives, program quality assurance audit, advisory committees, and surveys conducted by Ontario's Ministry of Colleges and Universities. At TC, the maximization

of educational leadership includes encouraging the academic potential of faculty expertise within the collective organizational mission. In this context, the organizational culture promotes inter-departmental and cross-disciplinary collaborative approaches among faculty teams. Although TC's (2023) inclusive cultural approach encourages team collaboration, internal data indicates that the implementation of its mission is misaligned with its vision and values because front staff are under-represented in decision-making. Simultaneously, structural leadership at TC tends to over-emphasize expertise skill domains.

TC's (2023) leadership includes the office of the President, the Board of Governors, and the program advisory committee, which reports to the Board of Governors through the President. Program advisory committee members are internal leaders with no voting privileges and external leaders who are experts in their fields. Given its mandate to review and revise programs, including associated policies and procedures, the program advisory committee contributes to student success and graduation rates, making the program advisory committee an important community partner.

Political Frame

The political frame relates to hierarchical power within TC's organizational structure, as well as policy governance and communication within decision-making processes, including conflicts, negotiations, and competition (Bolman & Deal, 2021). Within this frame, the vertical power in higher leadership positions, from the stations of President to Vice President, to Director, to post-secondary program managers, indicates increased distance among hierarchical levels. Entrusted to oversee the campuses and online programs, the President relies on distributed leadership communication to subalterns. Within this top-bottom functional structure, the President makes key strategic decisions by delegating broad transactional actions to

subordinates, who further delegate tasks and responsibilities to their own subordinates. This ultimately provides middle managers with some flexible decision authority, which I emphasize throughout this DiP. As a front-line NFT member, my direct supervisor is the onsite post-secondary program manager, who acts as an authority figure to guide my concerns toward intermediate and upper management or specialized internal management, including the nursing program manager. The post-secondary program manager also influences the pace of change in an intertwined management and leadership role (Riggio, 2017). I anticipate a positive reception toward my DiP based on feedback from prior successful projects and my appointment to the curriculum lead role. In this DiP, I recognize that TC's management is broadly interested in initiative leadership, emphasizing the achievement of success indicators, which are graduation rates and graduate satisfaction.

The policy governance structure at TC (2023) includes bi-annual program advisory committee member meetings. In Appendix B, I explain how the policy process includes four steps after consultation with the program advisory committee, and I situate myself within the structure.

The Board of Governors approves the policy, the directorship approves the directive, the director approves the procedure of the respective campus, and the post-secondary program manager communicates the approved policy to staff. Eacott (2013) identifies the need for more space, while Volino et al. (2021) emphasize educational outcomes impacting policy.

Human Resources Frame

Bolman and Deal (2021) associated the human resources frame with employee work duties, welfare, skill development, and empowerment processes. For specific programs, AAs can be challenging to support within nursing education given the field's scope of practice, which

includes accountabilities of competency—defined as knowledge, skill, or judgment demonstrated by an individual for safe, ethical, and effective nursing practice (CNO, 2023). Specifically, the CNO's competencies include establishing requirements for entry to the profession; developing and promoting standards of nursing practice; administering a continuing competence program; and enforcing standards of practice and conduct by responding to complaints (Moghabghab et al., 2018). NFT members must determine competence using assessment tools in educational and clinical settings; upon graduation, all nursing education programs expect graduates to have adequate competence to fulfill their duties safely and effectively (Bellacicco & Demo, 2023). In supporting AAs, NFT members must also consider ethical dimensions requiring students to demonstrate competencies safely and appropriately in clinical settings (Smith et al., 2021).

In this section, I have confirmed my capacity to address my PoP as an NFT member focused on mental health and given my non-management role as a curriculum lead. The amalgamation of organizational elements includes culture, governance structure, and context, combined with my socio-constructivist lens. Also, commitment to ethical leadership provides me with unique preparation and ability to undertake these proposed organizational changes through my proposed leadership PoP, described next.

Leadership Problem of Practice

In my PoP, I focus on the need for support of NFT pertaining to AAs by examining curriculum integrity concerns, with respect to theory and knowledge competency expectations in nursing and perceived practice gaps. Gassas (2021) defined practice gaps as disconnects between knowledge or skills taught at school and the ability to perform them safely and independently in practice. AAs describe changes in the environment, technology, timing, or assessments that support student learning abilities (The Understood Team, n.d.). However, through my PoP, I

consider a new dimension. I examine how AAs support students with MHDs for disabilities, including anxiety, depression, and insomnia. However, I mainly explore the broader impact of these disabilities on student learning within a structured nursing education program.

Problem of Practice Statement

The prevalence of MHDs is relevant in female-dominated professions (Kawsar et al., 2022), as the number of nursing students with MHDs enrolling in Canadian post-secondary institutions increased (Epstein et al., 2021) by 67 percent between 2006 and 2011, with anxiety disorder (Condra et al., 2015). Also, there is a 50 percent stronger correlation for students with MHDs to experience insomnia (Golding & Singh, 2023); nursing students are already at risk (Adachi et al., 2022) or are experiencing a landscape of insomnia up to 63 percent (Bibi et al., 2024), defined as difficulty falling or staying asleep (Bonnet & Arand, 2023; Güneş & Arslantaş, 2017). Belingheri et al. (2022) added that this potentially exacerbates learning difficulties, such as difficulty with concentration. Nursing students with MHDs are even more likely to experience challenges, given the intensity of academic study and clinical practice (Brown et al., 2020) related to preexisting or onset of learning disability diagnosis in the nursing field (Sparks & Lovett, 2009). Notably, students have the right to an AA in Canadian post-secondary institutions (Moghimi et al., 2023). It is important to understand how AAs support nursing students with MHDs and their impact on learning, assessment, and future practice because nursing education is a highly challenging field requiring significant self-direction (Philion et al., 2021).

In Ontario, the OHRC (2018) sought to address these obstacles by mandating AAs upon student requests to promote equitable post-secondary education access. Since then, Canadian enrollment rates for students with disabilities have significantly increased (King et al., 2021), with numbers similar to those reported in America, where enrollment of students with disabilities

has almost doubled from 10 percent in 2011 to 19 percent in 2017 (Englund & Lancaster, 2022). Despite this, nursing students commonly deploy a ‘self-accommodation’ approach by hiding personal challenges from faculty due to historical perceptions that nursing education programs will marginalize accommodated students (Englund & Lancaster, 2022) while failing to provide requisite support (Epstein et al., 2021). Consequently, in this DiP, I explore marginalization as a socio-political process that results in the peripheralization of individuals by the dominant, centralized majority (Englund & Lancaster, 2022). As a result, marginalized nursing students may feel devalued and worry that their disability causes them to be viewed as patients, seemingly ineligible to participate in a professional field like nursing (Bulk et al., 2017). As an ethical leader, I apply an inclusive nursing philosophy and view students as individuals (Neal-Boylan & Miller, 2020) capable of performing within an organization's health index (Gagnon et al., 2017). Thus, my PoP statement is the lack of institutional support for the NFT in addressing AAs. This will resolve curriculum integrity concerns and mitigate the perceived risk of gaps in practice.

Framing the Problem of Practice

Investigating the historical impact of AAs in nursing will clarify the extent to which NFT requires support from management at TC. Also, to better understand the DiP, I explore elements of the PoP and frame AAs using a PESTLE analysis that considers political-economic, socio-cultural, technological, legal, and environmental factors (Thakur, 2021).

Historical Overview of the PoP

Historically, students requiring AAs in nursing programs were subject to discrimination, including admission denials (Levey, 2018), demonstrating how NFTs require more support in adapting reasonable accommodations (Neal-Boylan & Miller, 2020). Importantly, the term 'reasonable accommodation' needs to be better defined by the OHRC (2015). Currently, each

educational institution must formulate its own interpretation and define the term, with limits and alternatives, in their respective standardized accommodation policies (Englund & Lancaster, 2022). In this DiP, I describe 'reasonable accommodation' as the absence of undue hardship, including financial, health and safety considerations, within the limit of my role and profession. I have tentatively defined reasonable nursing program AAs as a means to eliminate discrimination based on disability or other grounds prohibited by Canada's Charter of Rights and Freedoms (Government of Canada, 2022). In my definition, I also considered (a) adaptations to practice (Neal-Boylan & Miller, 2020), (b) individual and public psychological safety (Galloway & Ishimaru, 2020), (c) methodology design respecting clinical essential requirements (Mack et al., 2021); and (d) social justice (Elkington, 2020) in an adult learning environment for equitable education (James & Bewsell, 2020).

Educational institutions have administrative policies and a faculty commitment to accommodate student disability needs, abilities, and circumstances. These policies generally fail to consider nursing-specific implementation challenges and, according to Mack et al. (2021), do not apply to hospital settings. There are three primary reasons for these exceptions: (a) students do not have employee status at hospitals (Epstein et al., 2020) despite potential employment at the end of their clinical placements, (b) the predominant medical model in the nursing profession is primarily task-oriented (Epstein et al., 2020), despite technology access to nurses, and (c) nursing technical skills have slight variations in task methodology (Neal-Boylan, 2019) from a historical nursing training model (Wildman & Hewison, 2009). Consequently, traditional practice relies on clinical instructors to train students before they enter the workforce. Historically, this approach has created a culture in which so-called 'able bodies' learn in a practice-oriented profession that produces student competency and safe clinical practice (Epstein

et al., 2021). Nevertheless, nursing programs that adhere to this dominant medical model unwittingly generate barriers for students with disabilities by viewing them as educational risks (Hogan, 2019). Although study findings confirm that perceptions of risk differ from factual observations (Epstein et al., 2021), faculty staff view accommodated nursing students as a potential liability that will negatively impact their abilities to practice safely (King, 2018). In addressing the potential practice gap, I align with Mack et al.'s (2021) approach toward clinical essential requirements to determine what can and cannot be accommodated in placement settings.

It is precisely because the CNO places so much emphasis on public safety (CNO, 2023) that there is an urgency to better address AAs. In my current leadership role at TC, I review course learning outcomes based on board-directed postsecondary education quality assessments of degree-level expectations. Reflecting on these curriculum concerns and the perceived practical risk of accommodating students with AAs has encouraged me to reflect on the underlying assumptions about students with disabilities in TC's nursing program. My role—including my mental health leadership influence, ethical approach, and socio-constructivist lens—also impacts my framing of the PoP as Ryan (2014) defined as inclusive-oriented.

Problem of Practice

Addressing my PoP also contributes to healthcare's broader desire to better understand how and where students acquire clinical, conceptual, and empirical knowledge (Vinson, 2000). I examine these opportunities through a framework of political-economic, socio-cultural, technological, legal, and environmental (PESTLE) analysis, a concept developed by Thakur (2021).

Political-Economic Factors

Because of the absence of operational directives from Ontario's Ministry of Colleges and Universities to help post-secondary institutions with addressing AAs, the OHRC (2018) indirectly assumes indisputable authority over their implementation. The Association on

Higher Education and Disability also guides post-secondary administrators in planning and organizing many standards and services for students with disabilities (Salmi & D'Addio, 2021). TC's status quo accommodation delivery model requires that first, NFT notify the academic student centre of students needing service by the fifth class, supporting early identification (Brown et al., 2020). Second is that students seeking AAs provide medical notes from healthcare professionals to the school psychologist (Lovett & Harrison, 2021) at the academic student centre, who then emails the faculty to describe the accommodation request. Notably, TC's school psychologist follows the accommodation document delivery process rather than providing data-based services (Lovett & Harrison, 2021) and accountability on equity policy (Universities Canada, 2017). The document delivery process includes two pathways. In the shorter pathway, the academic student centre will provide accommodation instruction within two weeks of the student's request. The second pathway requires a lengthy psycho-educational assessment process, costing approximately $4,500.00, with an extra fee for French-language testing (Psychoeducational Testing, 2022). According to Witteveen and Velthorst (2020), this process can pose a financial challenge for marginalized populations, such as (a) adult newcomers to Canada, (b) financially constrained students, including single parents, and (c) international students who are novices in the Western world's academic system. Given the lack of evidence-based data, some accommodation requests listed on official health professional documentation are subject to inquiries regarding their effectiveness and appropriateness (Timmerman &

Mulvihill, 2015). Consequently, AAs may resemble a student's wish list of modifications (Sokal & Vermette, 2017) instead of a list of needs (Harrison & Armstrong, 2022). Such AA documents create an implicit bias that I define as sham accommodations. Understandably, little collaborative interest in meeting these accommodations (FitzGerald & Hurst, 2017) is demonstrated by NFT members. Nevertheless, as it is open to all students, the accommodation delivery process must comply with equity and inclusivity values. Educational organizations contribute to enhancing imminent nurse workforce needs in addressing healthcare needs. The increased enrollment of students in nursing programs (Epstein et al., 2021), like at TC, demonstrates the student population's interest in healthcare. Since student nurse readiness to practice adds to the availability of human resources in this profession, there is a significant correlation between nursing education and the economy.

In nursing education, associated competencies are necessary for licensing regulations that provide public protection (Moghabghab et al., 2018). At TC, the registered practical nursing program is a two-year program divided across four semesters. The CNO then applies 79 entry-level competencies for the program across five core categories: professional practice; legal practice; ethical practice; foundations of practice; and collaborative practice (CNO, 2023). These competencies, including standardized expectations, are used across all areas of nursing practice, such as pediatrics and psychiatry (Fukada, 2018). One such CNO (2023) expectation is that a nurse "has a legal and ethical duty to report incompetent or impaired practice or unethical conduct of regulated health professionals" (p. 8). At TC, this program hosts rigorous expectations for students with or without AAs, including (a) a minimum passing grade of 70 percent for nursing courses, (b) a maximum limit of three attempts to pass a course; and (c) a

mandatory medical note if absent on an evaluation day. Crucially, NFTs must uphold these requirements, which is reflected in my PoP's commitment to these expectations.

Socio-Cultural

TC's (2023) student enrollment statistics indicate that nursing is its largest program. Student demographic data delineates a ratio of 1:3—domestic and international—which can be further subdivided into minority and marginalized groups concentrated in international student enrollments (TC, 2023). From 2017 to 2020, a steady yearly increase of a 2:1 female-to-male full-time student ratio was identified (TC, 2023).

Unfortunately, according to Canadian data, international students experience academic challenges, social isolation, and cultural adjustment struggles, all of which generate stress (Wu et al., 2015). Since most AAs are initiated by domestic students at TC, it is reasonable to conclude that international student access to AAs may be limited by cost or health insurance exemptions that may prevent them from seeking psycho-educational testing. Despite AAs, students with disabilities frequently describe a lack of support that requires them to self-advocate within an unfamiliar and stressful environment with fewer academic supports when compared to the structure of Ontario's high schools (Roberts et al., 2016). Ultimately, adequately addressing student AAs aligns with TC's mission, vision, and values for two reasons. First, TC (2023) values its status as a French-language educational institute. Given that, Statistics Canada indicated that 594,735 Ontarians, or just over four percent of the population, speak French at home, it is crucial to support French-language nursing education (CASN, 2021). Second, data from the United States presents a potential correlation between mental health disabilities and a 23 percent decrease in newly graduated nurses' entry-level competencies and practice readiness (Kavanagh & Szweda, 2017). Canadian findings indicated a 25 percent failure rate in students'

first licensing examination attempts, which worsens with subsequent attempts (Canadian Nurses Association [CAN], 2021). By navigating this problem, I can better support the preparation of NFT members at TC to successfully train students through appropriate AAs.

Technological

Working in a non-management role at TC enables me to appreciate the active frontline collaborative value that my colleagues contribute to nursing. Furthermore, my work with the NFT provides me with a distinct understanding of the practical reality and seriousness of these curriculum concerns. Ultimately, addressing AAs requires an adaptive approach for two reasons. First, faculty members have historically had limited negotiation authority on policy options (Galuska, 2014). Second, the historical denial of students with disabilities (Levey, 2018) has demonstrated a lack of support for students, thereby necessitating AAs (Volino et al., 2021). Notably, there is administrative support for these changes at TC. TC's (2023) strategic plan emphasizes accessibility, quality, and visibility, indicating administrative support for innovative nursing leadership as part of the plan's emphasis on strategic engagement. Another way that TC's management has recently demonstrated its educational leadership is by focusing on diversity, equity, and inclusion (DEI). This includes hybrid instructions during and after COVID-19 pandemic, affecting collegiate mental health (Zhai & Du, 2020). Also, recently, TC introduced two UDL webinar sessions to interested staff. As an ethical leader, I appreciate the initiatives of hybrid and UDL approaches. Additionally, in my team-leading role, I have experienced management reception to changes that benefit common educational interests during curriculum and OD team meetings.

Legal

Better addressing AAs requires NFT members to embrace an adaptive approach that avoids infringing upon individual human rights and compelling legal action (Moghimi et al., 2023). Ethical and legal considerations address NFT member duties to accommodate students, factoring in TC's commitment to improving the availability of mental health supports that better align with the postsecondary educational accessibility standard. This commitment adds to NFT members' dual responsibilities to train nursing students with complex disabilities while supplying a qualified nursing workforce according to the demand for the profession (Council of Ontario Universities, 2020). Given that NFT members have been responsible for assessing student nurse competencies in applying the CNO (2022) framework since 1963. This responsibility is essential in determining the capabilities of future nurses (CNO, 2022). Thus, the ethical appropriateness of the accommodation policy must be considered. Concretely, NFT members lack formal institutional support while expressing concerns about perceived practice gaps (Moghimi et al., 2023): a practice divulged to me by NFT personnel.

Newhook (2018) notes that AA requests are not guaranteed. This demonstrates the multi-faceted nature of this issue. Also, it highlights how even well-informed and well-intended organizations struggle to balance the needs of all community partners in assigning and implementing accommodations. To this end, the AAs addressed in my DiP have particular resonance because of their link to MHDs. As a mental health nurse, I can affirm that anxiety disorders, with internalized or externalized behaviours, affect learning abilities (Nichols et al., 2021). However, not all students with AAs have a confirmed disability diagnosis with defined functional limitations (Butzbach et al., 2021). It is notable that diagnosis alone does not imply disability nor qualify a student for an AA. It is for this reason that academic student centers

should typically require that the impact on academic tasks like concentration or learning be documented by qualified health professionals (Lovett & Lindstrom, 2021). One such example is attention deficit hyperactivity disorder: a general term inconclusive to mandatory agitation unless specified (Harrison & Armstrong, 2022). In sum, these factors demonstrate that NFT members require significant administrative support to define reasonable accommodations in nursing education while distinguishing between real AAs that impact task competencies and previously described sham accommodations.

Environmental

The environmental factor of the PESTLE focuses primarily on the physical component and its impact (Thakur, 2021). In this DiP, I adapted it to the environment of instruction and its implication for nursing education. Post-secondary students pay tuition for the program in which they are enrolled, and they are also required to pay additional fees for extracurriculars and research activities. However, given that these students are adults, no mandatory attendance monitoring is expected (Wilson, 2019). Nevertheless, TC's (2023) registered practical nursing program frequently requires practical skill competency assessments that are only feasible in laboratory environments. While attendance is strongly encouraged to monitor progress, students with MDH-related AAs may have difficulty performing assessments in school environments that often trigger anxiety (Kawsar et al., 2022). Given my position as a front-line staff member, I have repeatedly witnessed the impact of this assessment model on student learning. Like my peers, I recognize constraints within CNO practice expectations and essential requirements (Mack et al., 2021) that limit support for both students and NFT members in navigating AAs.

In this section, I framed the importance of rethinking the historical context of AAs in nursing. I revealed my proposed PoP to better understand the need to support NFT members.

Similarly to TC, I join forces with scholars like Kuluski et al. (2021), who advocate for policies pertaining to accommodation, health, equity, and diversity. In the next section, I reflect on my PoP and describe my socio-constructivist approach to the change process, with additional questions that spur deeper reflection.

Guiding Questions from the Problem of Practice

Notably, elaborating on my PoP has inspired me to consider additional guiding questions that I explore throughout this DiP. The first question illuminates the need for healthcare leaders to identify and match the general profile of students receiving AAs (Blasey et al., 2023) with anticipated curriculum concerns. By answering the second question, I seek to promote psychological safety (Hsiang-Te Tsuei et al., 2019) between interdepartmental in addressing AAs. Lastly, the term reasonable AAs needs clarification (Neal-Boylan & Miller, 2020) in nursing programs, given NFT members' concerns at TC.

Question 1

Do nursing students receiving AAs share similar characteristics (Blasey et al., 2023) that can be profiled? The purpose of this question is to explore anticipated interventions for NFT. Although each student is unique (Brown et al., 2020), understanding student similarities can provide a better understanding of their needs. This will guide TC administrators in establishing and applying effective AAs while supporting the NFT who take on training in this profession, a practice encouraged by Hoffman (2016).

Question 2

How can the OD and the academic student centre collaborate with the NFT to address curriculum concerns? This question is essential to establishing the necessity of internal communication about AAs. Garringer et al. (2017) indicate the importance of determining

appropriate support from stakeholders in a psychologically safe learning environment. The culture at TC and my relationship with current post-secondary program manager leaders may lack frames of reference for these changes. Additionally, the general application of appropriate evidence-based support still requires investigation. This is an enduring concern about how to mirror research context to various practical settings in different organizations (Kazdin, 2021).

