# Implementation of a participatory management model: analysis from a political perspective

ANDREA BERNARDES PhD [1], GRETA G. CUMMINGS PhD [2], CARMEN SILVIA GABRIEL PhD [1], YOLANDA DORA MARTINEZ ÉVORA PhD [3], VANESSA GOMES MAZIERO RN [4] and GLENDA COLEMAN-MILLER RN [5]

[1]Professor, [3]Full Professor, [4]Masters Student, *College of Nursing at Ribeirao Preto, University of Sao Paulo, Ribeirao Preto, Sao Paulo, Brazil,* [2]Full Professor, *Faculty of Nursing, University of Alberta, Edmonton, AB and* [5]Executive Director, *Network of Innovation for Senior's Care at Covenant Health, Edmonton, AB, Canada*

*Correspondence*
Andrea Bernardes
*College of Nursing at Ribeirao Preto-USP*
*Av. Bandeirantes, 3900*
*University Campus*
*Ribeirao Preto*
*SP*
*CEP 14040-902*
*Brazil*
*E-mail: andreab@eerp.usp.br*

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**Implementation of a participatory management model: analysis from a political perspective**

*Aim* To analyse experiences of managers and nursing staff in the implementation of participatory management, specifically processes of decision-making, communication and power in a Canadian hospital.
*Background* Implementing a Participatory Management Model involves change because it is focused on the needs of patients and encourages decentralisation of power and shared decisions.
*Methods* The study design is qualitative using observational sessions and content analysis for data analysis. We used Bolman and Deal's four-frame theoretical framework to interpret our findings.
*Results* Participatory management led to advances in care, because it allowed for more dialogue and shared decision making. However, the biggest challenge has been that all major changes are still being decided centrally by the provincial executive board.
*Conclusions* Managers and directors are facing difficulties related to this change process, such as the resistance to change by some employees and limited input to decision-making affecting their areas of responsibility; however, they and their teams are working to utilise the values and principles underlying participatory management in their daily work practices.
*Implications for nursing management* Innovative management models encourage accountability, increased motivation and satisfaction of nursing staff, and improve the quality of care.

*Keywords*: administration, nursing, organisation, power

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## Background

Authoritarian organisational management structures with well-defined lines of command have generated dissatisfaction and conflict in the work of health-team professionals in many settings (Bernardes *et al*. 2012, Brunetto 2012). The resulting staff turnover leads to disruption that directly reflects in a reduction in quality of care provided to patients (Alotaibi 2008, Kim 2012). Thus, changing the paradigm to enable implementation of an innovative management model that allows collective participation of all multidisciplinary health care professionals is urgently needed.

LEAN is a method focused on eliminating activities or actions that are not required which identify waste in resource use that can be removed (Al-Araidah *et al*.

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2010) and participatory management (Campos 2010, Bernardes *et al.* 2012), the Care Transformation Initiative (CTI) was implemented in a Canadian public hospital in 2009 as the solution for many of these institutional problems. The CTI aimed to build, communicate and provide an integrated plan of care to patients and their families.

LEAN is a method focused on eliminating unnecessary activities or actions that result in wasted use of resources. It is also a comprehensive and comprehensible way of thinking about issues of everyday life that requires broad participation and involvement (Al-Araidah *et al.* 2010). However, the initiative involves many other changes – one being to change the agenda from being totally focused on institutional and political interests to being focused on patients and their families. In a patient-focused agenda, power and decision-making are clearly attributed to the professional health care team that should have a broad view of patients' needs and responses to health care services. The three goals of the CTI and its working groups are to: improve quality and safety of patient care and services; increase shared governance, and the ability and capacity of health care professionals to work their full potential; and improve efficiency of care delivery (University of Alberta 2009, Unpublished data). With CTI, this patient-focused organisational experience, as well as democratisation of organisational life were introduced to overcome stagnation of the traditional management style used in many hospital facilities. Participatory management models not only contribute to the reorganisation of work, but also serve to redefine the meaning of care and work life in this sector (Campos 2010, Bernardes *et al.* 2011).

