

3.1 Introduction

The term organizational development can be described as an objective based approach to implement a change within an organizational context. It is a planned and systematic approach of improving the effectiveness of an organization. It helps in aligning an organization to its strategy and processes, which in turn helps in defining the integrated models of business development. Therefore, the organization development process can be termed as a systematic approach that mainly helps in improving the organizational effectiveness (Benn, Edwards & Williams, 2018).

The organizational development process relates to one of the most integrated models of development and management of a business. It helps in integrating the models of business development that contributes to efficient growth of the organization. It is observe that there are a number of factors that affect the success of implementation of system within the project. The organizational development process is important for a project as it enables the employers to determine the processes that can help in improving all the business-related activities (Al-Haddad & Kotnour, 2015).

A number of problems related to patient safety care are identified in the hospitals of Saudi Arabia that gives rise to the need of ensuring effective organizational development. Implementation of the organizational change process is an action-oriented phenomenon that is necessary for ensuring appropriate business growth. There are a number of factors that contribute to the success of these types of project. Organizational development process enables an organization to identify the changes needed in an organization in a much more effective way (Al-Haddad & Kotnour, 2015). The organizational development process is further necessary to identify the personal and professional skills that the organization needs to consider in order to eliminate the major issues in the organization.

The organizational development process of the chosen hospital involves a number of processes that are needed to be planned effectively in order to ensure successful project implementation. The following section of the organizational development process identifies

different models of implementing change development in a process. The methods of bringing in much needed change in the organization are indicated as follows.

1. Identification of areas that can be improved or changed in an organization
2. Evaluating whether the organizational structure can be modified
3. Checking whether changes can be brought in a system
4. Reviewing the system that is being proposed

The above points indicate the steps that can help in bringing about positive changes in an organization. The issue of patient safety culture in the chosen hospital can be addressed by implementing an effective change model within the organization (Kuipers et al., 2014). One of the major processes of implementing those changes includes providing effective training to the staff members and nurses of the hospital regarding the importance of patient care and patient safety culture.

A recent patient safety culture indicates that the chosen hospital needs to improve in a number of categories. The following sections of this chapter provides a brief overview of the organizational development process and approaches to organizational development.

3.2 Critical Review of Approaches to Organizational Development

The process of organizational development can be viewed through several different approaches. Some of these approaches are described below with a critical analysis of each.

1. Action Research

The action research approach to organizational development basically aims at involving those people whose lives and health are directly affected by implementing changes in the organization. Often changes proposed in an organizational context do not happen as planned; hence, when key stakeholders are involved in the change processes, it is more likely that changes implemented will be, for the most part, on track. It is a combination of action and

reflection, theory and practice, where changes suggested are practical solutions formulated keeping in mind the clients of the organization (Sankaran and Ranjan, 2010).

The action research approach involves collaborative participation of all stakeholders for analyzing a social situation and suggesting democratic changes to the organization. The objective here is to analyze problems in the organization and to implement changes for bringing about a positive change in the organizational processes. It is a collaborative effort involving all stakeholders of the organization which ensures equal representation of all participants in the change implementation process (Burns, 2015). Especially in the healthcare setting, it acts as a bottom-up approach where researchers along with practitioners and patients formulate strategies for change that will lead to higher satisfaction in patients and lesser stress levels for hospital staff (Montgomery *et al.*, 2015).

2. Lewin's Force Field Analysis and 3 Step Model of Change

Force field analysis refers to the systematic analysis of the relationship between the forces that drive change and the resistive forces that prevent change in an organization. Kurt Lewin, who proposed this model, believed that every organization has several constraining forces that prevent changes from being implemented fully in the organization. Hence, it is essential to identify and address these forces that resist changes in order to ensure no barriers in the implementation of new strategies for improvement in the organizational development framework. This is in contrast to action research which believes in direct action regardless of factors that may pose a hindrance to the implementation of changes in the organization. Often, the recognition, control, and direction of resistive forces alone can pave the way for improved organizational dynamics (Swanson & Creed, 2013).