Question 3

How do management, the NFT, and the academic student centre at TC perceive reasonable AAs (Neal-Boylan & Miller, 2020) in nursing education? As previously noted, definition inconsistency can trigger hesitant behaviours among educational professionals in specific environments (Gille et al., 2022). This is partly attributable to the term lacking evidence-based appropriateness and effectiveness strategies. Further, Volino et al. (2021) and some NFT members have broad concerns about the impact of accommodating students. Since adult learning assumptions emphasize mental orientation as a crucial element in learning (Knowles, 1984), addressing this problem must occur in an optimal learning environment.

Understanding the responses to these questions will require time for effective adaptation and construction in this transformative change process. The following paragraphs discuss the importance of my vision, priorities, and micro-management levels that influence my work.

Leadership-Focused Vision for Change

Change is necessary when an organization's current state no longer applies to its new dynamics (Northouse, 2021). Adelman-Mullally et al. (2023) indicated when change actions should be initiated; in my opinion, these indications became prevalent the instant the NFT expressed curriculum concerns.

Current State vs. Future Organizational Change

Successful change requires thoughtful navigation from the current to the desired state (Adelman-Mullally et al., 2023). Currently, NFT members commonly express concerns with the nursing program curriculum and the risk of potential gaps in practice due to AAs. As a leader, I must analyze the educational impact of this situation. From a front-line NFT member perspective, I align with Deszca et al. (2020) and the need for actions to address urgent, time-sensitive matters. The current situation presents an opportunity to address AAs by proposing a change vision (Fletcher, 2022). Therefore, with authority figures approving the initiative (D'Antonio & Connolly, 2021), I envision the NFT receiving the support needed to address AAs. The desired incremental change is affiliated with a clear and tangible group approach (Castanheira, 2016). This includes re-examining the AA delivery process while considering faculty members' concerns, the nursing program's growth, and TC's broader mission statement.

Vision

Although I envision assuming a leadership role in this change initiative, I intend to collaborate with internal partners throughout the process. As previously discussed, this change requires team-based collaboration at every step (Uhl-Bien et al., 2018); hence, all sections in this DiP are inclined toward achieving this vision. I address this DiP from a socio-constructivist approach. I acknowledge the sensitivity of multi-factorial elements of AAs (Ingram, 2023). That includes professional ethics, the historical context of the nursing profession and its training models, social bias in mental health, and individual intentions and emotions. Consequently, I intend to collaborate with management, and the implementer team, discussed in Chapter 3, within my capacity and through my connections. Given the need and my colleagues' interest in

the change vision, described during conversations and informal meetings with management, I have confidence in my ability to lead this change.

As a result, communication is the driving force throughout this change process, including consensus in selecting models and leadership frames. Safaeinili et al. (2020) described the importance of consolidating models, leadership styles, and change frameworks to enhance approaches to change in healthcare. I also strive to minimize potential burnout risk (Miake-Lye et al., 2020) by selecting familiar nursing philosophy, and nursing tools (Cho et al., 2021).

Priorities

Educational institutions must cultivate some level of adaptive practice to remain competitive. As part of its formal 2020-2025 strategic plan, TC (2023) launched new academic programs. However, organizations require continuous adaptation to their ever-changing realities, including the growing demand for student mental health support (Moghimi et al., 2023). The Government of Ontario mandated post-secondary institutions to prioritize student health and well-being (Council of Ontario Universities, 2020). In this document, the authors emphasized the need for a community approach that extends beyond traditional healthcare services. This ensures that students can access mental health support and campus services through a medical pathway consisting of doctors, nurses, and counsellors (Lawrence, 2020). As a trained mental health nurse, I do not discredit traditional services; nevertheless, I acknowledge their limits in addressing AAs.

My first priority is raising awareness (Deszca et al., 2020). The goal is to increase the post-secondary program manager's awareness and recognition of NFT member concerns. Also, is the impact of AAs on curriculum integrity and potential gaps in practice by describing a pressing situation and an opportunity for change. Preceding, all parties must be psychologically

safe before instigating any changes (Galloway & Ishimaru, 2020). I believe TC's culture inculcates a psychologically safe team environment. However, the link between human rights and AAs can inadvertently predispose academic student centre staff to adopt an attitude of insularity through silo behaviour due to status quo comfort. Thus, my participation is essential in establishing communication (Ruck, 2020), discussed in Chapter 3.

My second priority is to support internal partners in developing a shared understanding and definition of reasonable AAs (Neal-Boylan & Miller, 2020) in nursing education. This is essential for promoting equity among students and NFT members while protecting curriculum integrity. Precise terminology and definitions are broadly helpful in supporting communication. It is particularly important when there is an aspect of equity and social justice (Porter, 2021), as in this PoP. Achieving consensus support for a specific definition will allow management to better coordinate actions (Harrison & Armstrong, 2022). This is for addressing equity policies and practices, ultimately benefiting TC's students, NFT members, and mental health nurses.

Macro, Meso, Micro

Kaseorg and Uibu (2017) discussed three management levels: (a) macro, or organizational, (b) meso, focusing on middle management; and (c) micro, or team-based. AAs exist at all three levels when examining my PoP. Stakeholders responsible for developing the college's accommodation policy are part of the macro-administration scale. This could minimize the interest, role, and participation in organizational change from non-management personnel. The meso reflects upper and middle management communicating about AA policy updates. My DiP is a micro-level (team-based) level, defined as a small system of families, relationships, and individuals focusing on topics aligned with levels of inquiry (Kaseorg & Uibu, 2017).

Conversely, AAs exist at the micro level within the post-secondary nursing education program and the Nursing Bachelor Consulting Committee.

To this end, while focusing on my leadership-focused vision for change, I have described how I envision my work on addressing TC's current state and my vision for the future. Further, I discussed how I value personal ethical leadership approaches and the need for collaboration with community partners, including in priority identification and management-level influences.

Chapter 1 Summary

In Chapter 1, I revealed how Neuman (2011) and Knowles (1984) have inspired my leadership philosophy. In elaborating on my personal leadership position and lens, I described my agency as a change leader in the NFT in which I act as both a front-line clinical instructor and a non-management curriculum lead. I also elaborated on my socio-constructivist leadership lens, through which I apply a team approach within an ethical framework to address the need to better support NFT members with student AAs. These perspectives contribute directly to my conception of the proposed PoP statement, after which I offered the historical context of the nursing profession, including its treatment of AAs. Through investigating TC's organizational structure—including its symbolic, hierarchical, political, and human resource dimensions—I provided insight into the college's organizational context and culture. I provided further context to reinforce the need to examine this change initiative through a PESTLE analysis. Finally, I concluded the chapter with guiding questions emerging from the PoP that will shape the change process. Subsequent analysis confirmed the gap between current and desired states; additionally, the analysis presents opportunities to implement future changes. I describe particulars in Chapter 2 while elaborating further on the change process.

Chapter 2: Planning and Development

Throughout my dissertation-in-practice (DiP), in Chapter 1, I divulge my leadership vision and proposed changes to better support the nursing faculty team (NFT) at Top College (TC) in managing student academic accommodations (AAs), given concerns with aligning curriculum expectations with those for future clinical practice. In Chapter 2, I describe change planning and development phases by identifying a specific leadership approach and a framework for organizational change with theories that propel it. I also outline the impact of AAs on the NFT, describe the urgency for the proposed changes, and discuss potential solutions.

To begin, I discuss Heifetz's (2009a) adaptive leadership and Ubuntu's socio-ethical leadership principles (Laloo, 2022) and their combined influence on Shields's (2020) transformative leadership approach to change. I then describe Deszca and Ingols' change path model (CPM) (Deszca et al., 2020) and discuss its suitability throughout the change process. Subsequently, I divulge my organizational change readiness and outline my ethical components throughout the process. I summarize proposed solutions and select the one to address my problem of practice (PoP): A lack of institutional support for NFTs in addressing AAs. I conclude this chapter by discussing my change drivers.

Leadership Approach to Change

Diverging from routine practices, whether established by the organization, group consensus, or personal practice adopted by preference, entails a necessary shift from comfort to uncertainty (Anderson et al., 2019). In this DiP, I propose a change model based on a reflection-oriented transformative leadership framework (Shields, 2020) consistent with Heifetz's adaptive leadership (Heifetz et al., 2009a) and Ubuntu's socio-ethical leadership (Laloo, 2022).

Shields's Transformative Leadership

Transformative leadership is a valuable approach for leading a change process because of its emphasis on psychological and spiritual factors (Montuori & Donnelly, 2017), as well as on equity and social justice (Shields, 2020). Late nurse Seacole (2005) exemplifies transformative leadership with her resilience in confronting the historical invisibility of nurses of colour during the mid-19th century. This was when professional organizations were defending legitimacy boundaries and social authority rather than focusing on obtaining qualified nursing candidates (D'Antonio & Connolly, 2021). Montuori and Donnelly (2017) indicate that transformative leadership's main characteristic is the premise that everyone, consciously or not, is an agent of change contributing to and cocreating our world with incremental actions. As such, recognizing the potential influence of individuals on addressing the PoP is essential when acting as an agent of change. As a transformative leader, it is also of the utmost importance that I invite individuals involved in the change process to reconsider the role of traditional systemic injustices (Tilghman-Havens, 2020). This is mainly related to the scarcity of current organizational support (Linden et al., 2021) for NFT members with AAs, combined with the regulated standards of practice for nursing students. For these reasons, I seek to collaborate with decision-makers (Galloway & Ishimaru, 2020). The goal is to innovate contemporary educational strategies that align AAs with the reality of TC culture, educational context and respectful communication among staff at all levels. As curriculum lead, I can influence change processes by emphasizing alternatives and potential solutions beyond simply re-orienting students to school psychologists or academic student centers. Shields (2020) indicates that transformative leadership is well-suited to support change, particularly given its broader connection with adaptation.

Heifetz's Adaptive Leadership

Adaptive leadership is particularly valuable to apply in this DiP as "adaptive leadership is the practice of mobilizing people to tackle tough challenges and thrive" (Heifetz et al., 2009a, p. 21). Alhosis (2020) indicates that "adaptive leadership is a collaborative effort of stakeholders to find the best solution to the challenges of the organization" (p. 57). Put differently, in utilizing the adaptive leadership approach, a polyarchy with shared power among individuals is created. In post-secondary educational organizations, Nelson and Squires (2017) indicate the routine recruitment of subject-based experts for many technical problems. Heifetz et al. (2009a) suggest adaptive leadership methods in team-based environments to solve complex, ever-changing issues, like my PoP, rather than technical ones. As a mental health nurse, I emphasize the importance of thriving in a psychologically safe setting, as according to Alhosis (2020), up to 60 percent of nurses work in a stressful environment. As an adaptive leader, I promote a transformative and adaptive transition focusing on sustainable strategies and periodic monitoring to reduce the likelihood that TC will revert to a prior state. Further, I can encourage explicit changes in group priorities, such as listening to staff about new policies and goals, including curriculum concerns. Ultimately, as an adaptive leader, I will adopt a follower-centred approach by helping others adapt to their challenges (Northouse, 2021). My goal is to encourage people to change and learn new ways of living (Northouse, 2021), seeking to create a new equilibrium.

Baker et al. (2020) discuss the challenging decision-making process for leaders. Adaptive leadership promotes adaptability to leaders (Heifetz et al., 2009b). That leadership evolves from four principles (Heifetz, 1994) to six (Heifetz & Laurie, 2001) and seven Heifetz et al. (2009a). In Appendix C, I describe the seven principles of adaptive leadership (Heifetz et al., 2009a) and corresponding behaviours. In order of sequence: 1) Get on the balcony; 2) Identify the adaptive

challenge; 3) Regulate distress; 4) Maintain disciplined attention; 5) Give work back to the people; 6) Protect leadership voices from below and 7) Guiding leaders to take care of themselves. Using the metaphor of 'the balcony,' the adaptive leader is provided with a panoramic platform view for an organization's holistic and systemic outlook, including its culture, collaborative efforts with external forces, and implications of its overall strategy (Heifetz et al., 2009a). This perspective impacts strategic decisions, such as the organization's vision and interventions, while building on past experiences and increasing knowledge while exploring alternatives. I must pay attention to essential elements of organizational culture, including behaviours, beliefs, and assumptions, during interactions while maintaining psychological safety (Hsiang-Te Tsuei et al., 2019) dynamic with internal community partners during interventions. By weekly meetings with management members and team groups allow me to examine these facets of TC's organizational culture. I will leverage a team's expertise, analysis, and decision-making to solve problems with needs for operational adjustments. TC's (2023) culture encourages utilizing internal staff expertise to achieve common organizational goals. I will invite the voices of all (Ruck, 2020) and show patience and experience in conflict management abilities to filter conflicting comments or behaviour from individuals (Ugirase, 2022) not inclined with the adaptive process or focus. Finally, I will model work-life balance activities, allowing self-care to recharge (Uhl-Bien & Arena, 2018), to achieve the goal.

Alhosis (2020) indicates that adaptive leadership is scarce in the literature pertaining to the nursing profession but discusses the linearity between Heifetz's adaptive leadership principles (Heifetz et al., 2009a) and this line of work. Kuluski et al. (2021) emphasize that adaptive leadership principles are applicable to person-centred care at the frontline care level and

how complex care needs are critical in nursing. This reality aligns with my nursing practice and my work on this change initiative in addressing AAs.

As previously noted, TC's culture of adaptive leadership (Heifetz et al., 2009a) aligns with Uhl-Bien and Arena (2018), encouraging environments rich in collaboration, creativity of ideas, and new learning activities that occur among faculty members throughout an organization. Utilizing a team-based approach (Northouse, 2021), I collaborated during Covid-19, by reducing an accommodations waitlist with deliberate actions such as extending assignment deadlines to balance students' workloads collectively to ensure the success of appropriate, effective AAs. During internal informal exchanges between the NFT and TC's interdepartmental teams, I strive to generate new ideas while strengthening connections (Uhl-Bien and Arena, 2018). Jasper (2018) emphasizes the benefit of this decentralized social exchange. I will offer the flexibility of preference styles (Kuluski et al., 2021) to NFT during internal exchanges, with a communication framework (Ruck, 2020) for ideas through various sources and methods such as informal group discussions. This collaborative approach will allow me to better identify concerns associated with AAs (Ogundokun & Hamel, 2020) and curriculum integrity (Wright & Meyer, 2017), ensuring that everyone's voice is heard (Ruck, 2020). In addressing this PoP, I must consider innovative ways to increase knowledge and explore alternatives while addressing students' AAs (Wright & Meyer, 2017), utilizing adaptive leadership principles (Heifetz et al., 2009a) and socio-constructivist approach (Mohajan & Mohajan, 2022).

Ubuntu's Socio-Ethical Leadership

Although most collective human interactions and gatherings result in establishing groups (Aliye, 2020), few leadership philosophies emphasize the importance of social justice within these groups (Elkington, 2020). In describing the importance of Ubuntu's socio-ethical

philosophy, Netshitangani (2019) emphasize the richness of this critical African leadership strategy focusing on solidarity and collaborative modelling behaviour in women's educational leadership. This philosophy focuses on the effectiveness of group change rather than individual change (Mangaliso et al., 2022), with the leader providing knowledge, clearly defining the change process, clarifying misconceptions, and subsequently inspiring the group (Hussain et al., 2018). As a Caribbean nursing scholar, I appreciate how the community approach of Ubuntu's leadership (Laloo, 2022) harmoniously aligns with humanistic caring in nursing (Muhammad-Lawal et al., 2023). I follow Ubuntu's holistic philosophy of "I am because you are" (Netshitangani, 2019, p. 201), which invites collective behaviour based on human dignity, compassion, and justice. In the context of this DiP, I encourage NFT members to embrace a collective approach to addressing students' academic struggles by adopting the Ubuntu philosophy (Laloo, 2022). Notably, the seriousness of the DiP requires revisiting the policy status quo and Netshitangani (2019) acknowledges that discomfort is both a valuable and necessary part of the change process. Netshitangani (2019) emphasizes that discomfort encourages the replacement of old behaviours and attitudes, ensures strong support from management and peers, and promotes management approaches that clarify doubts and concerns. This approach is essential because it reflects my vision and mission. Also, Burnes et al. (2018) precise that this communication includes and considers change elements, including theories, models, culture, and assessment; barriers, such as resistance and climate; and action strategies, or the monitoring of outcomes. Given that the nursing profession emphasizes the importance of modelling professional behaviours (Van der Cingel & Brouwer, 2021), the Ubuntu leadership style demonstrates the need to collaborate on transformative change processes (Laloo, 2022) by NFT members, supporting the work on the PoP.

Shields's (2020) transformative leadership reflects key features of Heifetz's et al. (2009a) adaptive leadership and Ubuntu's socio-ethical leadership (Laloo, 2022), proposing a harmonious approach toward addressing my PoP. These leadership frameworks insist on internal reflection and personal commitment to correct the problem by increasing collective motivation and interest in the proposed change. Ultimately, the frameworks combine with an organizational change model to focus on process, role, and collaboration. In the following section, I discuss the framework I will use to lead the change process.

Framework for Leading the Change Process

All transformative changes require implementing a conceptual organizational model to guide the change process (Loorbach, 2020). Given my PoP and leadership style, I will utilize Deszca and Ingols' change path model (CPM) (Deszca et al., 2020) because it is suitable for combining with complementary models or monitoring tools to further advance the changing state (Burke, 2018) while considering its strengths and weaknesses.

Deszca and Ingols' Change Path Model (CPM)

Deszca and Ingols' change path model (CPM) (Deszca et al., 2020) is a guide to assess current organizational practices and develop a disciplined approach focused on understanding and responding to community partners' values, perceptions, and reactions. The model has four phases: awakening, mobilization, acceleration, and institutionalization (Deszca et al., 2020). One strength of the CPM model is that it promotes participation by creating a communication exchange space at each implementation phase (Deszca et al., 2020), permitting the collection of progressive and constructive knowledge synchronous with Ubuntu (Laloo, 2022) and adaptive approaches toward learning new concepts (Heifetz et al., 2009a). Another significant strength is that, when applying CPM, I can emphasize a collaborative climate that is congruent with team

leadership (Northouse, 2021). Exchanges among individuals are essential in addressing complex situations requiring adaptive (Heifetz et al., 2009a), and transformative (Shields, 2020) outcomes, particularly relevant in all CPM phases (Deszca et al., 2020). Further, Leino and Puumala (2021) emphasize its application to different complexity scales, contexts, and cultures and is easily adaptable for small- to medium-sized organizations across various contexts, including public, not-for-profit, and government organizations.

A weakness associated with CPM relates to the need for more detail or prescription in providing a linear change process, especially for larger and more complex organizations (Northouse, 2021). However, the CPM's simplicity corresponds to TC's being a small—to medium-sized organization. The constructive presentation of the CPM's four phases (Deszca et al., 2020) in the following paragraphs adds to the continuous innovation supporting the change process (Korengel, 2019).

Phase 1: Awakening

In the awakening phase, there is a focus on raising awareness, validating the need and vision for the change, defining the problem, and building readiness among crucial community members (Deszca et al., 2020). By gathering data from all sources, I will obtain a more comprehensive understanding of the organizational dynamic(Deszca et al., 2020), like fostering and restraining forces that affect organizational change. Notably, I have already introduced the importance of Ubuntu's collective participation (Laloo, 2022) in addressing AAs in a meeting with the post-secondary program manager, who subsequently introduced me to the nursing program manager. During the awakening stage at TC, I will focus on communication strategies that tailor how messages are conveyed (Ruck, 2020) to entice college administrators' willingness to collaborate, enable change, and provide support as they have done with previous projects.

Ultimately, the desired future organizational state involves collaboration (Hussain et al., 2018) between management and the NFT to address AAs, reflecting Ubuntu's conviction (Laloo, 2022).

Phase 2: Mobilization

During mobilization, the focus will be placed on tasks that need to be done, assessments of current power dynamics, stakeholder participation, and acquiring the resources necessary to launch the change (Deszca et al., 2020). Building on what is learned during the awakening phase, this second phase emphasizes interdependence, commitment, and collective empowerment (Leino & Puumala, 2021). Effective organizational change necessitates readiness and monitoring tools (Theeb, 2020); I discuss these later when describing TC's organizational change readiness. Initiating conversations is essential (Ruck, 2020), as is building a team to lead the change's progress (Deszca et al., 2020). An example is when the nursing program manager has indicated an interest in my PoP by inviting me to attend interdisciplinary meetings. The post-secondary program manager's formal agreement and commitment to the change vision will be ultimately decisive in forming the implementation team.

Phase 3: Acceleration

The acceleration phase emphasizes efforts and additional buy-in between broader change recipients, including managers and the NFT, to maintain the vision and continue the change (Deszca et al., 2020). Thus, change momentum includes empowering, developing, encouraging others, and celebrating gains (Hussain et al., 2018). Combining multiple approaches to developing solutions and learning (Rousseau &Have, 2022) in this phase could include training, education, recruitment, and policing model procedures. Collective interactions generate potential solutions and responses, firmly aligning with Ubuntu's leadership approach (Laloo, 2022). In this phase, it is imperative to empower members from all areas to continue perpetuating the change

(Deszca et al., 2020). Crucially, celebrations of short-term wins throughout the change phases reinforce and enhance momentum, thereby further propelling change (Rousseau & Have, 2022).

Phase 4: Institutionalization

Finally, the institutionalization phase emphasizes ways that allow the organization to reap the optimal benefits of the change while setting the stage for future initiatives by maintaining change momentum and ensuring continuous communication (Leino & Puumala, 2021). Monitoring efforts will enable me to detect variations in sustainability and any subsequent need to react (Deszca et al., 2020).