Existing management systems, particularly with their emphasis on vertical structures, no longer respond to expectations of managers, workers and especially patients. In these traditional management models or 'old' way to lead, control is emphasised because more people are under direct supervision of the manager/nurse whose scope of action and responsibility is greater (Rocha & Trevizan 2009, McKee *et al.* 2013). Thus, with emergence of contemporary structures and management models, a radical change is occurring in the work organisation in health, especially in nursing (McMurray & Williams 2004). Decentralisation of management back to patient care settings brings elimination of several professional departments, sharing of power and responsibility between government, local health authorities and resource users, and organisation of services around populations of patients with care provided by interdisciplinary teams (Berkes 2009, Casanovas *et al.* 2009, Wong *et al.* 2010). Institutional micro- or unit-level policy about decentralisation of power, decision-making and achievement of consensus leads to implementation of participative and democratic practices (Bernardes *et al.* 2011, 2012). Participatory management models focus on sharing decisions among staff, patients and other stakeholders of the organisation, so that leadership is flexible and autonomy is shared by all involved. People are responsible for their own performance and such behaviour predominates (Penterich 2006).

This study aimed to analyse experiences of managers and nursing staff in the implementation of a participatory management model, specifically the CTI, from the political perspective, regarding processes of decision-making, communication and power, and outcomes for nursing staff, in one Canadian acute-care hospital.

## Review of the literature

The development of 'care networks' implies management with participation of regional representatives, representatives of health care professions and patients. These care networks have brought opportunities for nurses to demonstrate their leadership skills and play a greater role in interdisciplinary decision-making. As integral members of this team, nurses have opportunities to positively influence other workers, ensuring that nursing care and professional practice perspectives are expressed in relation to organisational direction, quality management and utilisation of available resources (Clancy 2003, Thorman 2004, Kirk 2008). Nursing staff are able to be active in developing ways to improve quality outcomes, and equity of services to the population, because they are professionals involved in most processes of health care organisations (Magalhães & Duarte 2004).

Canadian health care institutions have invested in change management and practical methods to improve the delivery of care (Liddy *et al.* 2013), so that the nurse, as a team member, has more autonomy and power to decide on issues related to daily work. However, as these are principles of a participatory model, traditional nursing service structure must be reviewed to support nurse performance. It is not always easy to break vertical lines of organisation authority and establish new and clear ground-rules for participatory decision-making (Bernardes *et al.* 2007, 2012, Bernardino & Felli 2008, Herbert & Best 2011).



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To expose and demystify previously hidden assumptions, such as managers' claim to authority and control, critical theorists encourage reflection upon alternative epistemologies, such as sharing of power between managers and staff, that will ultimately lead to addressing power imbalances (Twiname *et al.* 2006). In health care, decentralisation of power is important to ensure interprofessional collaboration. Shared objectives, responsibility and power arising from working together to solve patient-care problems are required (Broom & Tovey 2007). By focusing on reducing disparities and providing staff with opportunities to voice their perspectives, leaders can reduce power differentials among various professional groups, so that everyone can be sufficiently empowered to participate (Broom & Tovey 2007, Petri 2010). In addition, communications are shared openly by all involved in a change activity and become multiple-party reflective conversations captured in the mode called dialogue rather than command (Raelin 2012).

Another essential tool at the core of management is decision-making (Isosaari 2011). In participatory management models, the more information the team has the better, so that professionals can make informed and evidence-based decisions. Knowledge is an important part of decision-making (Isosaari 2011). Informed decisions must have enough information about potential alternatives to ensure that people from different professional backgrounds have knowledge on the subject (Isosaari 2011, Pieterse *et al.* 2012). From this perspective, an alternative way to empower teams to operate differently from the current traditional way is through participatory management in which all members who represent different disciplines and sectors participate (Bernardes *et al.* 2012).

The following research questions emerged from our previous work (Bernardes *et al.* 2012) and the literature: How does the process of implementing a participatory management model happen? What are the difficulties that nurses and nursing teams found regarding the adopted management model, concerning decision-making, communication and power?