Lewin's three step model of change is based on unfreeze-change-refreeze for the management of change in an organization. In order to bring about changes in organizations, first the old behavior needs to be unfreezed, then the specific changes will be implemented, and the new behavior will be refreezed to make the new framework permanent (Cummings *et al.*, 2016). Unfreezing fixed habits in the organization requires going against the restraining forces of individuals and the group to create an environment conducive for change. This stage

also involves identifying and enhancing the driving forces that embrace change in an organization. This is followed by the actual implementation of change based on the needs and requirements. The final step is refreezing to ensure that the implemented changes are sustained over time. This is the most important stage as permanent habits are difficult to develop and it may be done by enforcing policies and procedures in the organization (Kritsonis, 2005).

3. Appreciative Inquiry

This is a modernistic approach to organizational development which involves asking probing questions and then implementing change on the basis of these answers. Asking questions helps verbalize the problems that are present in the organization and possible solutions that can help shift the organizational dynamics for the better. It makes people aware of the problems either on an individual or group level and brings these problems into focus. Bringing problems into perspective makes it easier to implement changes that can provide specific solutions for the organization (Stavros *et al.*, 2016).

Where action research focuses on solving problems, appreciative inquiry aims at verbalizing questions and possibilities so that targeted changes can be implemented in an organization. Also, in contrast to Lewin's three step model which is quite a simplistic approach, appreciative inquiry aims at providing specific methods that can drive change in an organization. Both the action research and Lewin's models focus on identifying and addressing problems, whereas appreciative inquiry is more of a group discussion where good processes can be made better and new ideas can be put on the table (Asumeng and Osae-Larbi, 2015).

3.3 Rationale for selecting Appreciative Inquiry as the model of change

Lewin's three step model of change has had a stronghold on organizational development for quite a few decades, and is only now being replaced by the appreciative inquiry approach. The appreciative inquiry model strongly upholds the values of social constructivism, diagnosis as an essential step for organizational change, and a strengths-based model for change. The most outstanding feature of this model is that it is not a methodology or

technique; rather it is a concept for promoting change in an organization. It is because of this that a lot of organizations have over time developed many different procedures to implement appreciative inquiry in their operational systems (Bushe, 2011).

Appreciative inquiry combines the collaborative principle of action research and the unfreezing stage of Lewin's model. It begins with a collective discussion regarding the state of the organization and what changes the participants would like to see implemented in the near future. As all participants are actively involved in the discussion, it is easy to identify opposing views and possible resisting forces that might pose a hindrance to change implementation in the organization. Following extensive discussion, all members of the group are invited to propose ways to bring about positive changes in several key issues in the organization. This ensures active interest and participation from all group members and an enhanced drive to sincerely bring about improvements in the workplace. Hence, appreciative inquiry combines the salient features of the action research as well as Lewin's models for change (Bushe, 2011).

However, as the discussion is open in case of this method, it is quite easy to get waylaid and move onto matters that are not of prime concern at the current stage (Clouder and King, 2015). Hence, in my study I have specifically defined the theme to be patient safety culture in the chosen organization. Based on this I have used a culture survey to elicit responses and comments on matters where I aim to implement change framework in the organization.

3.4 HSE Change Model (2008) for Organizational Development

Change is not a one-time implementation process; rather, it needs to constantly occur in all organizational settings to ensure progress. The HSE model for change has been developed to address this constant need in an organization, which gives patients and staff members a considerable say in the organization's work and safety culture. In any organization setting, it is easier to implement new structures, processes, and methodologies to bring about changes in the operations and hierarchy. However, bringing about a change in the patient safety culture of the hospital is more challenging as it requires the dedication and effort of each and every person in the hospital. Hence, the HSE model of change promotes the involvement of people in implementing change in an organization (HSE, 2008).

Changes in an organization are intricately connected to changes on an individual level too for the staff members. Hence, for the success of change implementation, it is imperative to support the people that will be involved in the adoption of change. Their acceptance and reactions to the change are key parameters in determining the success of change implementation in the organization. The inter-relationships between the management and the staff members also have an effect on how well proposed changes are accepted in the workplace. As the HSE model of change is more people-centric in nature, the use of this model ensures that the staff members' needs and emotions are taken care of at a personal as well as professional level (HSE, 2008).

A lot of people may undergo stress and anxiety as a result of uncertainty and unpredictability that accompanies change. This is especially more probable when change happens without prior notice or consent of the staff members. In this case, there may be higher levels of resistance for the change to take place. In such a scenario, the HSE model can provide a structured framework to implement change in order to ensure voluntary and active participation of all staff members in the change implementation process. Some of the ways by which this can be achieved are establishing trust, having honest and open communication, and providing training in change implementation procedures (HSE, 2008).