In this section, I have described Deszca and Ingols' (2020) CPM and outlined how each phase contributes to organizational change implementation (Burke, 2018), which addresses my PoP. By associating CPM (Deszca et al., 2020) with adaptive (Heifetz et al., 2009a) and Ubuntu leadership methods (Laloo, 2022) and using the readiness and monitoring tools, I will be well-equipped to provide the flexibility necessary in the change process. Among available readiness tools (Theeb, 2020), I select the organizational readiness to change assessment (ORCA), which I will elaborate on next.

Organizational Change Readiness

Organizational change readiness is "the degree to which the organization perceives the need for change and accepts it" (Deszca et al., 2020, p. 136) or "an organization's psychological and behavioural readiness for general change. Psychological readiness comprises openness to change among frontline staff and managers and behavioural readiness to system resources, with readiness linked to the adoption of change" (Quach et al., 2021, p. 2). Change typically includes incremental, strategic, reactive, and anticipatory reactions (Asikhia et al., 2021). In my experience with the student AA surge during the COVID-19 pandemic, I witnessed the rapid

shift toward hybrid teaching and creating a temporary, transactional accommodation policy, indicating TC management's strategic approach to change. I acknowledge that the established urgency to hybrid teaching relies on adaptive leadership (Heifetz et al., 2009a) as a convenient process approach with incremental interventions that support psychological safety; I discuss this in more depth later. There are many possible tools to measure readiness (Theeb, 2020). However, the ORCA is most appropriate due to TC's current organizational culture and its anticipated incremental response to change.

Organizational Readiness to Change Assessment Tool (ORCA)

In any change process, determining the organization's readiness and capability for change is the primary step (Burke, 2018). To facilitate this, I have adopted the ORCA tool, from Helfrich et al. (2009), also known as the Promoting Action on Research Implementation in Health Services (PARIHS) framework. This tool gained popularity among leaders who found it appropriate for measuring willingness and readiness for change because it aims to identify and monitor organizational strengths and weaknesses to support the implementation of evidence-based practices. Helfrich et al. (2009) emphasized the ORCA tool's reliability-validation strength**,** making it a good fit for assessing and determining organizational readiness for the active implementation phase, in any organizational context. The tool's online surveys with adaptable questionnaires and step-by-step instructions are particularly beneficial for novice leaders easing data collection (Helfrich et al., 2009). In Appendix D, I adapted the ORCA questionnaire items, and the data of my assessment indicates TC's readiness for change at 86 %. The details are in the following paragraphs.

My questionnaire addresses working collaboratively with management to make appropriate changes (RADPA, n.d.). The compiled readiness assessment data, rating strength of

agreement with ratings and statements from 1, or strongly disagree, to 5, or strongly agree, confirms that TC is ready under a statement section and the three surveyed sections: evidence assessment, context assessment, and facilitation assessment. Based on past experiences, I rated all sections between 3 and 5, so the score could not be lower than 3 in all sections. The statement is: Supporting NFT with AAs includes exploring innovative initiatives specific to nursing programs.

The evidence assessment section comprises research, clinical experience, and student educational preferences. The scholarly outcomes discussed throughout my DiP with supportive arguments validated my scores. The importance of familiarity (Swan et al., 2023) with literature related to the proposed changes and associated success indicators (Helfrich et al., 2009) is highlighted in the 'educational/clinical experience' section. Familiarity and success are incentives for administrators to leverage risk inquiry (Burke, 2018). Since any source of hesitation is a significant barrier impacting the change process (Deszca et al., 2020), I am inclined to use a familiar educational tool in nursing training (Cho et al., 2021) among NFT members.

The 'context assessment' section refers to the culture at TC from senior management and its openness to change, which is very fitting while the college explores avenues to address AAs. My proposed change coincidently aligns with TC's educational initiative openness and receptivity as well as its strategic plan focusing on DEI. This openness is part of the TC cultural leadership approach to explore educational alternatives, reflected in the receptivity among NFT members. That exchange invites the leader in all of us to fully participate, look for opportunities (Hussain et al., 2018), and support leadership initiatives to address concerns. Ubuntu leadership encourages this collaboration (Laloo, 2022) Adaptive leadership indicate that processes take time and require variety in communication for transformative outcomes (Heifetz et al.,2009a).

The 'facilitation assessment' section includes items that could cause obstacles to organizational change readiness, including financial, human resources, commitment time, and budgetary considerations. In recognizing the importance of ORCA outcomes (Helfrich et al., 2009a), I have been guided toward appropriate criteria through which to select the best solution. Additionally, the ‘facilitation-clinical champion’ section supports the selection of the most appropriate leader, mirroring the fit leadership profile by asking questions such as how others perceive the agent of change (Burke, 2018). As the leader of this change, I realize that self-awareness and influences on performance are inevitable (Ferraro, 2020). Further, TC is no exception to Deszca et al.’s (2020) position that organizational changes in healthcare involve collaboration with community partners. The ORCA tool supports identifying and monitoring team strengths and weaknesses to further support the implementation of evidence-based practices (Helfrich et al., 2009a) while assisting with the development of a clear, strategic, and robust communication plan to guide change direction and reduce delays (Campbell et al., 2015).

Furthermore, I recognize the value of the organizational development (OD) team in supporting all sections of the assessment tool. According to Hannon (2017), it is important to certify conformity to implementation readiness. The OD team is crucial to change (Burke, 2022) because of its mandate to support TC administration with information-guiding decisions through feedback and examining technology tool accessibility and project implementation. TC’s management determines readiness based on OD intervention reports and the subsequent timeline for launching any proposed educational initiative. Once readiness is confirmed, monitoring progression will guide necessary and appropriate actions to achieve the goal, which is further discussed in Chapter 3.

The ORCA tool is essential in guiding leaders through a change process while Deszca et al. (2020) support the selection of a change champion who will enhance implementation success, conditional upon establishing team-based readiness in agreement with the champion. Based on my ORCA result, I am both confident and optimistic about TC's organizational readiness to change. Another aspect of the change process is the leadership ethics in the organization.

Leadership Ethics in Organizational Change

Although ethical leadership is a vast field, it generally describes what a leader does—or should do—given the leader's personal values, mission, and beliefs (Northouse, 2021) and reflect the organization's actions and values. Ethics is critical and TC must first recognize the uniqueness of its adult population, using a holistic approach that considers constructive and inclusive values. Wood and Hilton (2012) discussed five relevant types of ethics: procedural justice, critique, care, profession, and local community.

Ethics of Procedural Justice and Critique

According to Wood and Hilton (2012), the ethics of procedural justice suggest that objective decisions based on established rules are non-consequentialist. This aligns with a positivist belief in one truth (Bolman & Deal, 2021), reflecting a convincing requirement from TC that human rights laws be followed to assure indemnity against consequential actions. Second, ethics of critique acknowledge the limits and challenges of established rules beyond their authority, as evidenced by the current educational hierarchy system (Harmsen & Tupper, 2017). In considering these ethics, listening to the voices of staff, aligned with social constructivist knowledge to solve problems, such as my PoP. Inclusivity and equity are part of the TC's (2023) organizational strategic goal and contribute to administrator receptivity to my educational initiatives. Additionally, the ethics of critique align with Ubuntu's (Laloo, 2022) and

Heifetz et al.'s (2009a) leadership, as both approaches enable leaders to progress toward transformative outcomes (Shields, 2020) while considering human rights (Government of Canada, 2022). The last three ethics (local community, profession, and care) encompass Ubuntu leadership (Laloo, 2022), and are linked to TC's mission, vision, and values.

Ethics of Local Community, Profession, and Care

Wood and Hilton (2012) discuss the importance of local community colleges in serving the needs, interests, and public good as educational institutions. In the context of my DiP, the ethics of the local community assure the sustainability of our French heritage and health service accessibility for Ontario's Francophone population (Heritage, 2021), a remarkable distinction for both personal and professional identities. Ultimately, the ethics of the community are the *raison d'être* for TC's broader mission, vision, and values. Belonging to a professional entity is equally important.

In examining the nursing profession, Wood and Hilton (2012) emphasize that the ethics of the profession acknowledge expected and required behaviours. Historical modelling of caring behaviour is fundamental in the nursing profession (Abbott & Meerabeau, 2020) and the code of conduct from the College of Nurses of Ontario (CNO, 2023), fostering a socio-constructivist approach (Mahajan & Mahajan, 2022). Similarly, Wood and Hilton (2012) describe how ethics of care contrast principles against people's fundamental values, like nursing student competence readiness. Ultimately, administrator support is essential to appropriately address AAs (Condra et al., 2015) in an adult learning theory environment (Knowles et al., 2015). Consequently, I must consider the internal and external factors influencing nursing students—with or without AAs—to re-examine their learning needs, formulate goals, identify human and material resources, and evaluate their progress.

Ethics of Care: Problem of Practice Ethical Issue

As an agent of change, I agree with Gaffney (2020) that exploring the ethics of care requires a transformative engagement fostering holistic well-being, ethical decision-making, and collaborative innovation within organizations. I also support the discourse of self-care as articulated by Foucault (1997) that ‘‘Care for others should not be put before the care of oneself. The care of the self is ethically prior in that the relationship with oneself is ontologically prior” (p. 287). Thus, caring for oneself in intellectual, moral, and spiritual dimensions is a prerequisite to becoming ethically responsible for developing the individual and others (Ferraro, 2020). The ethics of care encourage self-care and self-development (Uhl-Bien & Arena, 2018) and align with adaptive leadership’s seventh principle (Heifetz et al., 2009a) but present an issue in the transformative process (de Souza Sant’Anna, 2023). One issue that I anticipate is the maintenance of psychological safety, which Hsiang-Te Tsuei et al. (2019) recognize as a key element in the education of health professionals.

In a psychologically safe learning environment (Hsiang-Te Tsuei et al., 2019), physical and emotional learning needs are addressed, prompting individuals to take risks without fear of negative consequences (Turner & Harder, 2018). While some studies on psychological safety in learning environments exist, Hsiang-Te Tsuei et al. (2019) encourage more literature on maximizing psychological safety in the broader educational context. Examining the ethics of care and psychological safety is somewhat paradoxical when comparing the focus on ethics of care from the administration and NFT in supporting this change initiative. As a change agent, I am committed to fostering and modelling psychological safety in individuals (Park & Kim, 2021) by guiding TC’s administration to appropriate intervention targeting approach-oriented coping strategies. This includes the growing popular healthcare simulation standard of best

practice (McDermott & Ludlow, 2022), universal design for learning (UDL) design (Flood & Banks, 2021); and equity action in health education (Galloway & Ishimaru, 2020). Also, I will support NFT members in considering ethical dimensions. That requires students to demonstrate competencies safely and appropriately in clinical settings (Smith et al., 2021). As an agent of change, I am optimistic that the combination of transformative (Shields, 2020), adaptive (Heifetz et al., 2009a) and Ubuntu (Laloo, 2022) approaches will make the challenge surmountable.

Through an ethical leadership lens, I have described contextual challenges and respective strengths presented in this DiP. Wood and Hilton's (2012) five ethical dimensions give meaning to my leadership approach and confirm how organizations benefit from collective interest and team effort during change projects. While considering ethics of care that may present more crucial barriers to this change, I became more confident in my intended solution, which I described next with other potential strategies to address my PoP.

Solutions to Address the Problem of Practice

In Chapter 1, I indicated that the increased enrollment in nursing programs of students with mental health disabilities (MHDs) has become an educational leadership concern (Neal-Boylan & Miller, 2017), especially in determining the necessary support for NFT members to manage student AAs. Given the multiple challenges associated with these concerns, I offer three potential solutions to determine the best approach to address my PoP. First, I describe the recruitment of a DEI coordinator. I then propose a review of the current accommodation policy model with the NFT. Lastly, I discuss the potential implementation of universal design for learning (UDL) principles in nursing programs in curriculum development.

First Solution: Diversity, Equity, and Inclusion Coordinator

Instead of an AA coordinator, a diversity, equity, and inclusion (DEI) coordinator could be recruited to lead an implementation team with a mandate to examine AAs. The selection of DEI over AA coordinator is explicable. Primarily, the role of the AA coordinator has too often been associated with implementing student requests (Condra et al., 2015), limiting consideration of its impact on faculty or specific programs (Sweener et al., 2002). Given TC's commitment to enhancing equity, it is crucial to consider AAs within the specific context of MHDs in the wider nursing profession. This consideration is significant when we look at the historical nursing school admission process and the selective determinant factors that compromise prospective students (Jung et al., 2021) and worsen the situation for students with MHDs (Neal-Boylan & Miller, 2020). These students often face significant challenges in adapting and, as a result, struggle (Philion et al., 2021) to navigate the rigid structure of nursing educational programs (L'Ecuyer, 2019). Brown et al. (2020) further underline the need for a more supportive environment for affected students, stating that "nursing students' anxiety may be attributed to the competitive program entry process, to working with the ill, to a perceived lack of support from faculty and clinical nurses, and to challenging coursework and exams ”(pp. 579-580). This underscores our collective responsibility in the nursing profession to create a more supportive environment for these students, motivating us to act.

Thus, I present an opportunity to create and innovate with an educational equity approach that could broadly transform nursing education programs. Along with the coordinator, this implementation team could include external stakeholders that are not necessarily limited to mental health specialists, expert scholars, physicians, legal representatives, Registered Nurse Association of Ontario stakeholders, academic student center employees, and TC administrators.

In adopting this approach, the primary goal and benefit would be to create best practice guidelines (Melnyk & Fineout-Overholt, 2022) for AAs. The CNO (2023) has long used decision tree process tools as best practice guidelines to address ambiguous situations and guide behaviours and decisions to protect the public. This approach is consistent with current professional practice (CNO, 2023). At TC, the process of creating a new best practice guideline for AAs that examines curriculum concerns must include the NFT. Additionally, since post-secondary institutions have unique student profiles and organizational realities, this guideline for AAs will provide opportunities for ethical consideration during the CPM's awareness phase (Deszca et al., 2020). The familiarity (Swan et al., 2023) with other nursing-specific best practice guideline tools could increase receptiveness for this new tool (Cho et al., 2021), among NFT members and college management. In implementing this solution, the focus would be on socio-professional awareness (Palladino & Thapa, 2023). More importantly, the change would be rooted in a team approach with an emphasis on ethical thinking and adaptive strategies.

Unfortunately, this solution presents two challenges: finances and resources. The finance is related to TC receiving government funding and must prepare an annual budget subject to approval by the college's Board of Governors (TC, 2023). Since I do not hold a management role at TC, my access to financial data is limited. Despite the value of the ORCA tool (Helfrich et al., 2009) and the recognition that this may be a suitable solution, expenses associated with this type of specialist and the salary cost (Homauni et al., 2023) of a DEI coordinator could surpass an allocated budget line for this type of initiative.

Regarding resources, Ontario is already experiencing a resource challenge due to a shortage of Francophone (Drolet et al., 2014) healthcare professionals, including mental health specialists **(**RNAO, 2021). Thus, my limited authority within my current role challenges the

decision to recruit a qualified DEI coordinator with expertise and experience in mental health. Given the potential limitations associated with affordability and sustainability, I explore another option.

Second Solution: NFT Involvement in Reviewing the Current Accommodation Policy

My second proposed solution would be to revisit the TC's current formulation of its accommodation policy. TC has currently adopted an operational and transactional approach to AAs. That aligns with mandated expectations in the Ontario Human Rights Code: a social justice value (Evans et al., 2017). Nevertheless, concerns from NFT members about the current TC's wider accommodation policy inspire an ethical invitation to revisit this policy and the delivery process model. Notably, AAs are defined differently within and across contexts (Englund & Lancaster, 2022). Moreover, the term 'reasonable accommodation' is not well-defined at TC or in the wider literature (Neal-Boylan & Miller, 2020). In addition, there are challenges with the status quo AAs delivery process in which medical notes are sent to counsellors at the academic student centres who then provide email communication to instructors. Ultimately, this approach detaches TC administrators and instructors since there is no collaboration to discuss reasonable accommodations. Thus, as an ethical leader, I believe in the involvement of selected members, like the NFT, at the discussion table about accommodation policy (Galuska, 2014). Together, they could create a newer official accommodation document, offering a neutral ground to express curriculum concerns and collaborate on case-by-case solutions and options. This constructive ground is inclusive (Mohajan, & Mohajan, 2022), supports decision-making, and offers an excellent team-building approach in line with Ubuntu leadership's focus on social considerations (Laloo, 2022). Ongoing discussions permit learning adaptive processes (Heifetz's et al., 2009a) with new ideas and generating transformative outcomes (Shields, 2020).

This proposed solution requires faculty administrators to revise current accommodation policies. This solution coincides with TC's current policy revision date within 1 to 2 years. Additionally, this strategy is consistent with my capacity and authority as a non-management curriculum lead to join a policy committee. This proposed solution also permits clarifying critical terminology, such as ‘reasonable accommodations' (Neal-Boylan & Miller, 2020). Thus, these proposed content and delivery changes can influence the current student AA delivery model. Given TC's emphasis on incremental change at an organizational level, this team-inclusive approach (Northouse, 2021) would support faculty and administrators at various organizational levels. Crucially, involving NFT members in this decision-making process exemplifies innovative educational leadership (Roberts et al., 2014). Additionally, current hybrid and digital meeting platforms expand the possibilities for this collaboration when compared to traditional face-to-face meetings (Trepanier, 2023). This presents more flexible opportunities for instructors and counsellors to engage in constructive dialogue (Laloo, 2022) about AAs.

A significant strength of this approach is that it does not involve any additional resources. Thus, budget implications should be insignificant. Additionally, revisiting the current policy model could help policymakers navigate the ethical component of this organizational change. TC could shift towards an adapted change state rather than its current reliance on transactional change. In the long term, this will positively impact my work on this PoP. Nevertheless, there is a challenge with this solution. It temporarily shifts stakeholder involvement away from the NFT, which is the population I focus on throughout this DiP. However, including the NFT in the policy committee can address that shifting probability.

Third Solution: Universal Design for Learning with Nursing Solution

In this third solution, I propose incorporating universal design for learning (UDL) principles to develop the decision tree process**,** offering a potential solution to address AAs in nursing programs. This proposition could be optimized with teaching and learning conditions, modifying the traditional two-year Registered Practical Nurse program to a three-year one. Unfortunately, TC's (2023) management explains that Ontario's Ministry of Colleges and Universities consistently rejects this later proposal to Ontario post-secondary institutions. This reflects the limited authority of post-secondary institutions in decisions of this nature (Harmsen & Tupper, 2017). This is in addition to colleges facing financial budget constraints (Homaunim et al., 2023), the business transactional focus between institutions and the Ministry of Colleges and Universities (Beach & Milne, 2019), and the legal power of allied human rights clauses (OHRC, 2018). The UDL can overcome these constraints of a time-limited program in the classroom and on placement.

The UDL framework, as detailed in E, has three main principles: engagement, representation, and action and expression (Kennette & Wilson, 2019). UDL is widely used in Ontario's kindergarten to twelfth-grade education settings (Hromalik et al., 2020), and it's equally applicable to the adult andragogical model. Traditional nursing practice's focus on execution methodology requires an innovative approach (Roberts et al., 2014). The UDL framework emphasizes task-to-outcome measurables (Ecker, 2023), encouraging all stakeholders to work together to maximize student success. Additionally, in the post-secondary educational context, UDL entails an adaptive learning process that accommodates diverse learning needs (Gronseth & Hutchins, 2020). This includes consideration of MHDs (Smith & Lowrey, 2017), by ensuring educational content and assessment strategies are flexible, accessible, and support a wide range

of learning styles (Christodoulakis et al., 2022), reducing the overall need for student AAs in the first place (Dewi & Dalimunthe, 2019). In other words, according to Flood and Banks, (2021), UDL is "an approach to learning, teaching, and assessment design that proactively addresses the varied identities, competencies, learning strengths, and needs of every learner in our learning environment" (p. 2). This includes clinical nursing (Heelan et al., 2015), consistent with maintaining robust standards (Kennette & Wilson, 2019). Thus, UDL uses heuristic techniques that enable instructors to optimize learning conditions for a wide range of learners with a range of individual traits, behaviours, and values (Kennette & Wilson, 2019).

According to Lieberman (2005), one challenge of this approach in nursing education is that teaching faculty tend to be content matter experts rather than instructional design experts. Consequently, faculty members may need to familiarize themselves with seminal learning and education-focused theories (James & Bewsell, 2020). Further, professional development opportunities at community colleges in Ontario have not always produced change due to inconsistent evaluation progress monitoring and a perceived lack of administrative support (Hromalik et al., 2020). Notably, this solution is conditional on the OD department’s decision to pursue a UDL approach at TC. According to Bartunek and Moch (1987) that corresponds to first-order organizational changes. The proposed solution is to explore, with internal stakeholders, a UDL nursing solution tool (like UDL-NS), with a task-to-outcome focus, adapting and constructing on knowledge. UDL-NS may entice TC administrators to leverage policies based on the realities of AAs. In the next paragraph, I compare and summarize all the potential solutions.

Comparison and Chosen Solution

In comparison, I have selected these three integrated solution approaches while considering six criteria:

1. Implication of NFT at the negotiation decision table for complex situations.
2. Incremental adaptive approach, promoting Shield's transformative approach.
3. Opportunity for team collaboration, per Ubuntu principles.
4. Financial constraint is an important administrative incentive.
5. Human resources access to support this initiative with the OD team.
6. Familiar educational strategies embraced by TC administrators.