## Theoretical framework

To answer these questions we were guided by a theoretical framework (Bolman & Deal 2008) that describes organisations using four major frames: structural, human resource, political and symbolic. The structural frame has rules, roles, goals, policies, technology and environment as its central concepts. The assumptions of this frame reflect a belief in rationality that a suitable array of formal roles and responsibilities will minimise people's distraction and maximise their performance on the job. The human resource frame deals with needs, skills and relationships between employees and the organisation. In this case, the assumption is that the organisation exists to serve people's needs, as people and organisations need each other. The symbolic frame deals with culture, meaning, metaphor, ritual, stories and heroes. The assumption is that what is most important is not what happens but what it means. Changes have multiple meanings because people interpret their experiences differently. In the face of widespread uncertainty and ambiguity, people create symbols to resolve confusion, find direction and anchor hope and faith. The political frame involves use of power, conflict, competition, organisational politics and its impact on organisational effectiveness. Teams working within a model of care are coalitions of diverse health care providers, with enduring differences among them, who experience important decisions involving scarce resources. Scarce resources and enduring differences make conflict central to model dynamics and underline power as the most important asset (Bolman & Deal 2008).

Use of power, the focus of this study, has been defined from many perspectives; one is the Weberian explanation where people do not lose the opportunity to establish their will, even though others disagree (Weber 2000). Thinking of a disciplinary society, power lies in the possibility of defining values, norms and actions according to the structures and practices in question (Machado 2008). However, from a contemporary view, power has been conceptualized with three dimensions: domination, freedom and hegemonic. In the last dimension, power can be gained through shared information and autonomy is facilitated by leaders. Hegemony refers to domination by consent (Isosaari 2011). While all four frames help to provide multiple perspectives, we emphasise the political frame, because it demonstrates how power operates in the institution.

## Methods

### Study design

This is an exploratory descriptive, observational study, with a qualitative approach to data collection and analysis. In this study, aspects of a situation are observed, described and explored (Polit *et al.* 2004), in this case a management transformation, the CTI, being implemented in the study hospital. The

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researcher interacted with nursing staff, unit managers, patient care managers and directors, and collaborated with implementation of the CTI. The researcher became embedded in the context of the care units through observational sessions in order to obtain an emic perspective (Spiers 2000). Of specific observational interest were processes around inclusion of all workers in this implementation process, importance of investing in communication' strategies and integration of those involved in decision-making.

## Study setting

This study was carried out in a public hospital, with more than 650 beds, in Alberta, Canada. Two programmes were included. in Programme 1, a medical service with 72 inpatient beds, transformation of the management structure and functions was underway at the time of researcher observations. In Program 2, an emergency department, a more centralised management model with well-defined lines of authority was maintained. Conducting data collection in both units allowed for comparison as they were experiencing different ways of managing care and unit policy. The researcher observed interactions in the two programmes to identify perceptions of nursing staff on the management models adopted in this hospital.

## Study sample

Programme 1 had 66 nursing staff, three unit managers, a patient care manager and a director. Program 2 had 273 nursing staff, five unit managers, a patient care manager and a director. All workers in both programmes were subject to observations and a number of participants were interviewed from each programme ($n$ = 11 in Programme 1, $n$ = 6 in Programme 2).

## Data collection procedures

The researcher collected data in four phases. First, documents related to the hospital organisational structure were retrieved, reviewed and analysed for a historical report of management structures and the recorded objectives, principles and expected outcomes of the CTI. The second phase was observation, spending time in the programmes under study, observing and making field notes of the health care team in practice. This included interactions, collaboration, identification and resolution, formal and informal communication patterns, etc. The researcher actively interacted with staff in the two programmes under study to establish researcher/participant engagement and researcher acceptance in the environment prior to the observation period. The researcher conducted observations for 2–3 hours/day during weekdays over a 4-month period, using a field diary to record observations. The third phase included 18 short interviews with representatives from management (M), registered nurses (RN), licensed practical nurses (LPN) and nursing attendants (NA) to identify perceptions and experiences related to changes that had already occurred or proposed changes in management structure. For face and content validation, interview questions were given to four nursing management experts who reviewed questions for clarity, ease of reading, and understanding and presentation of the instrument. In reporting findings, we used the acronym 'M' to designate all management respondents to avoid identification of individual managers by title. In the fourth phase, themes and detailed findings were verified with four participating managers and five nurses in a face to face discussion (Figure 1).