According to the HSE 2008 model for change, there are four stages of any project lifecycle – initiation, planning, implementation, and mainstreaming. The initiation stage involves preparation for the change to take place by creating a sense of readiness and responsibility among the staff members. In this stage, the plan is discussed and decided between the management and the employees. This is followed by the planning stage where the entire change implementation process is defined in excruciating detail. Different staff members are entrusted with specific tasks and support is provided to them to carry out these tasks appropriately. The planning stage is followed by the implementation stage where the discussed plans are implemented across the organization. This is also the phase where any strategies or methods that are not giving results are identified and discarded in the early stages. The final stage is the mainstreaming stage where processes from the previous stages are evaluated for

their success rate. Those processes are selected that have demonstrated a proven benefit in the organization and they are made permanent by incorporating them in policies and best practices of the organization (HSE, 2008).

The following sections aim to focus on each of these four stages and how these stages will be followed in the change implementation process of patient safety culture in the chosen organization.

3.4.1 Initiation

This project focuses on the analysis of patient safety culture in a secondary hospital in Saudi Arabia. Several studies have demonstrated a marked reduction in patient safety in several local hospitals in the region, and so this project aims to perform a comprehensive review of patient safety parameters and strategies in one particular hospital. Although the chosen hospital is quite reputed in providing on par medical services to the patients, this project focuses on the attitudes of the staff members towards patient safety culture in the hospital. These attitudes will then shape the changes that need to be implemented to ensure that patient safety in the hospital is not compromised.

The foundation of this project is in the fact that there is a decrease in the number of patients visiting the hospital for medical services. This could be due to lack of proper training of medical staff in providing appropriate healthcare services to the patients. It may also be due to increase in the number of medication errors taking place in the hospital. Based on this initial analysis, several SMART objectives were developed and it was decided that the results of the project would guide the development of a training program for the hospital staff and employees to ensure improvement in patient safety at the hospital.

The SMART objectives for this project are as follows:

- To establish a list of safety culture barriers and improve the highest three domains by 60% by May 2020

- To deliver safety culture training to all staffs of the chosen hospital by the end of May 2020
- To improve safety culture effectiveness by 60% percent till the end of September 2020

As part of the initiation stage for implementing the HSE model for change, it was essential to identify the areas where patient safety was compromised and the barriers to achieve excellence in provision of medical services to patients. In order to do this, the Safety Attitudes Questionnaire (SAQ) was used to identify attitudes and behaviors of the hospital staff towards patient safety. Response rates to the questionnaire varied among the different departments of the hospital. Overall, there were several important themes and barriers that emerged through this survey that will serve as an important foundational step to plan for change implementation. The causes for concerns relating to patient safety are described in detail below.

The staff members have a negative attitude towards the teamwork culture in the hospital, with only 33 to 67% of the employees across various departments feeling that the hospital has a positive teamwork culture. Hence, there is lack of proper team coordination and collaboration between the staff members of the hospital. The encouragement for nurses to weigh in with their inputs and suggestions is low, with only 45 to 79% nurses feeling that their suggestions are welcome. Up to 38% of the employees feel that it is difficult to speak up if they perceive problems with patient care in the hospital. About 44 to 72% of the people are satisfied with conflict resolution methods keeping in mind their impact on patient care. On the up side, up to 83% of employees feel that they are free to ask questions and get support for providing excellent medical services to their patients. Also, up to 92% of the respondents feel that physicians and nurses work together in coordination for taking care of patients.

With regards to patient safety, a major cause for concern is that less than 60% of the staff members feel that the hospital environment is safe for the patients. In contrast, about 70% of the respondents feel that they would feel safe in being treated at this hospital as patients. Only 44 to 66% of the respondents feel that medical errors are handled appropriately in the hospital. Less than 70% of the employees are given appropriate feedback and up to 46%

feel that the hospital environment is not conducive for discussing errors. Particularly in the Emergency Department, only 48% of the people feel that they are encouraged to report any patient safety concerns that they may have, with the number going up to 83% in the other departments. As a consequence, respondents report that learning from other staff members' mistakes is not a norm at the hospital.