Appendix F presents the visual elements of each solution's outcome using happy face, cloud**,** and stop sign icons. The happy face indicates a favourable outcome**,** the cloud depicts potential sources of resistance**,** and the stop sign denotes an unfavourable outcome. In the order of their presentation, the results show solution 1 with 2:1:3, solution 2 with 3:0:3, and solution 3 with 4:2:0. When considering the criteria which I allude to above**,** it's clear that the UDL-NS approach is the most suitable for TC's context. This conclusion is drawn from the fact that UDL-NS addresses most of my considerations with no significant barriers identified in the column for this solution. Also, given my facilitation ability, authority, and vision, the approach is most appropriate in TC's context.

In sum, the visual elements emphasize the feasibility and effectiveness of the proposed UDL-NS. I also acknowledge the influence of change drivers (Whelan-Berry & Somerville, 2010) while working toward this solution.

Change Drivers

Whelan-Berry and Somerville (2010) define change drivers as " events, activities, or behaviours that facilitate the implementation of the change" (p. 176). In this DiP, I acknowledge several internal and external change drivers that underpin the PoP. Each of these drivers exerts a significant influence. Internal change drivers have direct or indirect influence inside the

organization, while external change drivers, such as persons, legislation, and government directives, influence the organization from the outside (Deszca et al., 2020). This distinction is important as it helps us understand the different roles and impacts of these drivers.

Internal

The internal change drivers at TC are from various departments and management levels. In this DiP, the NFT has the role of stakeholders and change drivers directly impacted by curriculum concerns and practice gap risk. Being on the frontline facing policy expectations and CNO regulations while debating AAs needs attention and validate my PoP. This reality causes moral distress (Platt, 2021) and adds stress to the environment (Alhosis, 2020), amplified by unprecedented or unforeseen situations, such as COVID-19 (Sagherian et al., 2020). In addition, all implementation team members (ITM) are key change drivers with their respective expertise and demonstrating their participation in the DiP. In particular, the OD team is directly involved in assisting management with all TC change initiatives, affecting change initiation, pace, and direction. The post-secondary program manager and my nursing-specific program manager act as social and organizational actors. Both individuals share accountability and responsibility to steward and promote educational interest and leadership—considering the college's vision, mission, and values—in enacting internal change processes (Bolman & Deal, 2021). Lastly is the senior management. The PoP necessitates a financial commitment from senior management to allocate program funding so that the ITM can attend potential extra meetings (paid straight time as per the Collective Agreement). New task descriptions require flexibility and protected release time to collaborate on the integration of the strategies for the DiP. A change driver can simultaneously be internal and external.

Internal and External

In Chapter 1, when discussing TC's organizational context, I underscore its hierarchical nature. Internal stakeholders focus on students and external members involve in TC's program advisory committee. The committee's significance in the change process is closely tied to its mandated focus on safeguarding the quality and availability of French-language student educational programs. This commitment supports academic success and student satisfaction and influences policy and procedure. I view this committee as powerful catalysts that actively seek interventions or initiatives, such as my DiP, to enhance the academic success of French-speaking students, which directly impacts workforce availability.

External

TC's reliance on external political drivers is for funding, student outcomes, and organizational improvement plan metrics. The Association of Colleges and Universities of the Canadian Francophonie, or its French name, Association des Collèges et Universités de la Francophonie Canadienne (ACUFC, n.d) plays a crucial role in preserving the French heritage at TC. This was evident when the association successfully exempted French educational institutions from the foreign student cap allegation, a clear validation of TC's commitment to its French heritage. This exemption holds particular significance given the student population at TC. Equally important is the influence of Ontario's Ministry of Colleges and Universities on Ontario post-secondary institutions (Skolnik, 2020), particularly in program duration and direction. Evidence is the development of nursing degrees, validating my current role, and alternative pathways to nursing licensure, such as bridging programs (McCloskey et al., 2023).

Moreover, the World Health Organization (2022) projects a global workforce shortage by 2030, particularly in nursing. The improvement in the global health workforce stock (Boniol et

al., 2022) includes TC's participation. Accordingly, the CNO (2023) has been unwavering in its mandate to protect the public by promoting safe nursing practice since 1963, with competency expectations in training and professional practice for all nursing programs. This commitment ensures that the trajectory to support students' AAs does not compromise nursing curriculum standards (Neal-Boylan & Miller, 2020). Another significant driver is the Registered Nurse Association of Ontario (2021), which I am proud to be a member of. This association represents all nurses and provides a network of professional resources and best practice guidelines that benefit nurses and educational organizations. My proposed UDL-NS, as an additional resource, promises to further enhance the quality of nursing education. Ultimately, within the nursing profession (Van Bruggen, 2019), these drivers offer professional community assets to help address the more significant impact of AAs. All discussed internal and external drivers impact nursing education's capacity, equitability, and accountability.

Examining this PoP, I attempt to orchestrate policy, curriculum, and accommodations at a lower scale. I also acknowledge broader concerns within the current nursing profession. Thus, working through my PoP impacts change to nursing scholars and practitioners as an educational leadership initiative. On a broader scale, the outcomes improve safety, protect healthcare quality, and promote continuous learning development in both of Canada's official languages, underscoring the significance of the proposed change.

Chapter 2 Summary

In Chapter 2, I have outlined my leadership approach to change, combining Heifetz's et al. (2009a) adaptive leadership and Ubuntu's socio-ethical leadership principles (Laloo, 2022) for Shields's (2020) transformative outcomes. To address AAs at TC, I applied Deszca and Ingols' CPM (Deszca et al., 2020) to lead the change process. I explained how this model includes four

overlapping phases: awakening, mobilization, acceleration, and institutionalization. After considering leadership ethics in organizational change, I discussed potential solutions to address my PoP, indicating a universal design for learning (UDL) framework with a nursing solution (NS) (UDL-NS) approach as the best solution with a nursing task-to-outcome focus, and I elaborated on change drivers and their respective influences in the change initiative. In Chapter 3, I focus on implementation, communication, and evaluation.

Chapter 3: Implementation, Communication, and Evaluation

In Chapters 1 and 2, I illustrated the connections between the strategies, frameworks, and leadership. In Chapter 1, I divulged the influences that Neuman (2011), Knowles (1984), leadership position and lens, and organizational context have had on my work. I conclude with a gap analysis and guiding questions. That rationalizes my Problem of Practice (PoP), through which I seek to support the nursing faculty team (NFT) at Top College (TC) with providing student academic accommodations (AAs). In Chapter 2, I described the transformative goal of this dissertation in practice (DiP) by situating the PoP in the context of Shields's (2020) transformative leadership, Heifetz et al.'s (2009a) adaptive leadership and Ubuntu's socio-ethical leadership (Laloo, 2022), particularly emphasizing collective participation in change. The outcome of applying the organizational readiness to change assessment (ORCA) tool (Helfrich et al., 2009) to my analysis indicates TC's readiness to change.

In this chapter, I discuss the four overlapping phases (awakening, mobilization, acceleration, and institutionalization) of Deszca and Ingols' change path model (CPM) (Deszca et al., 2020) that will guide the change implementation plan, set to begin in September 2024 with the inclusion of an academic term with no summer semester. As a transformative leader, I find this timeline creates the opportunity for reflection and feedback analysis. The provisional implementation date will take place during the September 2025 academic term. In my proposed implementation plan, I include goals and priorities; a communication plan with an alignment, voice, identification, and dialogue (AVID) framework (Ruck, 2020); a knowledge mobilization plan; and a plan, do, study, act (PDSA) cycle (Deming, 1986/2018) for plan monitoring and evaluation. I conclude this chapter by describing the next steps and future considerations that will deepen the roots of the required systemic change at TC. In the conclusion, I synthesize the

three chapters to create an overview. Lastly, I share my narrative epilogue. First, however, I feel compelled to elaborate further on universal design for learning (UDL), in preparation for the work of implementation.

Universal Design for Learning in Education

In 1984, researchers, Dr. David Rose and Dr. Ann Meyer incorporated the Center for Applied Special Technologies and began the UDL framework (Kennette & Wilson, 2019). The UDL is a learner-centred pedagogical approach (Keengwe et al., 2009) that describes learning as a cognitive and social act within a culture of engagement and the capacity for engagement (Huba & Freed, 2000). The framework aligns three conceptual shifts aiming for educational accessibility advancements in architectural design, developments in education technology, and discoveries from brain research (Meyer et al., 2014). This approach gains momentum in community colleges (Hromalik et al., 2020) for learners with or without disabilities (Smith & Lowrey, 2017) by adapting the learning environment design with instructional technological practices (Gronseth & Hutchins, 2020).

It's crucial to highlight the potential benefits that nursing programs can reap from UDL (Heelan et al., 2015). The UDL principles (engagement, representation, and action and expression) have the potential to bridge the gap in practice and foster collaboration and consensus (Gronseth & Hutchins, 2020). The engagement principle relates to flexibility and resource choices, as well as sustaining learner interest and motivation. The representation principle outlines how learners with diverse learning styles can acquire, process, and integrate information and knowledge (Huba & Freed, 2000). Christodoulakis et al. (2022) underscore the importance of actively seeking out teaching strategies that cater to different learning styles and

enhance student learning. Lastly, the action and expression principle provides faculty with a range of teaching strategies (Young, 2023) based on student choice and preference.

However, Bickerstaff and Cormier (2015) stress the need for caution in professional development sessions that advocate for an inclusive environment without demonstrating the practical steps for UDL application. Further, Dacus-Hare (2023) mentions the hurdle teachers experience in the implementation of UDL. Despite this, UDL presents a promising avenue for engagement, helping to alleviate the burden of accommodating certain tasks (B. Roberts, personal communication, December 18, 2023). This message strategically reinforces the administrator's accommodation policy expectations. However, UDL, beyond mere accommodation (Kennette & Wilson, 2019), is about accessibility (Meyer et al., 2014) as a proactive method to reduce unnecessary stress and burnout (Young, 2023). Appendix G illustrates my key takeaways from a professional UDL learning session, emphasizing that (a) student academic functioning in a non-adapted educational setting is like a 'regular' sized box, (b) students requiring an adapted educational setting need a 'larger' box for accommodations, and (c) UDL has no existing box (B. Roberts, personal communication, December 18, 2023). The absence of a box aligns with Meyer et al.'s (2014) focus on ever-evolving methodology and technology platforms that address impairments by removing barriers to students. I further explore how to implement UDL concepts in the nursing program at TC.

As a change initiator, I have remained vigilant from the 'balcony' view, per Heifetz et al.’s (2009a) first principle of adaptive leadership. I maximize reflection on the UDL sessions for constructive knowledge processing required for transformative and adaptive change. I understand that accommodations are often reactive, posing a burden to individuals (Young, 2023), as experienced by the NFT and TC’s academic student centre. As an ethical leader, I must

weigh the value (Heifetz et al., 2009a) of applying UDL specifically to nursing education programs. And further, to align it with other departments, such as diversity-equity-inclusion (DEI). The exchange of values forces the exploration of specific assessment modalities for nursing task competencies supported by challenging literature data. In so doing, I identified a crucial gap necessitating an adjustment for UDL to be applicable to the nursing program reality at TC and in addressing my identified PoP.

Therefore, through this implementation plan, I aim to strengthen TC's capacity to meet program output expectations by addressing my PoP with a combination of UDL and nursing solution (UDL-NS). The focus is on nursing task-competency outcomes using the Deszca and Ingols' (2020) CPM. I will lead the change by proposing a nursing accommodation-accessibility decision tree, a visual tool depicted in Appendix H that will guide decision-making processes related to UDL-NS implementation.

Change Implementation Plan

In applying the four phases of the CPM (Deszca et al., 2020) with the team-based perspective, I envision this implementation plan as a general process guide instead of a rigid change criteria series. Notably, the use of the ORCA tool identifies the change champions (Helfrich et al., 2009)—such as the post-secondary program manager—as key individuals. That person will likely serve as the primary initiator until the completion of this change project (Burke, 2018). In this DiP, the change champion will inform the staff about my change initiative and identify me as the leader or change agent. Deszca et al. (2020) distinguished a change initiator as someone who identifies the need for change from a change implementer who participates in a change initiative, highlighting these distinct leadership roles that may be held by the same individual in the change process. In this initiative, an active initiator, like myself, is

essential in all phases of the change plan, particularly in the awakening phase (Deszca et al., 2020), due to the need to focus on the vision for change. As an adaptive leader, I am both a change initiator as well as a change recipient or a participant in the change plan (Deszca et al., 2020). In this chapter, I use the term ‘change agent’ to refer to the dual role of initiator and recipient. With the focus on implementing a UDL-NS in nursing education, I must work with the NFT in these roles to reach CPM’s institutionalization phase (Deszca et al. 2020). I refer to the implementer team members (ITM) to denote the group of educators, clinicians, and experts from various departments participating in the change initiative. In applying CPM principles, I associate the change champion role with the post-secondary program manager. I apply each CPM phase and PDSA cycle to my proposed UDL-NS to further elaborate the implementation plan. I propose feedback to be tracked using formative and summative assessments (Ismail et al., 2022) and Smartsheet (2019). The “formative assessment allows for feedback which improves learning while summative assessment measures learning” (Ismail et al., 2022, p. 2). Whereas Smartsheet (2019) is a project management software with a succinct view of the achievement. In Appendix I, I furnish a full description of Deszca and Ingols’ CPM (Deszca et al., 2020), PDSA cycle, and monitoring and evaluation for the UDL-NS with a timeline.

Awakening Phase

September and October 2024: Awakening is about spreading awareness of a problem, drafting a vision, and planning for a change capable of unsettling the status quo (Deszca et al., 2020). This phase first entails contemplating and understanding the PoP before determining whether—and how—the organization and key stakeholders will approve the implementation plan (Deszca et al., 2020). Notably, as an adaptive leader, I acknowledge the awakening challenge (Heifetz et al., 2009a) and the importance of 'diagnosing' the system to help with understanding.

Further awakening will occur with approval and commitment from the change champion. In September, I will meet once or twice with the change champion, preferably face to face, with the specific goal of increasing awareness impact (Deszca et al., 2020). This will occur after our monthly formal team meetings and biweekly one-to-one check-in meetings to furnish a comprehensive understanding of my PoP and proposed change plan. Therefore, I will attempt to awaken the change champion by disseminating my proposed vision and the reason for this change (Deszca et al., 2020). As a transformative leader who acts as change implementer and recipient, I will extend the benefits of the UDL learning sessions to the change champion by sharing public internal data, such as TC's mission, DEI policy, and external data, depicting the surge of AA, including provincial nursing registration exam reports.

In October, with the change champion suggestion and according to the program specialization line authority hierarchy, I will meet, once or twice, with the nursing program manager, preferably face-to-face (Deszca et al., 2020). I intend to divulge nursing historical data, using nursing literature pertaining to AAs, while discussing the prevalence of MHDs among adult nursing student populations and the insufficient focus on mental health approaches in conventional nursing education programs. I will also invite and answer questions from various management levels and teams throughout this phase. In so doing, I will conceptualize and share my proposed change to reduce resistance (Burnes et al., 2018) by incorporating learning sessions with my proposed definition of reasonable AAs in nursing education, encouraging team development to foster an understanding of common language. In addition, I will introduce to management my proposed nursing accommodation-accessibility decision tree, adapted with permission from the UDL guest speaker’s work from a professional educational session. Together, we will discuss different approaches, such as simulations, and case studies (Moreland

et al., 2020) —as interactive sessions to explore nursing concerns regarding clinical safety and competency assessment. As an adaptive leader, the 'balcony view' allows me to share, listen, and observe reactions (Heifetz et al., 2009a).

Mobilization Phase: Preparation

November and December 2024: I am positioned to receive staff feedback on the proposed tools presented to management. This exchange of information aligns with the Ubuntu leadership view of a socio-ethical and collective approach (Laloo, 2022) to solving complex issues reminiscent of adaptive leadership (Heifetz et al., 2009a). The CPM will be applied to emphasize the change system, process, gap analysis, and any resistance to support change (Deszca et al., 2020). As the change initiator, I will be 'on stage' to identify adaptive complex challenges, consistent with the second principle of adaptive leadership (Heifetz et al., 2009a). In this phase, I will seize the opportunity for tactical transition with my change plan by compiling the UDL knowledge. Notably, transitioning to the preparation phase involves some overlap, given its emphasis on "people and resources needed to launch the change" (Deszca et al., 2020, p. 8). Ultimately, the goal of the change plan includes participatory planning (Leino & Puumala, 2021) and acquiring sufficient resources, including ITM, to drive the change and disseminate findings across faculties involved with AAs at TC. The mobilization phase focuses on identifying and prioritizing tasks, assessing power dynamics, encouraging collective participation, and determining specific roles for all implementers—between 10 to 50 people—for a suitable team size (Deszca et al., 2020). To reduce confusion (Deszca et al., 2020), the change champion and I will clarify the roles of selected ITM, as described next, at the first monthly team meeting.

In November, the selection criteria are based on their connections with AAs or their adoption of UDL-NS. Members and roles include:

1. The nursing program manager to supervise the impact on the nursing curriculum.
2. The UDL guest speaker to observe legal implications.
3. Three NFT members to explain and analyze the implications for nursing competency.
4. Two accessibility centre members to expose complaints in context-specific situations.
5. Two OD members to examine UDL-NS logistics and training.
6. Two academic student centre members to compare student AA requests to the curriculum context.

The two-hour monthly group discussion meetings with ITM will allow coordination of task-specific activities. These meetings will be hosted in addition to monthly meetings with the change champion to discuss the team's progress. Ultimately, drafting a change plan with a specific timeline activity is critical to its success (Deszca et al., 2020). I will accomplish that with a master implementation team draft timing presented to the ITM. Additionally, I will increase my availability by using virtual meeting platforms to participate in meetings as requested by the ITM to provide clarification during the change initiative. The interdependence of ITM emphasizes collective empowerment from group interaction, fundamental to Ubuntu leadership (Laloo, 2022), in implementing educational initiatives (Leino & Puumala, 2021), conditional on human resources and funding capacity for subject-based experts and tool creation (Deszca et al., 2020) like the UDL resource and funding.

Mobilization Phase: Action Stage

January to April 2025: The preparation stage overlaps with the proposed action stage (Deszca et al., 2020). I will schedule sufficient time to secure interest and resources during

monthly two-hour in-person group discussion meetings at a confirmed scheduled location. This stage focuses on the "determination of what specifically needs to change, and the vision for change is further developed and solidified by additional analysis" (Deszca et al., 2020, p. 52). I intend to work closely with each ITM, respective to delegated responsibilities and roles, while maintaining agendas and consulting with management about priorities guiding my change plan. I also anticipate discussing nursing scholarly sources and legal inquiry with the UDL guest speaker. This is pertaining to my proposed nursing accommodation-accessibility decision tree tool to decrease potential resistance in:

- applying to the nursing program
- connecting with key OD stakeholders to better understand TC's educational tool implementation process for new nursing-specific UDL materials
- connecting with the NFT to prepare case study scenarios for discussions
- liaising with the NFT to formulate our definition of reasonable accommodations
- examining the definition and tools with the academic student centre and accessibility centre for input and feedback
- allowing room in the timeline to address unforeseen situations

As a change initiator and recipient, I will value the voice and role of each ITM involved in the change initiative, in line with Ubuntu leadership (Laloo, 2022) that encourages the full involvement of all group members (Leino & Puumala, 2021). Moving forward, I will provide training on the UDL-NS to the NFT during training meetings at management’s request.

In applying adaptive leadership (Heifetz et al., 2009a), I can identify engagement in activities that mobilize, motivate, organize, orient, and focus the attention of others: an adaptive challenge. Heifetz et al. (2009a) cautioned that the third principle of adaptive leadership requires

intense participation in this phase and subjects stakeholders to potential distress requiring regulation. Thus, I will support the ITM by applying an interdisciplinary approach rooted in reciprocity by modelling expected behaviour, encouraging efforts, and honouring contributions.

Acceleration Phase

May to August 2025: I will emphasize efforts and additional buy-in, including new understanding and skills, and share stories to maintain the vision and continue the change (Deszca et al., 2020). In May, along with the change champion, I will rally additional implementers, including the change champion, to strengthen expertise and increase interdisciplinary teams. During the monthly implementer meeting, the following new members and roles will be introduced to the initial ITM:

1. An academic student centre member to comment on the definition of reasonable nursing AAs and the nursing accommodation-accessibility decision tree tool.
2. A program advisory committee member to discuss and receive feedback on how the UDL-NS impacts student academic success.
3. A DEI centre member will discuss implementer team updates and refine the inclusivity perspective.
4. The change champion will discuss implementer updates and receive feedback.