To establish these themes, first, after exhaustive reading of the transcripts, we selected units of analysis, which are words or sentences that strongly represent participant perspectives (Bardin 2011). Eleven units of analysis were created: open door management; knowledge about managers and directors role; proactive/reactive managers; managers' personal characteristics; hierarchy; changes; decision-making; communica-

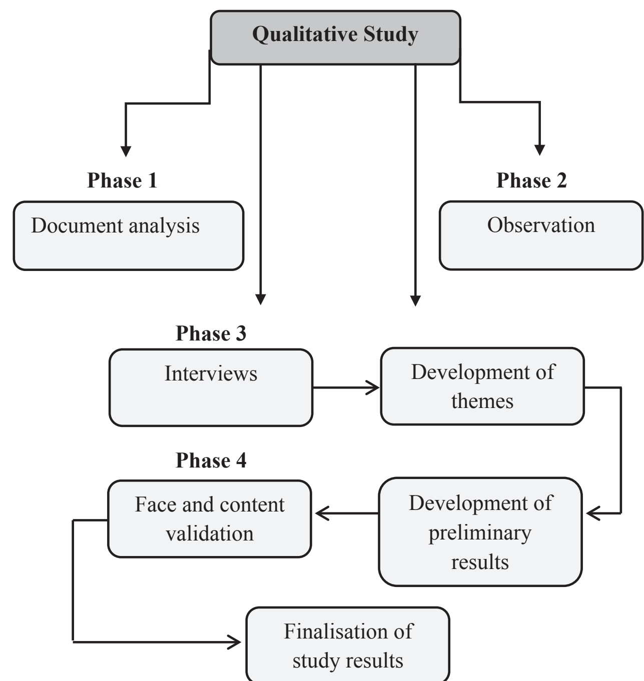


**Figure 1**
Study phases.



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tion; LEAN methodology/organisation; employees' functions; and transformation group. Next, in the analytical process, we strove to make sense of the data, by becoming immersed in it. Material was read through several times and six themes or categories emerged from the analysis.

Data collection was carried out between August and November 2010, and verification occurred in both 2012 and 2013. Ethics approval was received from the University Health Research Ethics Board followed by operational approval from the hospital (MS2_Pro00014625).

### Data analysis and interpretation

Content analysis was used to analyse all data in the following phases: pre-analysis, exploration of material, treatment of results, and interpretation (Bardin 2011). The four frames, structural, human resource, political and symbolic (Bolman & Deal 2008), introduce four interpretations of organisational processes used in data analysis. First, we categorised and presented qualitative interview data, and then discussed results using the four organisational frames, emphasising the political frame.

## Results

The 18 interview participants included the hospital vice-president, two directors, two patient care managers, three unit managers, seven RNs, two LPNs and one NA. Seventeen participants were female. Years of experience ranged from 2 to 37 years, and years of work in the institution ranged from 1 to 30 years.

### Themes

The following themes emerged from the data analysis: classical management model; motivation to adopt changes; open-door policy; decision-making; communication process; and hope for the future. These themes reflect perspectives on how the implementation process was conducted and then recognition of changes needed for care and management processes.

### Classical management model

The hospital organisational structure was very vertical and power and decision-making processes were centred at the highest levels:

> '…our whole history has been hierarchical, very controlling, and this is bottom up, it's completely foreign and opposite to all of us that have been in this workforce for 20–30 years, right, so to do this means change everywhere'.
>
> (M4)

The health care system in the province had recently been restructured and many previous decentralisation efforts were eliminated:

> '…Health System is very centralized now …We don't have direct authority or control, all we can do is utilise the venues that we have to tell our story and hope that the other groups hear some of the issues. And it's almost the right time to be doing change, you know, there's a lot of change theory about good things coming out of massive turmoil, so the whole place has been completely blown upside-down. …We're very strong creatures of habit, and it almost takes something massive to get us off the comfort zone to be able to even embrace looking at the world from a different view…' (M4)

### Motivation to adopt changes

Some factors that motivated implementation of the CTI included ways to improve staff retention and workforce planning:

> 'Prior to the restructuring, this building recognised that it had a problem, and the wakeup moment was when our exit rate equalled our intake. So we could recruit, but we couldn't keep anybody here …So that started a journey that included all of the areas …Our goal, though, was to make this the place to be, and all around focusing on our connecting with people, engaging, and changing roles'. (M4)

The CTI began in Programme 1 as a pilot project.