Regarding job satisfaction, only 43 to 67% of the staff members feel that they are satisfied with their jobs. About 60 to 80% of the employees like their job and think that this is a good place to work. Only 69% of the people working here feel that morale is high in the hospital. When tested on their ability to identify stressors in the workplace, only 66 to 69% of the employees are able to recognize that excessive workload affects their performance at the hospital and they are less productive when fatigued. About 33 to 64% of the employees state that they are more likely to make errors in tense situations.

With respect to working conditions of the hospital, up to 70% of the employees feel that they have the information required to make diagnostic and therapeutic decisions on a regular basis. Only about 40% of employees across all departments feel that the method of dealing with staff members is positive and constructive. Based on the responses, trainees do not receive adequate supervision and the training process for new employees needs to improve.

Only about 50% of the employees feel that the management does not compromise on patient safety intentionally. The same amount of people feels that employee efforts are recognized by the management. It is shocking to note that only 10% of employees in the Emergency Department state that they are adequately staffed to handle the number of patients, with this number ranging up to 71% in different departments. With regards to unit management, only 40% of the employees say that the managers don't compromise patient safety intentionally.

3.4.2 Planning

Once the Safety Attitudes Questionnaire (SAQ) results were obtained, they were organized into different themes and bar graphs were plotted for ease of understanding. The

following three problem points were identified based on the objective as well as subjective survey results.

The overall quality of teamwork in the chosen hospital is low. There are mixed feelings of nurse input being well received in the hospital and it is not easy to report problems with patient care. Disagreements are not always resolved in the best possible way. However, when directly asked, queries are answered appropriately and support for patient care is provided to nurses most of the time. Based on these results, there is a clear problem with communication in this hospital. The employees feel that their suggestions are not heard by the management and their co-workers are not very cooperative. When healthcare providers do not have an active say in the patient care procedures, it is quite likely that they become less concerned about patient care and related problems in the hospital. Hence, this communication problem needs to be effectively addressed in the chosen hospital if patient safety is to be emphasized.

Secondly, medical errors made by nurses are heavily penalized. A lot of nurses say that even the smallest of errors that do not directly impact on the patient's healthcare are treated as extreme offences and they often lead to salary deductions and other severe forms of punishment. Due to this attitude, a lot of employees have very low job satisfaction levels and quite a few of them intend to leave the organization in the near future. As nurses work under such pressure, they are bound to get tired and sick. Even when nurses apply for sick leave, they get penalized through salary deductions. Employees report that the work environment is very negative in that all instructions are accompanied by threats and possible punishments if the task is not completed properly. This is not a conducive environment for people to work together towards patient safety. When the objective is only to not get penalized or punished, nurses tend to think less about patient safety and more about how to escape punishment. Hence, this is a major issue that needs to be addressed when defining change implementation strategies.

Finally, a lot of employees complain that the organization is heavily understaffed. The workload is too high and there are not enough people to share the burden. This leads to increased pressure on the few nurses that are available which, in turn, increases the chances of

medical errors. Thus, when a few nurses are trying to handle a lot of patients, there is a very high probability that patient safety will get compromised. Hence, the issue of staffing is a major concern that needs to be addressed appropriately.

Based on this data, a SWOT analysis of the organization is presented below that gives an idea of the functional profile of the organization that needs to be addressed during the planning and implementation stages.

| Strengths | Weaknesses |
|--|--|
| <p>Nurses do have an opportunity to voice their questions and concerns, and these are appropriately addressed. They know whom to ask when they have specific queries related to patient care. Physicians and nurses work in coordination with each other towards reducing errors and improving patient safety. The employees do like their job and they are ready to work for improved patient safety.</p> | <p>There is lack of proper communication regarding instructions and feedback. Even the smallest of errors is dealt with quite harshly. The number of staff is less and so, the workload for the present employees is too high, which in turn leads to higher chances of errors.</p> |
| Opportunities | Threats |
| <p>A lot of employees report that they would feel safe being treated here as a patient. This shows that people do expect to get good treatment and this is an opportunity to build trust among the patient community. As nurses have to work for longer hours and handle more number of patients, they are frustrated and in dire need of new</p> | <p>The number of patients visiting the hospital have been going down in the last few years. A lot of nurses work under constant pressure and are on the verge of leaving the organization. The level of stress they endure can affect their physical and mental health and increase the chances of errors during patient care.</p> |

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| strategies and solutions. Hence, this situation can be used to lower their workloads by helping the hospital manage staff shifts appropriately. | |
|---|--|

In order to address the points that have come to light through the SWOT analysis, an extensive stakeholder analysis was undertaken to ensure that the organization's change team is filled with relevant stakeholders who will work for the benefit of the organization. According to the WHO guidelines for stakeholder analysis, stakeholders should be chosen based on the level of impact of change implementation strategies on them. Following from this, physicians and nurses fall under this category as any change that will be implemented in the organization will include a change in their work practices. Also, people who will make the Action Plans and monitor their implementation need to be from the higher management, and this needs to include managers and policymakers.