During subsequent group discussion monthly meetings, I will adjust interventions and actions in collaboration with the change champion to reflect on feedback from the new ITM as needed. I anticipate additional meetings upon request or, as needed—through face-to-face or virtual means—according to adaptive leadership's fourth principle: maintaining disciplined attention on conflict rather than avoiding it (Heifetz et al., 2009a). This phase "involves action planning and implementation" (Deszca et al., 2020, p.53) by combining all the insights at earlier

stages and creating a detailed action plan for change with specific short-, medium-, and long-term goals. Change recipients will have high expectations of the work conducted by the ITM in this phase as the group collaborates on solutions, emphasizing Ubuntu collective leadership principles (Laloo, 2022), as well as adult learning assumptions (Knowles, 1984) and adaptive leadership's fifth principle: to give work back to the people (Heifetz et al., 2009a). I will promote equity and inclusivity throughout this change by protecting leadership voices from below, synonymous with adaptive leadership's sixth principle (Heifetz et al., 2009a). Regarding work realities, I will provide flexible and multimodal communication methods (Barley et al., 2017), including discourse through email, in-person discourse, digital file sharing, and scheduled meetings. Additionally, I will actively listen for ideas, concerns, and insights by adjusting the focus of the change plan to ease understanding and emphasize the change target (Deszca et al., 2020). I will empower each ITM by clarifying both their respective and collective contributions through related skills, abilities, and knowledge (Deszca et al., 2020), as well as the benefits of the change plan's return on investment. I intend to achieve this by expressing appreciation for their respective contributions and efforts to each ITM by name during monthly team and management meetings. This will enable the group to create and maintain momentum by celebrating wins and milestones to propel the change (Deszca et al., 2020). To support the larger change plan, I will reach out to all potential resources capable of helping adapt or advance the change. In July and August, all interactions will assist me in monitoring progress after the recurring monthly meetings. My last goal in this phase is to "understand how existing situations can be leveraged in order to increase the prospect of success" (Deszca et al., 2020, p. 53). This includes Heifetz et al.'s (2009a) seventh principle regarding the importance of practicing self-care by encouraging the pursuit of TC's wellness activities and summer vacation.

Institutionalization Phase

September 2025 onward: The last CPM's phase corresponds to the successful implementation of the new state; thus, the initiated change becomes the new normal (Deszca et al., 2020). In this phase, Deszca et al. (2020) suggest guiding the process by reducing the likelihood of reverting to problematic patterns. I will achieve that by tracking NFT modifications, and vigilantly scanning for potential reversion to prior practices in line with adaptive leadership approaches (Heifetz et al., 2009a). Along with the change champion, I will reaffirm the veracity and magnitude of group collaboration, emphasizing Ubuntu leadership principles (Laloo, 2022). TC will, according to Deszca et al. (2020), "develop and deploy new structures, systems, processes, knowledge, skills, and abilities to bring life to the change and new stability to the transformed organization" (p. 54).

In this DiP, I demonstrate why and how a transformative change in individuals will impact various organizational levels with IMT participation. Consequently, during meetings, I will continue discussing and monitoring findings and changes with management. In these conversations, I and ITM will remind faculty members about the official new nursing accommodation-decision tree tool. Also, collectively, we will emphasize the importance of the change vision, including the need to support the NFT in terms of AAs. ITM must also express how change plan outcomes could provide meaningful solutions for educational leadership problems in other programs. For these reasons, my intention is to furnish a robust foundation that will remain adaptable as new perspectives emerge.

I have elaborated on an exceptional circumstance that aligns with my awakening phase and provides specifics on implementing my change plan with Deszca and Ingols' CPM (Deszca et al., 2020), four overlapping phases and corresponding timelines. The linear process of the

CPM does not reflect any realistic change pattern, as implementing change is challenging, but the outcome is rewarding (Deszca et al., 2020). I have outlined collective considerations for ITM selection, roles, and responsibilities. Next, I acknowledge specific change goals and priorities.

Goals and Priorities

In this implementation plan, I must include specific goals with various implementers at different times until the change initiative is completed. Goals are divided into three sections: (a) three months short-term, (b) four to five months medium-term, and (c) over six months long-term. In Appendix J, I present how these term goals can overlap to complement each other.

Short-term goals correspond to the awakening phase of the CPM (Deszca et al., 2020), which is set to take place from September to October 2024. First, I must initiate a conversation with the change champion to express urgency for the need to change while providing supporting evidence, such as a gap analysis, and outcomes made apparent using the ORCA tool. The OD's prior introduction to UDL principles adds a level of familiarity and legal reassurance comfort with this concept for TC's management team. The knowledge mobilization plan demonstrates the clarity of my change vision from the current to the desired state. Having the nursing program manager, who is open to exploring new initiatives, on the implementer team eases the buy-in process for change. Consequently, TC's leadership team will be better equipped to critique current policies, procedures, and normative practices.

Medium-term goals will occur between May and August 2025 and correspond to Deszca et al. (2020) CPM acceleration phase with buy-in focused on maintaining momentum. In May and June, the intensity of this period requires much more participation and effort from everyone. This is in addition to the distress risk associated with the phase, emphasized in adaptive leadership approaches (Heifetz et al., 2009a). Understandably, this coincides with last efforts to

achieve the desired future, which include adding change implementers and other necessary resources. Strategic selection of additional ITM to gain buy-in aims to include participation from potentially influenceable decision-making individuals. Because there is no summer semester in the nursing program, July and August 2024 will provide opportunities for reviewing feedback and planning with management, as well as practicing self-care (Heifetz et al., 2009a).

The long-term goal coincides with the CPM's mobilization phase, from November 2024 to April 2025, through which the group will explore possibilities and minimize hesitation (Deszca et al., 2020). This period is lengthier because it constitutes intensive group work that is rich in group discussions, case studies, and simulations, including personal and professional experiences with AAs from the ITM and opportunities for follow-up. Based on their interaction with AAs, the change champion's approval of our selection of ITM creates an inclusive and strategic team approach that minimizes hesitation and ensures sufficient members. Therefore, their involvement will allow them to voice their adult and professional learning experiences (James & Bewsell, 2020) during group discussion sessions. All ITM will explore how the UDL-NS is meaningful in addressing AAs. The proposed nursing accommodation-decision tree, used with suggested similar case studies and simulation scenarios at TC, makes the UDL-NS tool context-specific.

From September 2025 onward, the institutionalization phase is also a long-term goal, which includes a sustainability focus on the desired future that is impossible to capture within a time limit. Consensus must be reached among implementers to work together using my UDL-NS. Managers must adopt the new normal. The change champion and nursing program manager can advocate for the next steps, creating an official wellness resource by leveraging the proposed nursing accommodation-decision tree to UDL-NS. I will suggest that training using Kirkpatrick

and Kirkpatrick (2016) be explored on the UDL-NS for the NFT with OD support. Various communication channels will be deployed to disseminate potential new roles and responsibilities across TC regarding the need for the change.

Potential Barrier

Any implementation plan is not without potential failure risk (Burke, 2018). My PoP targets the NFT, whereas the ITM are from departments that primarily support student interests. Therefore, the ITM can experience ambivalence calibrating their professional interest target group, namely, the students. This discomfort is closely linked to the institution's potential fears of legal turmoil. In my change initiator leadership role, I am deeply committed to adaptive leadership (Heifetz et al., 2009a) within the group. In doing so, I acknowledged Neumann et al. (2018) suggestion to navigate possible unforeseen situations, challenges, and barriers to change.

Promoting practice standards is a professional responsibility and expectation. The CNO (2023) behaviour decision tree guides behaviour and decision-making, aiming for standards. The message is for nurses to withhold action if in doubt or if the situation could negatively impact the public (CNO 2023). The fundamental understanding of this message could be a barrier in my proposed UDL-NS should nurses refrain from exploring solutions. However, as an adaptive leader, the proposed UDL-NS incites exploring alternatives. Further, Marić et al. (2017) encourage to influence the understanding of the CNO standards. As an adaptive leader, the ‘influencing’ component is the transformative process where the NFT is willing to adapt its pedagogy, a valuable contribution, to foster my proposed UDL-NS.

After describing the implementation plan's CPM (Deszca et al., 2020), short—to long-term goals and potential barriers, I will articulate the communication plan for the change vision.

Plan to Communicate the Need for Change and the Change Process

Burke (2018) stated that communication is crucial for any change initiative. In this change initiative, the communication plan is aligned with the CPM (Deszca et al., 2020) and AVID framework (Ruck, 2020), which facilitates the exploration of employee channel preferences, information flow, communication satisfaction levels, and organizational engagement. The AVID framework provides an advantage due to its broad familiarity within the nursing profession (Mohajan & Mohajan, 2022) and is cost-efficient due to the limited requirement for internal human resources (Jasper, 2018). Consequently, AVID can be used within small groups—such as the NFT—but can also include a combination of interdisciplinary groups, such as the implementer team, which coincides with Ubuntu principles (Laloo, 2022; Nagda, 2019). Jasper (2018) indicated that AVID decentralized social exchange as an internal communication framework. Leino & Puumala (2021) also strongly related to the Ubuntu approach (Laloo, 2022) by generating new ideas and strengthening the connection between team members. My communication plan has incremental steps, including clarifying objectives, explaining the vision, and sharing data and resources that align with my socio-constructivism (Rannikmäe et al., 2020) and adaptive leadership approach (Heifetz et al., 2009a). Next, I examine the four AVID dimensions (Ruck, 2020), depicting their importance and applying them to implementing the UDL-NS with the CPM in Appendix K.

Alignment Dimension and Awakening Phase

The alignment dimension must foster a connection between teamwork and organizational goals (Ruck, 2020), which in TC's case, is academic success above others. This dimension also focuses on the interconnections between change champions and other decision-makers, factoring in the urgency of change initiatives and reinforcing goals among team members. In the

awakening phase, I must focus on raising the change champion's awareness of the organization's need for change (Deszca et al., 2020), emphasizing the pursuit of my UDL-NS. Hence, I must ensure alignment between communication strategies and the college's pre-existing decision-making hierarchy (Riggio, 2017). The change champion is the post-secondary program manager and the most influential and is primarily responsible for disseminating this change message to other program managers, primarily the nursing program manager.

In September 2024, I will meet with the change champion. I have chosen a face-to-face modality because this formal meeting style is more likely to produce the preliminary awareness required to act and implement the change (Deszca et al., 2020). I will achieve awareness by strategically iterating that TC has made an excellent decision to introduce UDL principles (Flood & Banks, 2021). Nevertheless, there is an urgent need to target UDL AAs in nursing based on convincing gap analysis data. From the balcony—per the first principle of adaptive leadership (Heifetz et al., 2009a) —I will demonstrate, with colleague feedback, how the NFT perceived the UDL principles. This will help me foster an understanding of how the UDL-NS can better address AAs in the nursing program (Kennette & Wilson, 2019), which I can relay to the change champion and others in the future. The topic of AAs is significant enough at TC to retain management's attention on suggested nursing educational initiatives.

In October 2024, as directed by the change champion, I will meet the nursing program manager—preferably in person—whose role is to improve nursing programs. I intend to describe how my proposed change plan corresponds to the manager's responsibilities, supported by my knowledge mobilization visual. I will encourage the pursuit of common terminology in defining reasonable AAs (Neal-Boylan & Miller, 2020) in nursing education. By presenting AA data—including internal and external items, historical context, and gap analyses demonstrating impact

on the nursing profession—I intend to foster an understanding of how this data can support program reviews and success indicators at TC. I will emphasize the need to examine UDL principles with the proposed UDL-NS and the implementer's respective expertise, open mind, transparency, and collaboration. Neuman et al. (2018) noted that transparency is crucial to building trustworthiness. Ultimately, management is encouraged to support the proposed outcome of this initiative and act transparently by sharing the required data and gap analysis with all eventual implementers through various communication channels, raising awareness and creating a sense of urgency in the change initiative process (Deszca et al., 2020).

Voice Dimension and Mobilization Preparation-Action Phase

The voice dimension asserts the importance of speaking up—including non-verbal communication—as an important ethical component in any change plan (Ruck, 2020). Voice equates to acknowledging human existence, realities, and thoughts capable of impacting others, reflecting personal and professional perspectives (Ruck, 2020). Deszca et al. (2020) also argued that gathering people and resources is essential to launching successful change.

My voice will be heard first in September when interacting with the change champion, and from October onward, implementer voices will echo during scheduled meetings throughout Deszca et al.'s (2020) remaining CPM phases: mobilization, acceleration, and institutionalization. Ultimately, I will verbally communicate with the implementers to ensure all voices are heard and support broader adaptation and sustainability.

From November 2024 to April 2025, the awakening phase will transition to overlap with the mobilization phase, which includes preparation and action (Deszca et al., 2020). The preparation phase is in November and December. I will collaborate with the change champion on deployment actions, resources, and people for the change by considering the system and the

process to support the change and understanding the resistance to change. I will discuss the importance of capturing IMT's learning during the two-hour monthly interaction sessions. This will be a collaborative effort, with the change champion and I to select the best approach, such as group discussions and our routine feedback practices, such as formative and summative assessments (Ismail et al., 2022) with software (Smartsheet 2019). The goal is to evaluate IMT's monitoring experiences, perspectives, impressions, and behavioural engagement level at each stage of the change process, ensuring a focused and aligned capture of learning progress.

During the action phase in January's monthly educator team meeting, the change champion officially announced the change plan initiative to address the surge of AAs in the nursing program. I will further discuss my vision and announce the members of the selected implementer team, with their previous participation commitment. In January, during our first monthly implementer meeting, I will share with the ITM the desired future outcomes. I will foster an understanding of the proposed UDL-NS to the team as a change agent to support change championing and drive change efforts. Encouraged by the change champion, the ITM will rally to address the complex challenges using adaptive leadership's second principle (Heifetz et al., 2009a). This social collective interaction supports Ubuntu leadership (Laloo, 2022). The task objectives are:

1. Agreeing on term consensus on proposed reasonable AAs in nursing education.
2. Exploring NFT concerns with AAs
3. Discussing perspectives and challenges of the respective departments about AAs
4. Exploring the proposed nursing accommodation-accessibility decision tree tool

The communication goal of the preparation phase is to be part of the 25 percent success rate for change initiative rather than the 75 percent failure category (Burke, 2018) by anticipating

and addressing unforeseen obstacles of resistance (Deszca et al., 2020). Consequently, the voice dimension—a communication goal—aims for meaningful conversation and trust building; notably, it can also be easily combined with the subsequent identification dimension (Ruck, 2020). The adult learning environment (James & Bewsell, 2020) is ideal for a transformative approach requiring reflection among members (Shields, 2020).

The ITM will be approached for their feedback on transformative change through the following questions: How does their professional lens contribute to this initiative? How do AAs address safety considerations? How should nursing competency assessments be revisited? How can this change initiative enhance the application of individual educational plans for nurse educators? Does the team believe that ever-evolving accommodation requests support the achievement of educational organizational objectives? The feedback will allow me to adjust my communication strategies or styles to fit ITM's preferences.

As a change initiator, I will explain my communication channels and information flow to the ITM. I will also seek to understand the member's preferred communication style for one-to-one interactions, primarily to address member disagreement. This strategy reflects DEI values within the parameters of adult learning theory, given the goal of increasing participation and satisfaction levels (James & Bewsell, 2020). Therefore, the understanding of the ITM regarding the proposed UDL-NS and satisfaction level in January 2024, April 2024, and September 2025 will be probed.

I will focus on maintaining the team's desire and participation to drive change. I will achieve this through an optional face-to-face meeting with a videoconference component in which I will share with ITM the knowledge mobilization plan and visual and a PowerPoint slide deck describing milestone progress and monthly calendar reminders. The change champion will

be carbon copied on associated emails. I will encourage change champion to participate in the dialogue, reinforcing Deszca et al.'s (2020) emphasising buy-in strategy and the influence and impact of immediate supervisors compared to senior leadership to shape employee responses to the change vision.

The voice dimension highlights the individual need to be visible and heard (Nagda, 2019). Therefore, I will acknowledge and provide feedback to the implementers on their collective work as an agent of change (Nagda, 2019). I will foster this participation tactic (Leino & Puumala, 2021) by promoting an adult learning atmosphere (James & Bewsell, 2020) that supports the inclusivity of all voices, in line with adaptive leadership's sixth principle (Heifetz et al., 2009a). As a change agent, I will consider perspectives on work realities from the ITM and management that pertain specifically to regular educational development sessions, given my proposed solution, which will require revising and delivering comprehensive and multi-disciplinary techniques, including case studies and simulations. Notably, I understand that decision-making skills and processes enhance networking quality, emphasized by adaptive leadership's fifth principle (Heifetz et al., 2009a) of engaging teams in problem-solving among themselves (Banda, 2019). As a mental health nurse and adaptive leader, I am cognizant of Heifetz et al.’s (2009a) third principle of adaptive leadership, addressing potential distress risk, and the fourth principle, describing the importance of staying on task. To ensure fluid communication that mitigates risk and divergence from the task, I will integrate specific task priorities, roles, deadlines, and celebrations of success in meeting agendas and frequent check-ins with ITM and change champion. I also remain aware of the need to provide the team with appropriate literature and tools to support this task's achievement. Check-ins are opportunities to address role clarification and task precision, which Deszca et al. (2020) emphasized to reduce

confusion. While I recognize that the voice dimension stresses the importance of providing a variety of avenues in support of sensitive conversations that may present dissent or disagreement, I must also consider these facets when factoring in the identification dimension of this communication plan.

Identification Dimension and Acceleration Phase

The identification dimension is initiated during the mobilization–preparation phase; however, from May to June 2025, I will revisit with the change champion, this dimension to support ongoing change momentum and continuous communication. Since discussions surrounding AAs may generate emotional responses requiring attention, in considering the identification dimension, ITM will be encouraged the expression of beliefs, values, and objects: all essential elements to test the group's psychological readiness for change (Quach et al., 2021). Notably, resistance can be generated at any time throughout this initiative. Given Heifetz et al.'s (2009a) adaptive leadership's seventh principle on self-care, my role as an adaptive leader will be, according to Hefferman (2023) to watch for any indicators of disengagement behaviours during the implementation plan. During the acceleration phase, the ITM will be approached to probe further understanding of UDL-NS. Feedback will guide me and change champion reflections on applying the UDL-NS to support the NFT with AAs in their courses, and potential adaptation of the nursing accommodation-accessibility decision tree tool. Additionally, exchanges among focus group members will guide the buy-in and support required to maintain project momentum: a key goal during the acceleration phase.

Deszca et al. (2020) discussed the importance of celebrating achievements in maintaining motivation and propelling change, which I will do at biweekly meetings. Particularly, in June, before the end of the academic term and during the last ITM meeting, along with the change

champion, I will celebrate achievements, milestones, and outcomes. After this meeting, by email, I intend to divulge a summary of our celebration updates that will support ongoing work on this initiative.

Dialogue Dimension and Institutionalization

The dialogue dimension spans the initiative from September 2024 to September 2025, when the institutionalization period starts. Dialogue underpins the entirety of this communication framework and is defined as a full scope of verbal and non-verbal communication with the need to inform, listen, and discuss (Ruck, 2020). Further, with regular and timely input and feedback, dialogue generates ideas, comments, questions, and concerns, builds trust, reduces resistance to change, and supports the change plan (Deszca et al., 2020). As an adaptive leader, during monthly meetings with the implementers and the change champion, I will align the group's interests and priorities, guiding them when necessary to keep the focus on the change vision and encouraging team decisions (Deszca et al., 2020). My active participation and input are crucial in this process, as it empowers ITM in our change journey.

The ITM's respective interdisciplinary team will report to their team departments to generate feedback, solicit comments, and seek clarification to achieve consensus. This collaborative approach, involving ITM from different departments, not only continues communication within their respective departments but also underscores the value of their contributions to the change initiative. Additionally, the allocated time for each dimension ensures incremental steps, thereby emphasizing collaboration strategies, transformative development, and adaptive processes until a new normal is established, provided dialogue remains at the forefront throughout the initiative. Ongoing feedback received from various sources will allow

learning tracking since January. These answers may assist the change champion and myself in identifying and adjusting interventions that facilitate the sustainability of the UDL-NS.

As discussed, the communication plan reflects how adaptive leadership (Heifetz et al., 2009a), Ubuntu leadership (Laloo, 2022), and Descza et al.'s (2020) CPM can harmoniously achieve transformative outcomes when utilized in conjunction with the AVID framework. Communication is essential in conveying the importance of organizational change and necessary strategies throughout the process. Transparency is equally important in knowledge sharing and can be reflected in the knowledge mobilization plan I intend to use, which I describe next. Once the communication plan is entrenched, knowledge mobilization can proceed. This commitment to transparency ensures that ITM are informed and can trust the process and its outcomes.

Knowledge Mobilization Visual and Plan

As a change leader, I am committed to supporting the NFT in addressing AAs, as 'effective leaders can overcome the key barriers of their peers' negative attitudes and behaviors about collaborative learning' (Najjar & Ascione, 2020, p. 1). This belief in change through joint effort drives me. I also want to underline the significant value of a knowledge mobilization plan, which can lead to "the reciprocal and complementary flow and uptake of research knowledge between researchers, knowledge brokers and knowledge users… in such a way that may benefit users and create positive impacts" (Social Sciences and Humanities Research [SSHR] Council, 2019, section 16). The potential for these positive impacts is what inspires me.

For me, the history of AAs in nursing stems from Seacole's (2005) and Neuman's (2011) philosophies. AA requests are frequently rejected or are not addressed by nursing faculty, who view AAs as challenging to support within nursing education (Levey, 2018). My knowledge mobilization is visualized in Appendix L, with a plan in Appendix M to demonstrate a problem

that must be remedied. For this reason, my initial conversation in September with the change champion—and the dialogue with the nursing program manager in October—during the alignment dimension must be composed of mobilization plan content supported and revisited throughout the initiative. Significantly, the nursing program manager's involvement in the implementer team enhances voice continuity and dialogue at the senior management level. The ITM shared expertise emphasizes knowledge mobilization plan content during workgroup sessions. Feedback from various channels, such as observation and group discussion, is valuable. Additionally, the revision process—occurring in the acceleration phase (Deszca et al., 2020)—is essential for knowledge mobilization. A later phase in the mobilization process involves the consolidation of the learning into a tool resource, such as the proposed nursing accommodation-accessibility decision tree. The UDL guest speaker will add legal credibility to the proposed tool. That tool will be shared internally, followed by sharing with external community partners such as the Registered Nurses Association of Ontario, as an eventual approved evidence-based nursing tool. Ultimately, content and process are incorporated in the non-exhaustive flowchart of my mobilization plan; while these processes will occur at the beginning of this change initiative, the tool resource will not begin until after the completion and approval of the change initiative.