> 'So the initiative did start in September of 2009, and at that time we were looking at severe roll backs, or cutbacks because of the financial burden. So, historically the health care costs rose by 10% per year. …so the original driver was to truly look at changing the workforce to a cheaper workforce overall. And that's because financially they would not be able to afford it. …so [Programme 1] was chosen because they have the right fundamental ground work, they obviously had a desire to continue because they wanted to make their place better so they kept working, even though the whole place was

changing around them, it doesn't matter, it's all about grass roots, right?' (M4)

## Open-door policy

Although managers were part of hierarchical lines of authority, some had an open-door policy:

> 'I guess there is a certain hierarchy but just in our department in particular there's an open door policy, so if you want to speak to the Patient Care Manager, you can without speaking to one of the other managers first. . . .I feel like I can come to talk to any one of them at any time'. (LPN2)

The open door policy promoted development of good relationships between group members. Leaders and staff developed spontaneous and cordial communication and a rhythm of progression and assurance of work continuance even when the leader was absent. Observation of the group revealed an atmosphere of satisfaction.

## Decision-making

After the participatory management model was implemented, a very centralised organisational decision-making process remained:

> 'If something has to change, and you have to make a decision, I would say it would probably be all the unit managers together would come up together with a significant change. I would think they would have input from each other. The staff never participate, not in a major decision'. (LPN1)

However, nursing staff identified greater autonomy in patient care decisions:

> 'I can make a visual assessment and decide to contact a physician, like to come and intervene on a patient, and that's basically it. If I decide that a patient has to move, to change bedrooms I can suggest it. But I have to talk to the manager. . .' (RN1)

Decisions were still centralised in direction and conducted by management, especially when they involved funding. However, when they related to care, decisions were taken by nurses themselves, depending on their skill, competence and level of training.

## Communication process

Managers and representatives of the different working groups were perceived to share information and ask a few people for input:

> 'The daily staff is the one that see it going on, when you work nights, you know everything's quiet and the lights are turned out and you're just paging the doctor when necessary . . .You wouldn't see anything going on. . .' (RN2)

This scenario depicts miscommunication owing to lack of inclusion of all employees in the transformation process. All professionals who work at night felt disconnected from this participatory management model as they had little or no contact with managers that work in the institution only during weekdays. This led to information not being received, information being distorted and non-participation of employees in decisions relating to their own work unit or institution in general.

## Hope for the future

Fortunately, some of the staff can see potential for a better future:

> 'Honesty I think it's been pretty chaotic lately because we've had to move our units to different places because our units are being deep cleaned . . .but in regards to the transformation all I've really noticed on the unit is like some of our stuff is organised better and I think it's positively, like our supplies in our med room was organised differently. . .' (RN2)

Working groups dealing with the CTI, initiated discussion about problems on admission and discharge, and they involved patients:

> '. . .When a patient comes in, to the hospital, they're trying to estimate the length of stay for whatever diagnosis they came in with, and kind of standardize . . .So they were going to certain patients, and there'd be like the physician, the charge nurse, and they would interview the patient when they came on the unit, asked their opinion as when they felt they should go home, integrate the patient with the physicians for patient care, ultimate patient care, employ the patient's opinions and goals. . . ..from what I heard from the meetings when they gave the feedback, it was very positive. . .' (LPN1)



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After listening to staff and patients, working groups focused on reducing waiting times in the emergency department by implementing a transition unit and monitored beds:

> 'Well I know they're doing the transition unit, and . . .they monitor beds, and aside from that, are there better things? It's more like everything for the council suggestions is hearing what the staff have concerns with'. (RN4)

Implementation of the transition unit and monitored beds enabled improvement of quality as patients spent less time in the emergency department, facilitating flow of care.