Through the knowledge mobilization visual, I aim to inspire colleagues at TC and other parties toward the change that contributes to an integral part of the communication plan I have described. As a change agent, I will also assess communication throughout the initiative, track the change plan's progression, and evaluate the appropriateness of the chosen actions to achieve the goal through continuous monitoring.

Change Process Monitoring and Evaluation

The monitoring and evaluation of the change process inform the implementation team of the successes, delays, impacts, and opportunities for iterations of the planning for sustainability (Markiewicz & Patrick, 2016). Monitoring is an "ongoing intervention with recurrent time-based assessment" (Neumann et al., 2018, p. 120) that generates questions to be answered in the evaluation (Markiewicz & Patrick, 2016). Evaluation is "a systematic assessment of the merit of an activity" (Neumann et al., 2018, p. 121) of the entire change process. The evaluation identifies areas requiring further monitoring (Markiewicz & Patrick, 2016).

Monitoring and Evaluating: Plan, Do, Study, Act

My monitoring process aims to track TC engagement in the change initiative; however, it is crucial that monitoring is used casually to avoid anxiety-triggering effects (Nichols et al., 2021). My definition of 'casually' entails voluntary participation that considers employee monitoring channel preferences with flexible deadlines. Notably, monitoring and evaluation processes have different functions, some overlapping, and offer the opportunity to assess progress and measure expected outcomes (Markiewicz & Patrick, 2016). The measures to track the change process can be qualitative and quantitative (Markiewicz & Patrick, 2016). In this DiP, the tracking tool could include the formative and summative assessments (Ismail et al., 2022) and project management software (Smartsheet, 2019). The acknowledgement and evolution of Deming's (1986/2018) PDSA cycle. are discussed in the next paragraph.

Acknowledging Attribution and Cycling Model Evolution

Shewhart (1939) is the father of statistical quality control. He introduced the four stages of the Plan-Do-Check-Act (PDCA) cycle (Xie & Mukherjee, 2017). Later, Deming (1950) developed the PDCA cycle into the plan, do, study, act (PDSA) cycle. Deming (1986;1993) further amended the cycle, with the earliest reported use in healthcare in 2000 (Taylor et al.,

2014) to better address complex situations (Zann et al., 2021) with a team (Katowa-Mukwato et al., 2021). Langley et al. (1994) further developed the PDSA cycle to include three questions embedded within the cycle, focusing on the aim, measures, and changes to be made. The questions are "What are we trying to accomplish? How will we know if a change has been an improvement? What changes can we make that will result in improvement?" (Langley et al., 1994, p. 81). The PDSA model continuously evolves (Langley et al., 2009; Moen & Norman, 2009) through the W. Edwards Deming Institute (Deming, 2018), emphasizing knowledge and application. This DiP will use Deming's (1986/2018) PDSA cycle model to include the questions previously listed by Langley et al. (1994).

PDSA

The PDSA cycling model, a valuable and evidence-based evaluation practice tool (Taylor et al., 2014), guides leaders and management in incremental change processes (Christoff, 2018). It does so by developing, assessing, and implementing change leading to improvement (National Health Service [NHS], 2023). Despite the oversimplification of the PDSA method (Reed & Card, 2016), its adaptability to various scopes and scales further enhances the achievement of goals and sustainability (Nanji et al., 2013) of the change plan. The iterative structure of the model not only aligns with but also reassures the increased focus on quality improvement models (Taylor et al., 2014), aiming for safe, timely, efficient, equitable and cost-efficient with measurable outcomes in healthcare settings (Reed & Card, 2016). Further, Taylor et al. (2014) emphasize that the PDSA tool does, at its core, enable a well-conducted and adaptable learning process based on the specific context of the team's needs and goals. Deming et al. (2012) emphasize that in all organizations, best efforts are not enough if you do not know what to do. Therefore, the PDSA cycle is a pragmatic scientific choice model in clinical care (Coury et al., 2017), in

educational organizations (Mayangsari et al., 2023) and in nursing settings (Katowa-Mukwato et al., 2021). Reed and Card (2016) indicate that "The intended output of the PDSA is learning and informed action" (p. 147). Ogrinc et Shojania (2014) further indicate that it consists of more than monthly collecting and analysis of data.

Consequently, this popular management tool supports readiness hints, communication steps, and timeline direction given the incremental team-based context of the nursing-specific setting (Reed & Card, 2016) of this DiP. The PDSA tool will combine AVID (Ruck, 2020) and Deszca and Ingols' CPM (Deszca et al., 2020) and prove effective in the monitoring and evaluation process. In this DiP, the PDSA tool plays a crucial role in facilitating learning. Defining each step indirectly increases engagement and limits barriers to frontline staff and management (Deming, 1986/2018).

The PDSA cycle, structured into four stages, each with a specific function (1986, 2018), is characterized by its iterative nature. The 'plan' stage is where the intervention and feedback collection are designed. The 'do' stage is where the intervention is implemented and monitored. The 'study' stage is where the feedback is evaluated. The 'act' stage is where decisions are made about stopping, repeating, or moving on to the next cycle. The following paragraphs detail these four stages, describing the monitoring activities and evaluation questions. The evaluative questions will promote a learning approach among the ITM, fostering the reflection necessary for dialogue (Markiewicz & Patrick, 2016) and for shared solutions (Magnuson et al., 2020). The emphasis on the 'do' phase allows change leaders to monitor, adjust, improve, and align actions (Deming, 1986/2018) to the application of UDL-NS.

Plan Stage

The Plan stage is the PDSA's first stage (1986/2018) and is scheduled between September and October 2024. The 'plan' corresponds to the awakening of the CPM phase (Deszca et al., 2020) and the alignment, voice and dialogue dimensions (Ruck, 2020). The 'plan' focuses on assessing and exploring a current situation and fully understanding the roles, responsibilities, potential problems and solutions, timelines, and actions to implement (Christoff, 2018). The goal is to raise awareness of the current situation, inform about the urgency of the organization's need for change, fully understand the problem, and acquire support to sanction a system response. In the 'plan,' initiating dialogue (Ruck, 2020) aims to disseminate feedback to stakeholders. In September, I must identify, to the change champion, the gap between current and desired organizational states with my vision, emphasizing the pursuit of my UDL-NS. Specifically, answering Langley et al. (1994) 's question about 'what are we trying to accomplish?' The answer is to explore the applicability of UDL-NS proposing a nursing accommodation-accessibility decision tree, with case studies to address AAs requests at TC to support NFT. In the 'do,' as a change initiator, my role necessitates effective communication channels emphasizing priorities, urgency and timeline achievement (Deszca et al., 2020). Therefore, to foster trust and motivation (Jensen et al., 2018) at a mutually scheduled time, preferably in person, I must communicate my PoP to the change champion, disseminate internal and external data, and my change implementation plan for feedback, while factoring in TC as the location and the solution focused on UDL principles toward nursing task competency outcomes. From an adaptive leadership perspective (Heifetz et al., 2009a), I will express my interest in mutual organizational goals with the two previous UDL information sessions in establishing communication through the alignment and voice dimensions (Ruck, 2020). This alignment with our organizational goals

should reassure you of the plan's direction and its potential to contribute to our shared objectives. In October, at a mutually scheduled time, preferably in person, I will disseminate my internal and external public data (Deszca et al., 2020), introduce my proposed UDL-NS to the nursing manager (and other managers upon request), and answer any questions to secure ownership of my implementation plan. I will also discuss the implementation team prospect to align with TC's established team approach, research-project protocols policies and ethics board's approval. In the 'study,' as a change initiator, with the change champion, we will explore the readiness for change indicators. During the weekly meeting, I will monitor the change champion's interest through feedback and email. Measurable buy-in can be determined by assessing communication with the change champion and the nursing program manager. Evaluation will focus on the prosperous approbation of the change champion and support from the nursing program manager as an ITM. Update reports to the change champion will consist of incremental communication of milestones, wins, and outcomes through dedicated biweekly meetings. The' act 'portion aims to evaluate progress about the desired state and get confirmation feedback and approval from management on readiness for the next or to repeat this cycle (1986/2018). The entire initiative will take place over 13 months. Notably, the planning stage is strategically synchronized with the TC's quinquennial cycle, discussed in Chapter 1, to include the 2025 review of the accessibility and accommodation policy.

Do Stage:

The Do stage, the second phase in the PDSA cycle (Deming, 1986/2018), is a pivotal period scheduled between November 2024 and April 2025. It aligns with the dimensions of alignment, voice, and dialogue (Ruck, 2020), and corresponds to CPM's mobilization phase (Deszca et al., 2020). This phase includes preparation and action and corresponds to the plan in

motion (Reed & Card, 2016). That stage focuses on communicating the vision through various channels and building momentum toward the desired outcome (Deszca et al., 2020). The goal is to establish and identify the change coalition (Langley et al., 2009) to provide local leadership to support the change process (Dukar et al., 2017). The voice dimension is crucial as it enhances dialogue and transparency among all implementers (Ruck, 2020). The 'plan' aims to create a dynamic of engagement within the implementation team to effectively execute the change initiative.

During the 'preparation' part of the mobilization (November-December), in the ‘do,’ I will play a pivotal role in leveraging communication pathways. The change champion announces the change initiative during the educator's monthly formal meetings to address the surge of AAs. I will lead by example and introduce the KMb presentation to propose the UDL-NS. I will announce the preselected ITM (nursing program manager, UDL-GS, NFT, OD, accessibility department and I). Operational tasks will be shared among myself and according to suggestions from the change champion, as Deszca et al. (2020) emphasize the impact of barriers and the importance of a seamless process. ITM’s understanding will be assessed through dialogue and personal reflection on UDL-NS in November, April, and September.

From Jan-April, the 'action' part of the mobilization starts with the first ITM meeting. In the ‘do,’ I will individually honour their participation as an engagement strategy (Deszca et al., 2020). I will present Deming's (1986/2018) PDSA cycle model and Langley et al. (1994) question to align the ITM. I will clarify the implementation's task expectations/roles and agenda (Deszca et al., 2020) and provide instructions with adult learning principles (Knowles et al., 2015). Teamwork facilitates improvement (Moen & Norman, 2009) with a collaborative effort in subgroup task objectives (e.g. defining reasonable accommodation (Neal-Boylan & Miller, 2020)

and exploring the UDL-NS tool with case studies), avoiding confusion (Deszca et al., 2020). I will use effective communication (i.e. listening intently without distractions, using non-verbal language, and being open to various communication methods) (DuFrene & Lehman, 2014). I will conduct activities (i.e. simulations) in two-hour monthly group discussion sessions. To maintain motivation and engagement (Deszca et al., 2020), as an adaptive leader (Heifetz et al., 2009a), I will do monthly check-ins with ITM with flexible booking calendar date options. For trust and transparency in the change (Deszca et al., 2020), I will schedule biweekly updates (e.g., small wins and concerns) with the change champion and ITM.

The 'study' is an ongoing process of collecting, documenting and analyzing data, problems and unexpected observations and gathering lessons learned and knowledge gained (Christoff, 2018) at various frequencies (Ogrinc et Shojania, 2014). The monitoring of ITM's understanding, engagement and interest in UDL-NS from activities will guide the direction of actions. To increase participation, various alternatives should be explored. Consideration of IMT's preferred style of communication (e.g. hybrid environments) (Barley et al., 2017) will increase participation. Ongoing verification of the plan for short and medium-term accomplishments is cross-checked with mutually preselected platforms and tools to ensure continuous learning and improvement. In the 'act,' success indicators from various feedback (i.e. Smartsheet) will guide decision-making and actions before commencing the next phase.

Study Stage:

The Study stage is the third phase of the PDSA (Deming, 1986/2018) and is a crucial part of our change management process. Scheduled between May and August 2025, this stage corresponds to the acceleration phase of CPM (Deszca et al., 2020) and the alignment, voice, dialogue, and identification dimensions (Ruck, 2020). The focus is to increase momentum with

motivational strategies while maximizing resources, making involvement as stakeholders and management vital. The goal is to remove barriers and increase participation in feedback, impacting the change process (Deszca et al., 2020). DuFrene and Lehman (2014) emphasize three communication goals during the 'acceleration' phase: To share details of the change with stakeholders beyond the change team group; to inform stakeholders of their future involvement, including the impact of change on their roles and responsibilities; and to redress misinformation.

The 'plan' which spans May and June, will be a crucial part of the 'Study' stage. It involves the development of motivational and buy-in strategies (Deszca et al., 2020). This phase consists of identifying contingent strategies to increase buy-in to the change champion, such as adding internal human resources (e.g. new implementation members) as allied bodies to achieve tasks. In the 'do' phase, The expectation is for ITM to provide more input and collaboration on learning experiences and next steps during set activities with the voice dimension that stresses the importance of individual and group feedback (Mohajan & Mohajan, 2022) to support transformative learning. As an adaptive leader, I pay attention to intense ITM's interactions that foster resistance (e.g. stress, burnout), necessitating further monitoring (e.g., psychological safety, commitment) (O'donovan & Mcauliffe, 2020) while exploring the proposed UDL-NS tool. I will continue to monitor barriers to change, such as fatigue, disengagement, or residual resistance (Burnes et al., 2018). I also intend to target monitoring strategies toward the NFT by discussing satisfaction feedback, reviewing common usage of terminology—such as reasonable AAs (Neal-Boylan & Miller, 2020) for the nursing program—and assessing familiarity with UDL-NS, a visual nursing accommodation-accessibility decision tree tool.

July and August are parts of the 'study'. During this time, ITM's feedback will be probed in terms of their understanding of UDL-NS from past and current performance, sharing

strengths, gaps, areas for improvement, and the effectiveness of implemented measures (Christoff, 2018). This comprehensive analysis will indicate if the desired transformative and openness outcomes in accepting the UDL-NS are progressively achieved by describing lessons learned during change implementation. Consequently, monitoring will focus on verifying and ensuring the timely execution of the change implementation plan with a checklist. In this stage, evaluation will include identifying clear, targeted progression for remaining tasks. I will share the outcomes with ITM and management. In the 'act,' a feedback progression will be shared with the change champion via an agreeable platform (i.e. Smartsheet) for discussions as managers are available between academic semesters. The decision is to advance to the next cycle or replanning for unsatisfactory results or results that are not in accordance with standardization.

Act Stage

Transitioning to the final PDSA stage, the Act (Deming, 1986/2018) is a pivotal phase set to commence in September 2025. That stage marks the institutionalization phase of CPM (Deszca et al., 2020) and the alignment, voice, and dialogue dimensions (Ruck, 2020). It represents the culmination of planning, where the testing and subsequent analysis are reviewed to guide the decision (Deszca et al., 2020). The ultimate goal is to either adopt or abandon the change plan (Christoff, 2018). The voice and dialogue dimensions will then serve as indicators of whether the change has truly become the new normal.

The 'plan' is to officially launch the UDL-NS under the nursing accommodation-accessibility decision tree tool resource at TC. This way, my vision of what I plan to do becomes realistic with UDL-NS as an official outcome. In the 'do' phase, the implementation team members will integrate the learning into their respective teams and at TC. As the change initiator and adaptive leader, my role becomes crucial as I will likely be the appointed resource in

addressing AAs with the new tools. As previously mentioned, September 2025 also aligns with the quinquennial policy review cycle at TC. This provides an opportunity for the change champion to include discussions about the UDL-NS in TC's policy review agenda. In the 'study', evaluation continuously tracks changes during the process and measures the plan's impact. Ideally, the feedback analyzed indicates a transformative increase in AA and some assurance in using UDL-NL confidently. Ongoing feedback demonstrates that evaluation indicators' outcomes factor in the budget, communications, and strategic planning. The decreased complaints about AAs to the accessibility department and NFT satisfaction confirm the change, reinforcing our commitment to continuous improvement. The 'act' is about maintaining momentum for sustainability. I may repeat using the PDSA tool to evaluate what I plan to do throughout continuous quality improvement (e.g. refining) from this change initiative. Therefore, the effectiveness of the DiP is confirmed by the evaluation's process, impact, and outcomes accomplishment, with the change champion's approval.

In conclusion, several monitoring and evaluation activities align with the proposed UDL-NS and the PDSA cycle, which will result in successful change. Communication, monitoring, and evaluation must remain adaptive and socially dynamic to allow for transformative outcomes. Throughout this DiP, I have elaborated on all necessary components to support this change process. However, more can be done, which I discuss next.

Next Steps, Future Considerations of the Plan for Organizational Improvement

Deszca et al. (2020) highlighted the importance of celebrating even the most minor successes in supporting change. This emphasis on celebrating successes is not just a formality but a crucial element that keeps the momentum going. The various stages of this change plan are

steps to a continuous journey leading to institutionalization. This is not the destination but an open-ended door to indefinite next steps and future considerations.

Reflecting on the next steps permits me to review the change process and ensure it reaches its full potential with the full adoption of the change initiative. My socio-constructivist stance on an inclusive approach (Rannikmäe et al., 2020) to the nursing profession emphasizes the extent to which it is a public servant role. Educational leaders play a crucial role in this initiative. NFT's role is not just to adhere to professional standards but also to act as role models who practice inclusivity with student nurses. The management and ITM’s active involvement are key to the success of this initiative. The next steps include executing the change plan, celebrating successes (Deszca et al., 2020) with the NFT, and fully adopting the tool to address AAs in other post-secondary programs to propel future momentum.

The UDL-NS is a cornerstone of the change process and hope for the future. By aligning with my DiP, the officialization of the UDL accommodation-accessibility tree tool as a wellness resource will bring transformative changes post-implementation and a wave of positivity. The initial UDL professional learning sessions were a preventive approach supporting TC's administration. My proposed UDL-NS is a more applicable approach, associating the process of accommodation and accessibility in nursing programs. From their implementation experience, each ITM is better equipped to make individual changes or adopt a behaviour inclined with the sustainability of the change within their respective professional department with supported literature data. This positive impact of UDL-NS has made me more confident in sharing my feedback with colleagues, friends, and family.

Future Considerations

Effective oversight of TC's nursing education includes understanding AAs as both essential for promoting academic change while recognizing the significant influence that leadership positions and capacity of influence can have, especially in practice (Najjar & Ascione, 2020). Future considerations could include professional development initiatives for nursing educational leadership that address improved safety, healthcare quality, and professional enhancement. Addressing my PoP will ultimately offer nursing scholars and practitioners continuous learning and development opportunities in collaboration with internal and external community partners. Successful outcomes could be extended to nursing organizations, such as the Registered Nurses Association of Ontario and become a new evidence approach.

Chapter 3 Summary

In Chapter 3, I elaborated on a change implementation plan developed to operationalize the change initiative while considering communication, monitoring, and evaluation practices. Deszca and Ingols' CPM (Deszca et al., 2020) permits me to offer timely intervention to refine the plan as it unfolds. Through communication planning with the AVID framework, I have devised strategies for a continuous exchange between change implementers. At TC, the importance of the change is also demonstrated in the process and content of the knowledge mobilization plan. I highlighted how AAs have been historically addressed while illustrating the need to model inclusive and equitable behaviours in nursing programs. The PDSA cycle provides me with monitoring and evaluation techniques to engage ITM in the change initiative. I also acknowledged the next steps and future considerations for TC as well as for scholars and regulatory organizations.

Conclusion

Instructors in nursing programs require support in addressing AAs given their professional responsibility to uphold educational and clinical expectations while assuring that student nursing competencies are addressed. In this DiP, I have explored solutions to address the current lack of NFT support at TC in addressing AAs. In Chapter 1, I focused on the ‘what’ of the problem-posing while I elaborated on TC’s organizational context and my position, influence, and leadership. In Chapter 2 is the ‘why’ describing TC’s readiness for change. My vision aligns with my preferred future at TC with UDL-NS, a proposed nursing accommodation-accessibility decision tree tool focusing on nursing task competency outcomes. In Chapter 3, I described the ‘how’ of the implementation plan that permits flexibility and adaptation to address potential setbacks before concluding the chapter with the next steps and future considerations for TC and beyond. This UDL-NS for nursing education programs offers a transformative outcome and a significant innovative nursing initiative, leading to new ways of thinking in this complex health system. I hope this DiP opens readers' eyes to the link between mental health and AAs, potentially being the tip of the iceberg for contemporary initiatives in nursing programs.

Epilogue

Facing ‘complex necessity in nursing’ is my creative term to define my professional academic journey. For me, the term is a means to an end, as this dissertation-in-practice is concerned with allowing nurses to thrive in practice. As a mental health nurse, I encounter the complexity of the health system in Canada in different settings. As an educator, I have experienced the complexity of the education system in Canada, from elementary to post-secondary institutions. Health and education are married together and are the root foundation of any prosperity. My Problem of Practice is the need to support nursing faculty staff in addressing academic accommodation in the best interest of our complex health system with individuals, from here and abroad, with complex health profiles, which include student nurses. Therefore, action is needed. My doctorate journey is a call to construct from past learning and adapt to the complex profile of emerging student nurses for a better future. The nursing profession and nurses need immediate attention and assistance in training and assessing competencies for the next workforce. As individuals and as a society, we must learn to view ‘accommodation’ not as an obstacle but instead as an avenue to learn from each other so nursing students can flourish to their best potential within the limit of public safety. Every action in that direction counts. We must open our minds to include ‘complex necessity in nursing’ in our practice to better serve our complex world. I sincerely hope this nursing education initiative, proposing a nursing accommodation-accessibility decision tree tool to assist in deciding about AAs, will catalyze change and inspire others to continue the journey.

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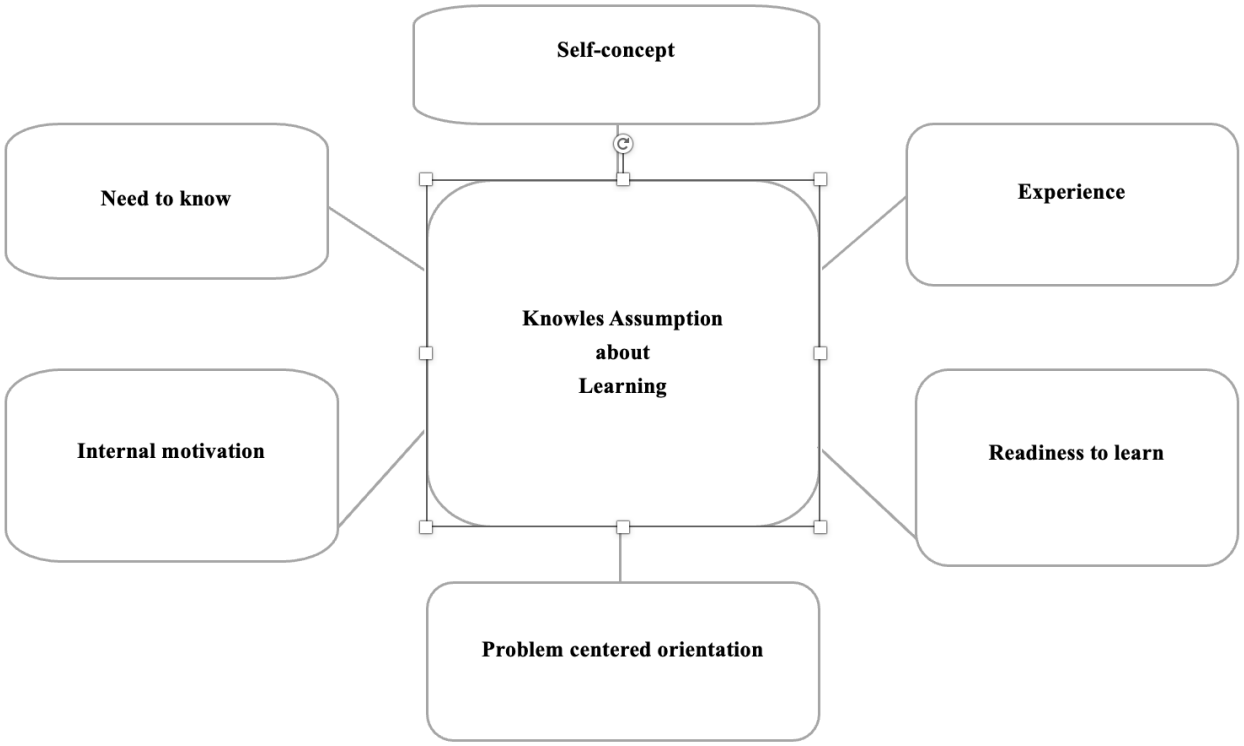
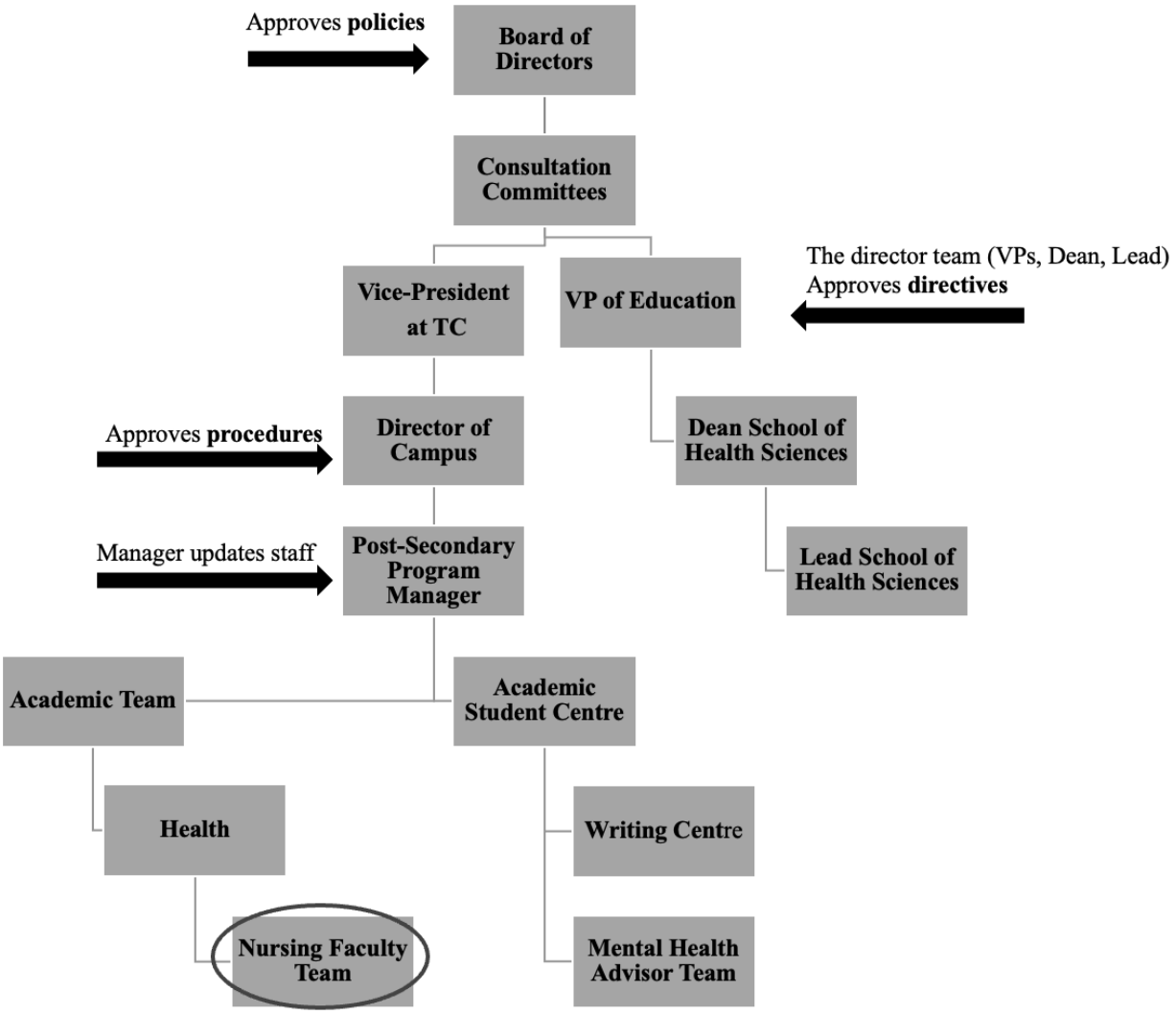
Appendix A: Infographic on Knowles' Six Assumptions about Adult Learning



Note. Adapted from Open Educational Resources [OER] Commons. (2024).

Appendix B: Policy Process of the Governance Structure at TC



Note. This is an adapted version of the policy process at TC. My current position is circled within the organization.

Appendix C: The Seven Principles of Adaptive Leadership with Behaviours

Principles	"Principles enable leaders to…"	Adaptive Leadership Behaviour
1.Get on the Balcony	Metaphor: Step back from action to observe and develop an objective perspective on the challenging situation.	1.Step away from the conflict without fully dissociating from it. 2.Get quiet time to increase focus and limit distractions. 3.Form a group of unofficial advisors to assess the retroaction of individuals. 4.Attend selective meetings on the topic as a participant and observant.
2.Identify the Adaptive Challenge	Determine if the challenge is technical or adaptive.	Identifying conflict is complex if: 1.People's beliefs, attitudes and values are affected. 2.People need new ways of coping to address the conflict. 3.A leader cannot solve the conflict alone 4.Leaders and followers must collaborate on solutions.
3.Regulate Distress	Provide a psychologically safe environment in which problem solving can effectively occur with guidance and encouragement toward maintaining productivity without becoming overwhelmed by the need for change, or by the change itself.	The leader: 1.Helps others recognize the need for change while anticipating a certain distress level among the group due to the change. 2.Monitors and contains distress at bearable levels allowing productivity.
4.Maintain Disciplined Attention	Coach and guide employees to remain engaged in their work throughout the challenge to ensure they focus on working through the challenge and achieve individual and collective outcomes as part of the change process.	The leader helps those addressing the change by focusing on any conflict rather than avoiding it with various behaviours, such as ignoring or minimizing conflict or exhibiting self-destructive behaviour.

Principles	"Principles enable leaders to…"	Adaptive Leadership Behaviour
5.Give Work back to the People	Demonstrate situational awareness and leadership to encourage and engage group members in ways that ensure the opportunity to problem solve and innovate remains with them and is not taken over by the leader.	The leader: 1.Guides individuals toward group decisions rather than directing the group. 2.Raises awareness of potential impact on the group and monitors indicators of group dependency.
6.Protect Leadership Voices from Below	Exercise conflict management and inclusion to ensure individuals have a voice: that each individual is heard in a way that adds to the social balance of the group and its impact on the organization.	The leader: 1.Allows all voices to be heard respectfully and equally without compromising social equilibrium. 2.Establishes an optimal environment using a structured framework to collect feedback.
7.Guiding leaders to take care of themselves	Balance work and personal activities for self-care and recharging to be better able to achieve the goal and work (Bowles et al., 2017).	The leader: 1.Models balanced personal and professional self-care. 2.Understands when to seek support if needed: a key principle in adaptive leadership.

Note. Adapted from Kolga (2021, pp. 26-37), with information on each principle enabling leader actions from Heifetz and Laurie (1997) and Northouse (2021) unless otherwise specified. I list the seven principles of adaptive leadership and provide descriptions of the behaviours enabled by each principle in practice.

Appendix D: The Organizational Readiness to Change Assessment (ORCA)

For each of the following statements, please rate the strength of your agreement with the statement from 1 (strongly disagree) to 5 (strongly agree)

strongly disagree 1	disagree 2	neither agree nor disagree 3	agree 4	strongly agree 5	Don't know / Not applicable

Findings: 86% readiness for the change

Statement: Working collaboratively with management to make appropriate changes in supporting NFT with AAs.	**Rate levels**
1.Based on your assessment of the evidence basis for this statement, please rate the strength of the evidence in your opinion, on a scale of 1 to 5 where 1 is very weak evidence and 5 is very strong evidence	4
2.Now, please rate the strength of the evidence basis for this statement based on how you think respected clinical experts in your institution feel about the strength of the evidence, on a 1 to 5 scale similar to the one above	4

I. Evidence Assessment

3. Research: The proposed educational initiative changes	
a) are(is) supported by other scientific evidence from literature	5
b) are(is) supported by other scientific evidence from other health care systems /setting	5
c) should be effective, based on current scientific knowledge	4
d) are(is) experimental, but may improve NFT support outcomes	3

4. Educational/Clinical Experience: The proposed practice changes or guideline implementation	
a) are supported by clinical experience with UDL	5
b) are supported by clinical experience with students in other systems (i.e. healthcare)	5
c) are conform to the opinions of clinical experts in this setting	4
d) have not been attempted in this educational setting	4

5. Educational Preferences: The proposed practice changes or guideline implementation	
a) have been well-accepted by educators/scholars in study/literature	5
b) are consistent with clinical practices that have been accepted by TC	5
c) take into consideration the needs and preferences of NFT	3
d) appear to have more advantages than disadvantages for NFT	5

II. Context Assessment

6. Culture: Senior leadership/clinical management in your organization	
a) reward clinical innovation and creativity to improve NFT outcomes	5
b) solicit opinions of clinical staff regarding decisions about student outcomes	4
c) seek ways to improve NFT education and increase staff participation in interventions	4

7. Culture: NFT members in your organization	
a) have a sense of personal responsibility for improving student care and outcomes	5
b) cooperate to maintain and improve effectiveness of student success	5
c) are willing to innovate and/or experiment to improve clinical procedures	4
d) are receptive to change in clinical processes	4

8. Leadership: Senior leadership/Clinical management in your organization	
a) provide effective management for continuous improvement of NFT	4
b) clearly define areas of responsibility and authority for clinical managers and staff	5
c) promote team building to solve educational problems	5
d) promote communication among departments and teams	5

9. Measurement: Senior Leadership/clinical management in your organization	
a) provide staff with information on previous performance measures and guidelines	4
b) establish clear goals for AAs processes and outcomes	4
c) provide staff members with feedback/data on effects of educational decisions	4
d) hold staff members accountable for achieving results	5

10. Readiness for change: Opinion leaders in your organization	
a) believe that the current practice patterns can be improved	5
b) encourage and support changes in practice patterns to improve educational success	4
c) are willing to try new clinical protocols	4
d) work cooperatively with senior leadership/management to make appropriate changes	5

11. Resources: In general, in my organization, when there is agreement that change needs to happen	
a) we have the necessary support in terms of budget or financial resources	4
b) we have the necessary support in terms of training	5
c) we have the necessary support in terms of facilities	5
d) we have the necessary support in terms of staffing	4

12. Characteristics: Senior leadership/clinical management will	
a) propose a project that is appropriate and feasible	4
b) provide clear goals for improvement of NFT	3
c) establish a project schedule and deliverables	4
d) designate a clinical champion(s) for the project	5

13. Characteristics: The Project Clinical Champion	
a) accepts responsibility for the success of this project	4
b) has the authority to carry out the implementation	5
c) is considered a clinical opinion leader	4
d) works well with the intervention team and providers	5

14. Role: Senior Leadership/Clinical management/staff opinion leaders	
a) agree on the goals for this intervention	5
b) will be informed and involved in the intervention	5
c) agree on adequate resources to accomplish the intervention	4
d) set a high priority on the success of the intervention	5

15. Role: The implementation team members	
a) will share responsibility for the success of this project	4
b) will clearly defined roles and responsibilities	4
c) will release time or can accomplish intervention tasks within their regular workload	3
d) will have staff support and other resources required for the project	4

16. Style: The implementation plan for this intervention	
a) identifies specific roles and responsibilities	5
b) clearly describes tasks and timelines	4
c) includes appropriate providers	4
d) acknowledges staff input and opinions	4

17. Style: Communication will be maintained through	
a) regular project meetings with the project champion and team members	4
b) involvement of quality management staff in project planning and implementation	4
c) regular feedback to clinicians on effects of practice changes on NFT outcomes	4
d) acknowledges staff input and opinions	4

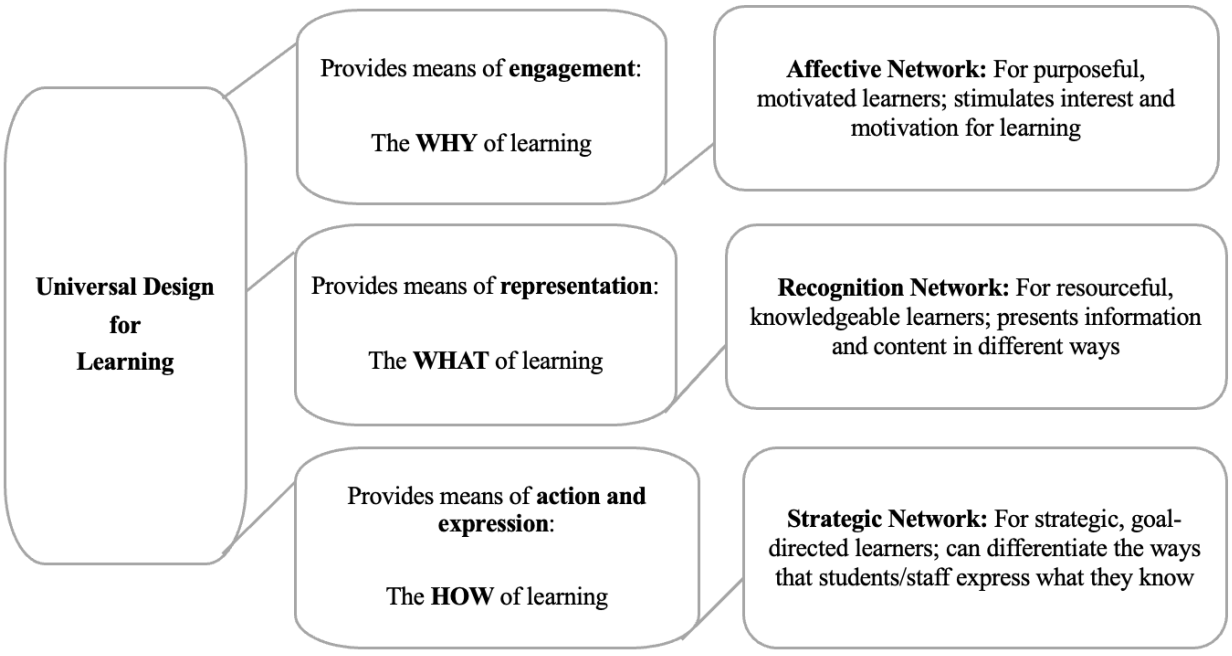
18. Style: Progress of the project will be measured by	
a) collecting feedback from management regarding proposed/implemented changes	4
b) collecting feedback from NFT regarding proposed/implemented changes	4
c) developing and distributing regular performance measures to management/ NFT	4
d) providing a forum for presentation/discussion of results and implications for continued improvements	4

19. Resources: The following are available to make the selected plan work	
a) staff incentives	4
b) equipment and materials	4
c) management awareness/need	4
d) providers buy-in	5

20. Evaluation: Plans for evaluation and improvement of this intervention include	
a) periodic outcome measurement	4
b) staff participation/satisfaction survey	4
c) NFT satisfaction survey	4
d) dissemination plan for performance measures	4
e) review of results by management/clinical leadership	5

Note. This is adapted from the Organizational Readiness to Change Assessment (ORCA) of Helfrich et al. (2009a). The data compilation of my assessment indicates organizational readiness for change. The details are statement section = 8/10; evidence section = 53/60; context section = 103 /115; facilitation section = 156/185. Result: 320/370 = 86%.

Appendix E: Universal Design for Learning's Framework



Note. Adapted (CAST, 2018). The UDL principle offers potential suggestions to reduce barriers and maximize learning opportunities for learners (CAST, 2018). The three main principles are engagement, representation, and action and expression.