## Discussion

The CTI was implemented as a pilot project, expecting that it would show positive results for this hospital, thereby leading implementation of change in all hospitals in the province. To better understand the difficulties and advances arising from this implementation, we used four frames (Bolman & Deal 2008) to discuss the findings. With the focus on power, we integrate the political frame with the other three.

### Structural frame and political frame

When viewed through the structural frame, the hospital still had a hierarchical organisational structure, whose decision-making processes focused on people who occupy superior positions and where communication was carried from the top down. Structures and processes within both programmes were obviously both vertical in operation; however, management from these areas portrayed a dialogic, open-door management approach to facilitate change to a more flexible structure. From the perspective of the political frame, coalitions formed because individuals and groups needed each other to get through the challenges of change, especially among managers and professionals (Bolman & Deal 2008). In addition, with constancy in vertical organisational relationships, individual power was perceived to increase as one moved up the hierarchy. To follow the chain of command, permission or resources had to be secured even after implementation of participatory management, which undermined system efficiency and effectiveness (Rouse 2008).

Although nurses were not always consulted in organisational decisions that affected them, they did identify greater autonomy to make patient-care decisions. Collectively, nurses' participation in the delivery of quality care to patients and satisfaction offered greater opportunity for all staff to engage with the leadership, allowing more participatory management and professional growth (McDowell *et al.* 2010). This reflects some degree of decentralised power.

The key to the transition from vertical to democratic structures is managing conflict within consensual parameters: health care environments need mechanisms to strengthen relationships between health professionals, and minimise sources of conflict (Haugaard 2011, Kaitelidou *et al.* 2012).

### Symbolic frame and political frame

Changes are often not well accepted by employees, even if a new initiative is essential (Bridges 2003). Whenever an organisational structure changes significantly, employees experience losses because old ways of doing things are gone and new ways are not yet confirmed, leaving a messy transition period (Bridges 2003). The leadership response is to acknowledge the losses and chaotic feelings that arise, continuing to work through the changes until new structures and processes become familiar.

When viewed through the symbolic frame, acceptance of change relates to disruptions in the meaning of work. From the political frame, participatory management represents change in power distribution, which can generate conflict. Organisational problems and constant change in health care organisations are reported as key issues creating conflicts in work environments (Vivar 2006, Maniou 2011, Kaitelidou *et al.* 2012). Therefore, identifying and confronting conflict early seems of paramount relevance (Vivar 2006).

By saying that humans 'are creatures of habit', a manager expressed concern about difficulties in accepting new ways of managing daily work of employees, particularly older ones. These managers were therefore forced to rethink their ways of managing, allowing employees' participation and supporting care provided to patients. To engage staff in accepting change and resolving conflict, health care leaders used occupational identity and loyalty commitments as organisational strategies. These leaders act as 'shock absorbers' by structuring tasks, stabilising staffing, using strategies to maintain trust, strengthening their position by formal and informal strategies, and giving support and encouragement to subordinates (Dellve & Wikstrom 2009).

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## Human resource frame and political frame

When viewed through the human resource frame, relationships between staff and management are mutually beneficial, as organisations access a professional, knowledgeable and competent workforce and clinical staff have meaningful paid employment (Bolman & Deal 2008). Our findings suggest that management/staff relationships were fundamentally strained during implementation and maintained differing perspectives, despite the open door policy, which had helped to establish closer relationships between staff and management. To be an inspirational leader, managers require closer relationships and interaction with employees, allowing them to voice their opinions and thoughts (Hoffmeister *et al.* 2014).

Despite the open door policy, nurses reported that management was too concerned about finances and organisational problems, and distant from the reality of patient care, while nurses were primarily concerned about quality of patient care and unable to see the 'big picture' and rationale for change. Nurses do not have an overview of the organisation, especially about management processes, and lack of manager involvement in patient-care issues requires a high degree of confidence in staff; therefore, staff autonomy in clinical decision-making is paramount. This paradox leads to relational frustration rather than conflict resolution. From the political frame, allocation of scarce resources (e.g. human resources deemed essential to make clinical decisions and provide quality care), leads to management/staff conflict and lack of understanding about different and essential roles that both managers and nurses undertake in health care decision-making to improve patient outcomes.