Appendix F: DiP Proposed Solution Comparison

Considerations	Solution 1 (DEI)	Solution 2 (AP+NFT)	Solution 3 (UDL- NS)	Selection Options
Proposed change	Diversity, Equity, and Inclusion coordinator	Accommodation Policy (AP) with Nursing Faculty Team (NFT)	Universal Design for Learning (UDL) with Nursing Solution NS	
Nursing Faculty Team: The solution prioritizes an NFT focus				
1				DEI, UDL-NS
Adaptive Approach to AAs: Solution to construct knowledge inclined to transformative outcomes				
2				DEI, UDL-NS
Team Focus: Solution requires active willingness collaboration of members aligned to Ubuntu's leadership				
3				UDL-NS
Financial: Solution requires additional administrative financial commitment impacting budget decisions				
4				AP-NFT
Human Resources (HR): Solution requires additional HR commitment impacting fiscal budget decisions				
5				AP- NFT
Administration at TC has approved and/ or is familiar with the solution				
6				AP+ NFT UDL-NS
Legend: **Acceptable**  **Neutral**  **Unacceptable** 				

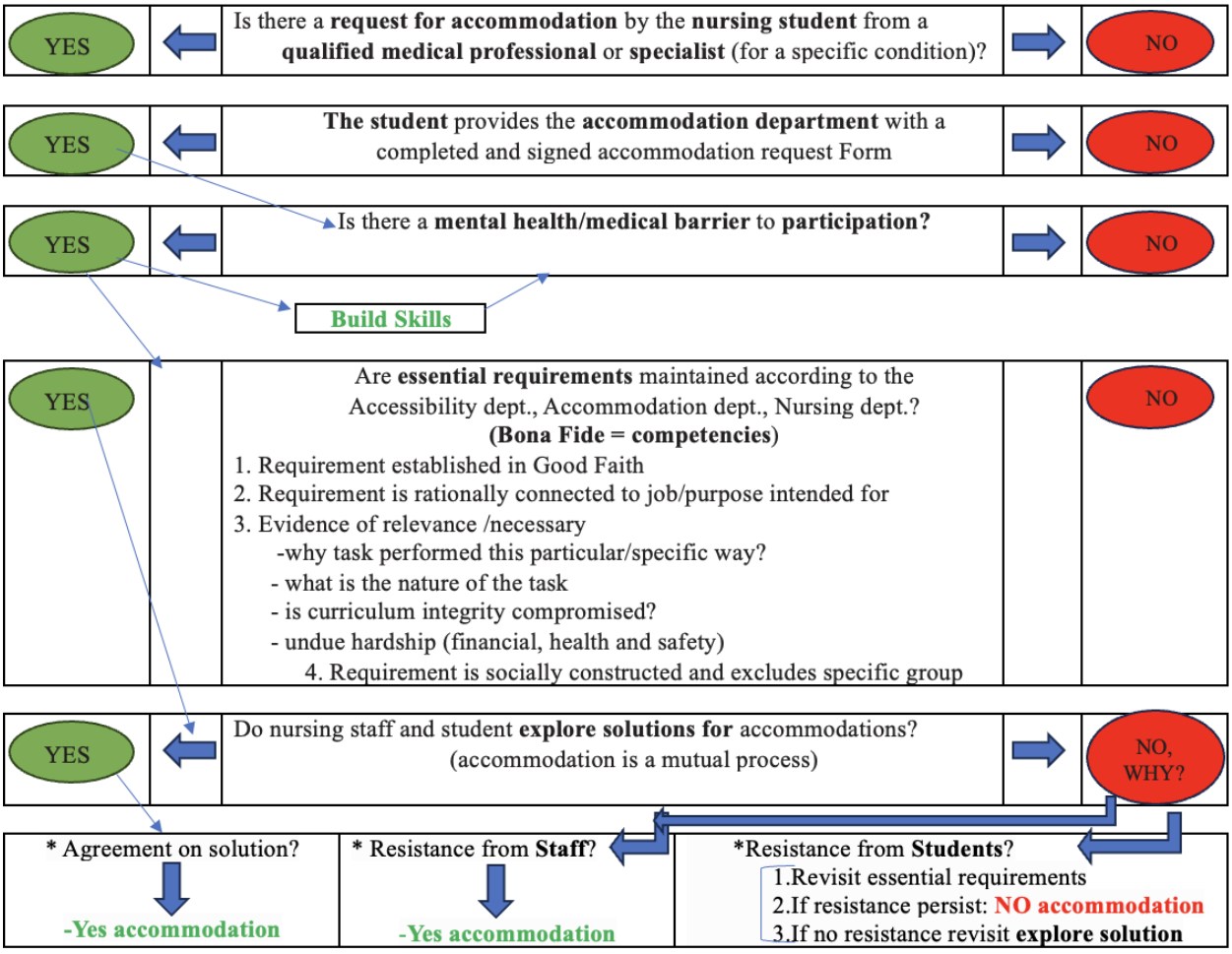
Note. The visual elements utilized in this figure include a happy face icon indicating a favourable outcome. The cloud icon depicts possible sources of resistance. The stop sign icon denotes an unfavourable outcome. Compiling data indicates that UDL-NS is the selected solution due to the most happy face icons, limited resistance and no stop sign icons.

Appendix G: Universal Design for Learning in Nursing Education

1. No accommodation | **2. With accommodations** | **3. With UDL**

Note. 1. If no adapted environment or intervention is needed = no accommodation. 2. If an adapted environment or intervention is needed = accommodations. 3. UDL is not about accommodation but accessibility. There is no box. As an adaptive leader, UDL needs to be adapted to literature for nursing education.

Appendix H: Nursing Accommodation-Accessibility Decision Tree



Note. Adapted with permission (B. Roberts, personal communication, December 18, 2023). This is my proposed UDL-NS to support the nursing faculty team (NFT) in addressing academic accommodations (AAs).

Appendix I: CPM, PDSA Monitoring-Evaluation for UDL-NS with Timeline

CPM Phases **PDSA focus** **Allocated months**	**PDSA Stages**	**Implementation September 2024-2025** -**Change initiator** is me -**Change champion** is a post-secondary program manager -**Nursing program manager** is the program specialization line authority hierarchy in the nursing program -**ITM** are the change initiator, nursing program manager, UDL-GS, NFT, OD, and accessibility department -**Added ITM** are academic student center, DEI centre, and program advisory committee
*Awakening-awareness **-Planning focus** Sept. – Oct. 2024 (2 months)	**Plan** September October **Do** **Study** **Act:** October	**Emphasis of CPM:** Underscoring the significance of the change initiative **Goals**: Spreading awareness of the -PoP, what, where, how, when to unsettle the status quo -needs and vision, and changing past behaviour patterns **Persons**: Change initiator and change champion **Goals**: **Awakening of change champion** by introducing a plan for change **Persons**: Change initiator and nursing program manager **Goals**: **Awakening of nursing program manager** about the need to change by introducing the proposed UDL-NS focusing on nursing task competency **Strategies**: Meet both managers monthly and 1 to 2 check-ins -Face-to-face formal meeting to identify the gap for the desired future and agree on the vision and need to change -Explore with both managers the readiness to change using ORCA and the monitoring plan with the PDSA plan -Explain the current state and desired state of the problem with public internal and external data, and KMb plan and visual **Monitoring**: Engagement interest biweekly by -Answering questions, aligning the vision (pros and cons) -Receiving convincing support arguments from both managers **Evaluation**: Understanding of the need to change PoP and PDSA plan **Tasks**: Will discuss internal and external data publicly available **Success indicators:** -Both managers support the implementation plan -The nursing manager committed to the vision by agreeing to supervise the implementation team with the change initiator as the leader
*Mobilization-preparation **-Planning focus** Nov. – Dec. 2024 (2 months)	**Plan**	**Emphasis of CPM: Engage and Enable Organization** **Persons:** Change initiator, change champion, and nursing program manager **Goals:** Deployment actions, resources, and persons for the change by considering the system and the process to support and understand the resistance to change

	Do	**Strategies:** *Monthly change champion, and biweekly with nursing manager 1. Identify specific actions (i.e. completion of all operational tasks) to clarify the vision, further the development, and conceal the change 2. Increase participatory planning among people to acquire sufficient resources -Inform (i.e. email) selected ITM about creating a group for my initiative and participation. The change champion and nursing manager will be cc-copied on the email -Clarify ITM preference communication style for 1:1 checking -Create a group chat on Teams for quick and efficient internal communication, which will enhance the team's collaboration and productivity -Confirm room booking for eventual group discussion -Confirm prescheduled monthly ITM and check-in meetings until September 2025 with the change champion, demonstrating our commitment to support and regular updates 3. Celebrate wins, with managers and ITM at meetings for the duration of the implementation **Monitoring**: -Engagement participation from feedback on formal/informal conversation -Operational task deadlines are being met -Address with satisfaction all questions, concerns, suggestions, and comments -Check-in outcomes are encouraging -Attendance on the group chat **Evaluation:** -The completion of checklist evidence demonstrates precise, targeted progression for the remaining tasks
	Study **Act** December	**Tasks:** will discuss positive feedback updates for baseline, satisfaction level, and progression **Success indicators:** -The ITM are confirmed -Positive and constructive communication and exchange between ITM -Positive updates on formative and summative assessments and Smartsheet
*Mobilization-action **-Do focus** Jan. – Apr. 2025 (4 months)	**Plan**	**Emphasis of CPM: Engage and Enable Organization (continuation)** **Persons:** Change initiator, change champion and ITM **Goals:** Implementation is in motion
	Do	**Strategies:** *Meeting monthly 2 hrs group discussion meeting with ITM with check-ins *Meeting biweekly change champion

		1. The pivotal role of the change champion is to publicly announce the initiative during the monthly formal meeting, effectively addressing surge AAs under the change initiator's leadership 2. The selected ITM, who play a vital role in our initiative, are announced with my public appreciation for their commitment and contribution 3. The KMb presentation, a valuable tool, is used to introduce UDL-NS, ensuring everyone is well-informed and prepared for the change 4. Clarify ITM task expectations/roles/modalities (group discussion) with short-term and long-term goals
	April	**Monitoring:** -Observe ITM attendance at monthly team meetings -Biweekly check-ins for engagement and interest (observing for resistance, comments, and behaviours) -Execution of key task elements in a timely manner. -Tracking trends emerging from group discussions -Respectful interactions during working group -Receive ITM feedback about UDL-NS for transformative inquiry progress
		Evaluation: -The impact of the group discussion is supported by the leadership approach to change (Shield's transformative, Heifetz's adaptive, and Ubuntu's social-ethical) -The checklist indicates evidence of completion with a targeted progression for the remaining tasks -Potential adjustments needed in the agenda/plan
	Study	**Tasks:** Will monthly track lessons learned, and knowledge gained for transformative feedback progress with formative and summative assessments
	Act April	**Success indicators:** -ITM's total attendance and participation at the first meeting in January and successive meetings indicate engagement and interest -Positive group dynamic and evidence of solid collaboration -Celebrate milestones feedback of collective work accomplished -Positive updates on formative and summative assessments and Smartsheet
*Acceleration-Action **-Study focus** May – August 2025 (4 months)	**Plan**	**Emphasis of model**: Acceleration with buy-ins to maintain momentum **Persons**: Change initiator, ITM, and additional ITM crew joining the team **Goals**: Fortify the change plan to increase buy-in to continue change until achievement
	Do	**Strategies**: *Meeting monthly 2 hrs group discussion meeting with ITM with check-ins *Meeting biweekly change champion 1. The addition of new ITM is crucial to address potential indicators of disengaging behaviours and to maintain the vision and continue the change. Their role is integral to our success

		2. We should take the time to celebrate the progress made by the ITM and the summer objectives plan. This recognition is important for morale and motivation 3. The change initiator will continue discussions with managers, but only during the summer period, to manage expectations and ensure a focused approach 4. Encourages self-care **Monitoring:** -Be aware of potential distress risks promoting ITM to stay on task **Evaluation**: -Engagement level maintained with group discussion, attendance check, on Teams -Meeting attendance check with check-ins -The checklist indicates faster task completion with a targeted progression for the remaining tasks
	Study **Act** August	**Tasks**: -Monthly revision, comparing feedback since September of various communication channels outcomes and sources (i.e. KMb content) -In August, I will summarize feedback progress for sharing—celebrating—in September 2025 **Success indicators**: -The checklist indicates that only a few tasks remain -Summary feedback indicates learning, ITM satisfaction and familiarity with UDL-NS as indicated on the Smartsheet
*Institutionalisation-Sustainability **-Act focus** Sept. 2025 onward	**Plan** **Do**	**Emphasis of model**: Implement and sustain the new normal **Persons:** Change initiator, change champion, ITM **Goals**: TC management to decide on maintaining the old or acting on the new status quo/normal **Strategies:** *Meeting with ITM to check-in *Meeting change champion and nursing program 1. Feedback from ITM about UDL-NS, revisiting the KMb visual for post-insight **New Normal:** Change initiator 2. Conduct a celebration meeting to acknowledge and celebrate the team's achievements, making everyone feel recognized and appreciated. 3. The celebration meeting will serve as a platform to acknowledge and appreciate the team's efforts and achievements in implementing the new normal. Confirms completion of implementation plan at the first professional team meeting 4. Announces the official status of UDL-NS as a wellness available resource/tool at TC

		5. Informs about next steps, ensuring everyone feels informed and prepared for what's to come: a) Promotes sustainability: There is a need to maintain dialogue for adaptation and sustainability with frequent interactions and, as needed, to support the change internally and potentially externally b) Change champion continuously supporting the initiative by including the UDL-NS on the organizational policy review agenda during TC quinquennial cycle policy review **Monitoring:** -Monitoring signs of returning to the precedent state or adapting to the new normal -Official systemwide launch of the accommodation-accessibility decision tree tool **Evaluation:** -The checklist indicates evidence of total completion of all tasks -OD is involved in refining the tool
	Study September	**Tasks**: Explore feedback from September to August of various communication channels, outcomes and sources to gather lessons learned and knowledge gained
	Act September	**Success indicators:** -Final positive confirmed updates on Smartsheet **Act:** Continue course with ongoing transparent communication with stakeholders. The nursing accommodation-accessibility decision tree is an official wellness resource/tool in the nursing orientation package and will be commonly used at TC **Abandon**: Return to old status quo **Realign**: Adapt (adjust/realign the solution)

Note. There could be a repetitive PDSA cycle throughout this change initiative to adjust to unforeseen situations, necessitating adapting to maintain momentum.

DEI = Diversity, Equity, Inclusion; ITM = Implementation team members; KMb = Knowledge Mobilization; NFT = Nursing faculty team; OD = Organizational development; ORCA = Organizational Readiness to Change Assessment; PDSA = plan, do, study, act; PoP = Problem of Practice; TC = Top College; UDL =Universal Design for Learning; UDL-NS = Universal Design for Learning-Nursing Solution.

Appendix J: Short, Medium, and Long-Term Implementation Goal

Short-term	Medium-term	Long-term
- Build urgency to the need for change - Clarity of my change vision from the current to the desired state	- Much more participation and effort from everyone - Address the distress risk associated with that period - Last efforts to achieve the desired future - Reviewing and planning opportunity and a resting opportunity for the implementers - Increase buy-ins	- Sustainability focus on the desired future by managers - Consensus must be reached among implementers to work together using my UDL-NS - Disseminate potential new roles and responsibilities across TC about the need for the change - Managers must adopt the new normal to replace the status quo - Nursing familiarity with application of the nursing accommodation decision tree

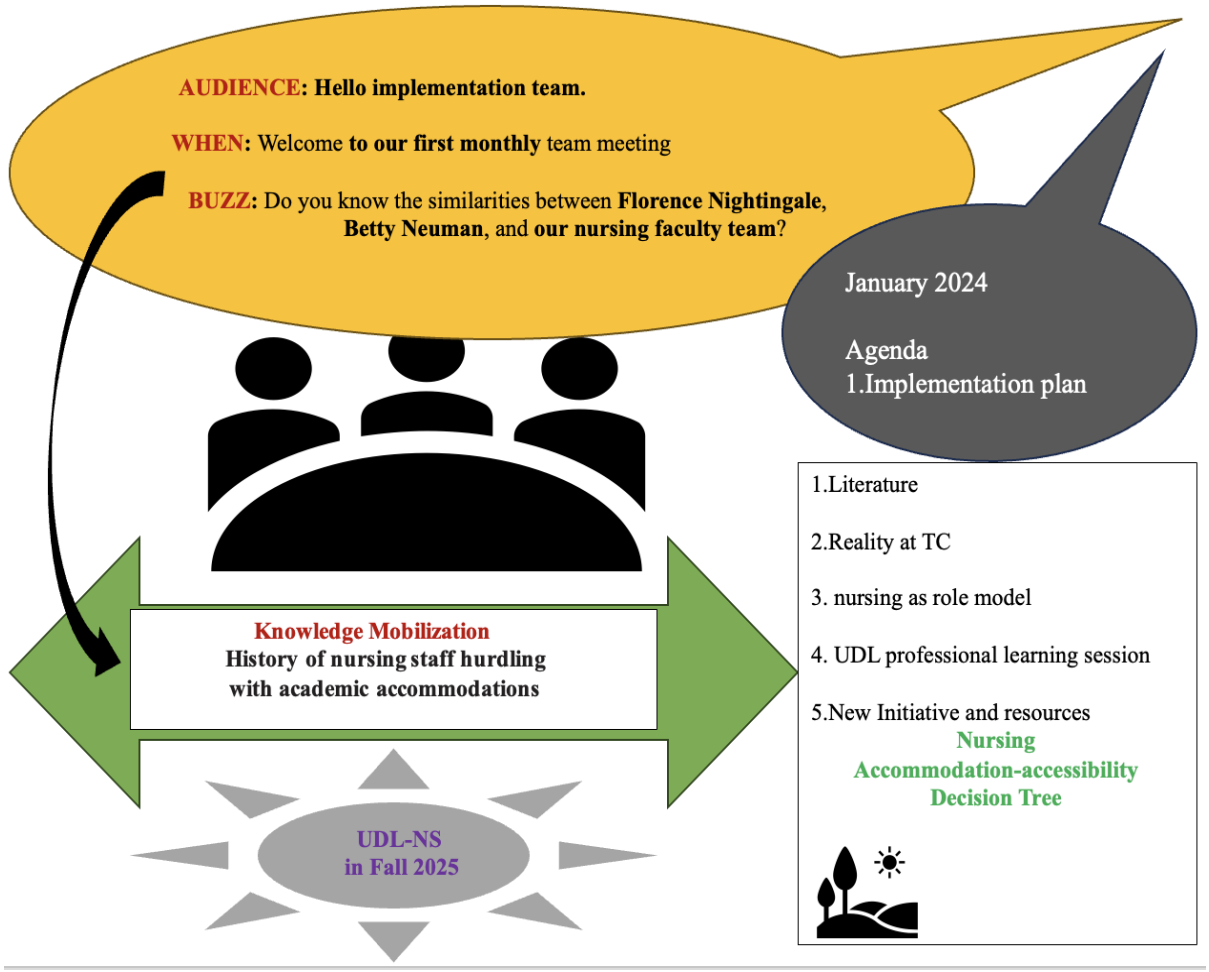
Note. The short, medium, and long-term goals help to view the progression of the change.

Appendix K: Implementing AVID, CPM and UDL Solution

ALIGNMENT VOICE DIALOGUE DIMENSIONS	**September 2024**	
	Time: September–October 2024	**Awakening phase-Alignment**
	-September: I will use my voice to connect with the (change champion) post-secondary program manager **Goal**: Create the 'awareness' of the need to change **October:** I will use my voice to connect with the nursing program manager **Goal**: Further explain the awareness of the UDL solution in the nursing program	
	Time: November 2024–December 2024	**Mobilization phase /Preparation**
	November: The change champion will officially announce the change plan initiative to address the AA surge at the educator team meeting. Our collective goal is to gather people and resources, with everyone joining the selection of the implementation team by the change champion, to effectively implement this initiative. Monthly recurrent implementation meeting and monthly management meeting for updates -I will foster an understanding of the UDL solution in meetings -I will encourage participation with a clear vision explanation -I will monthly do personal check-ins with implementers for trust-building and psychological safety -I will monthly clarify the implementer's role, tasks, and deadline	
	Time: January-April 2025	**Mobilization phase/ Action**
	- **January**: I will join my voice to the change champion to welcome back the implementation team and resume the focus -I will biweekly reconfirm availability and scheduled meeting commitment -I will biweekly adjust to comments and observations to decrease hesitations or challenges -I will biweekly share milestones, celebrate wins, and reclarify vision to the implementation team	
	IDENTIFICATION DIMENSION	
	Time: May 2025-August 2025	**Acceleration phase/ Maintenance**
	-I will biweekly do personal check-ins with implementers for trust-building and psychological safety -I will biweekly provide more verbal encouragement -I will biweekly share milestones, celebrate wins, and reclarify vision to the implementation team -I will biweekly promote self-care, balancing work	
	September 2025	
	Time: September 2025 onward	**Institutionalization Phase/Completion**
	-I will continue to support management in sharing the outcomes of DiP in internal and external meetings -I will communicate milestones, the need for sustainability efforts, and address potential challenges	

Note. The communication plan with the alignment, voice, identification, and dialogue (AVID)framework is significant in the UDL-NS.

Appendix L: Knowledge Mobilization Visual



Note. The message of this knowledge mobilization is an invitation for mobilization to collectively address academic accommodation.

Appendix M: Knowledge Mobilization Plan

Framework Questions	Answers: what they need to know	Communication Vehicle
1.What is a key issue and the plan to address with the audience?	The similarity between Florence Nightingale, Betty Neuman, and the NFT. **Answer**: The history of nursing hurdling with AAs needing attention.	-KMb visual
2. How to disseminate information	Explain the KMb visual during professional learning sessions for the ITM and open room for discussion using AVID	-KMb visual -Literature
3. How to collaborate with the audience	Engage in meaningful debriefing dialogue with ITM by identifying obstacles (challenges/barriers) and planning to mitigate them.	-Transparent in the dialogue
4. Recruit support (overlaps with the beginning of phase 5)	With management approval/support, the ITM needs to know that their expertise is crucial and essential in the solution process in the awakening/plan stage and accelerate/study stage.	-Validate implementers selection
5. When best to introduce the KMb?	Plan stage of the PDSA cycle, to the change champion (post-secondary program manager) and nursing program manager. Do Stage of the PDSA cycle, change champion will introduce the change initiative during the November team meeting and I announce the selected ITM. As a change agent, I will present my proposed solution	-In person team meeting
6. When to consolidate learning (process begins during change initiative)	Consolidation of the tool (nursing accommodation-accessibility decision tree) will not begin until after the completion of the change initiative.	-Supported with data analysis
7. Does the change initiative result in the creation of a wellness resource?	The involvement of the ITM is important in the co-creation of the nursing accommodation-accessibility decision tree tool as a wellness resource.	-Tool is being validated as case studies are presented
8. Does the change initiative serve as a prevention strategy?	UDL solution will: 1.minimize potential retroactive accommodation requests. 2.serve as conflict preventive strategy with dialogue approach while increasing transformative outcomes for the NFT	-Recent random requests are being made needing attention
9. How to disseminate information about the wellness resources created?	The co-creation of the nursing accommodation decision tree tool as a wellness resource at TC is adaptable to other programs at TC and potentially externally, such as the RNAO as an evidence-based tool and resource.	-Tool will become official at TC. The DiP will be scholarly recognized, and I will share the tool externally, such as the RNAO

Note. AA = academic accommodation; AVID = alignment, voice, identification, and Dialogue; ITM = implementation team members; KMb = knowledge mobilization; NFT = nursing faculty team; PDSA = plan, do, study, act; RNAO = Registered Nurse Association of Ontario; TC = Top College; UDL = universal design for learning