High-performing companies do a better job of understanding and responding to needs of workers and customers (Bolman & Deal 2008), in this case patients. Continuing education is a fundamental strategy to safeguard and develop health care professionals' competence as well as promoting adaptability to improve effectiveness (Cadorin *et al.* 2012). The CTI began with workshop training to orient all employees in Programme 1 to improvement processes: identifying, combining and reordering steps, simplifying processes and eliminating unnecessary steps to remove waste, releasing valuable resources (LEAN Methodology) (Al-Araidah *et al.* 2010). Educational meetings alone or combined with other interventions can improve health care outcomes for patients (Forsetlund *et al.* 2009). From our findings, this first step in the transformation process – refining processes – was the only change nurses had noted.

When viewed by the human resource frame, refining and simplifying care delivery processes are expected to help workers in their job by increasing motivation and satisfaction, while reducing duplication and delays (Al-Araidah *et al.* 2010). From the political frame, managers at all levels tried to foster collaboration with nurses in reworking care delivery processes (Bolman & Deal 2008). However, expectations to reduce process steps and costs were viewed negatively by most nurses because they were not asked about the impact of changes on their ability to provide quality care, and on patients.

To avoid conflict and enhance quality working relationships, organisational-level strategies such as participatory decision-making, formal/informal interpersonal communication, and support for staff participation in work group activities, are necessary for an engaged and responsive workforce (Hwang & Chang 2009, Malacrida & Duguay 2009).

## Human resource frame and structural frame and political frame

Despite lack of information and explanation, good things are still happening. The council and work groups are discussing the processes of admission and discharge, aiming to keep the patient in hospital for the shortest time possible, which has an impact on health care related to the human resource, structural and political frames.

Reducing wait times to less than 90 minutes in Programme 2 and admitting patients to a clinical or surgical unit quickly increases efficiency as well as patients' and team satisfaction and quality. The work groups also proposed opening a transition unit and adding monitored beds in the medical service to support resolution of this wait time issue so that patients could be transferred to the transition unit, opening a bed for another emergency patient. The monitored beds helped reduce total emergency department time for patients who needed cardiac monitoring. While the human resource frame emphasises dealing with issues by involving affected individuals, the structural frame argues for putting people in the right roles and relationships and the political frame focuses on who has power and decision-making authority (Bolman & Deal 2008). In this case, both strategies (90-minute wait times; transition unit and monitored beds) were decided on by people in senior positions without the clinical team's involvement.


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## Limitations of the study

One limitation of this study is that interviews were conducted only with nursing staff from two programmes in one hospital. In future research, the study population should involve interdisciplinary teams and other hospitals to see differences and similarities in perceptions of management model implementation. In addition, the CTI was adapted to the local context from LEAN methodology (Al-Araidah *et al.* 2010) which potentially reduces generalizability to other settings.

## Conclusions

Our findings confirm that the whole process of organisational change is difficult and takes time to materialise. Focusing solely on structural, political, symbolic, or human resource perspectives during implementation of organisational change can hinder its implementation. Rather, all frames need to be considered. Among the challenges to implementation, we highlight resistance of workers, particularly older ones. Despite the goal of increasing participation in decision-making, most decisions, including those affecting clinical-care teams are still made at higher or more centralised levels. Management and clinical staff still report little understanding of the contribution of each other's roles to achieving organisational goals and quality care. Despite these challenges, participants showed some optimism that things may change in the future. Future research should be longitudinal to capture implementation processes and complexity of changes over time and across multiple settings and contexts.

## Implications for nursing management

The findings of this study add to our understanding of the implications of implementing an innovative management model that entails transformation in care practice, as well as encouraging training of nurses in relation to management. In future, implementation of such broad and encompassing initiatives as examined here necessitate situating and educating nursing teams within the context of care transformation rather than viewing this initiative as an isolated event.

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## Ethical approval

Ethical approval was obtained from the Health Ethics Research Board, University of Alberta, Edmonton, Alberta.

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