The process of stakeholder analysis will involve the head of the organization conducting interviews of four key groups of people – managers, policymakers, physicians, and nurses. The objective of these interviews will be to identify representatives from each of these four groups who have the leadership skills to be a part of the change team. The interviews will serve as a means of obtaining information regarding the candidates' interests in the organization and patient safety, and their views regarding the changes that need to be brought about in the organization. Based on this data, ideal representatives from the four groups will be chosen to form a part of the change implementation team.

In order to address the major issues of communication gaps, heavy penalties for minor errors, and reduced staffing in the organization, appropriate training methods for the management and the staff members need to be implemented. In order to develop appropriate change implementation strategies for this organization, the TeamSTEPPS implementation protocol will be used as it emphasizes on a team approach to bring about changes in the organization. For this, a change team will be developed in the organization based on the

previously described stakeholder analysis. A meeting of the change team will be called to discuss the three major issues that have surfaced from data from the Safety Attitudes Questionnaire (SAQ) results. Each of these three issues will be examined in detail and the team members will be asked to collaborate and come up with practical solutions to address these issues.

Following this meeting or a series of meetings where all the relevant issues are placed on the table, a detailed Action Plan will be prepared for implementation. This Action Plan will outline every change strategy and medical team training protocol that will be implemented in the organization. It will note down details such as who will be the trainers, people who will attend the training programs, the content, and the duration of the training sessions. As far as the issue of communication gap is concerned, the entire team of nurses and physicians need to be trained to voice out their opinions freely and create an environment where open communication and honest feedback is encouraged. Regarding the culture of punishments, the management team needs to be trained on alternative methods to address medical errors in the organization. Also, the yardstick with which medical errors are evaluated need to change as nurses feel that even minor errors are heavily punished. Hence, the organization's leaders need to reconsider their approach to acknowledging and rewarding their employees' performance. The training sessions that will be designed in this phase will address both these issues and ensure that all key stakeholders are a part of these programs.

3.4.3 Implementation

The implementation of the TeamSTEPPS Action Plan in the organization is expected to produce a positive shift towards improvement in patient safety in the hospital. The reason is that the Change Team will be formulated after conducting extensive stakeholder analysis and the members chosen will be given the responsibility of working towards a positive and safe hospital environment. The Action Plan decided by them is expected to be based on their present situation and the barriers they need to overcome to bring about changes in the organization. As the Change Team members belong to their own organization, the employees

are more likely to cooperate with them to implement the culture of patient safety in the hospital.

The culture of teamwork that is promoted by TeamSTEPPS has been successfully employed and implemented by several organizations. One of the hospitals decided to use TeamSTEPPS strategies for improving communication in their hospital. They developed a change team of five nurses and nurse managers to represent the different units of the hospital. Their Action Plan included providing training to nurses, managers, and the home health staff separately. They also implemented specific TeamSTEPPS communication tools for the communication of critical information and patient safety concerns among the employees. They conducted regular meetings that enabled them to discuss their plans and weekly outcomes. One of the concerns that emerged during these meetings was that the enforcement and usage of the TeamSTEPPS communication tools was inconsistent. They immediately addressed this and ensured that every employee was given sufficient training to bring these tools into practice. Thus, through the use of the TeamSTEPPS framework and having regular discussions about the implementation progress, they managed to succeed in overcoming communication barriers in their organization (Zhu *et al.*, 2016).

Another hospital that implemented several TeamSTEPPS tools for promoting a patient safety culture found a positive improvement in their organization. Their change team consisted of several physicians and nurses from different departments to encourage collaborative efforts. Every employee was provided with explicit written instructions on what was expected of them in terms of performance. They were empowered to speak up or ask questions if they felt uncomfortable with any of the strategies being implemented at the organization. The hospital's management collected data through surveys before and after implementation of the TeamSTEPPS strategies in their hospital. The result was that there was a 48% improvement in the teamwork climate and 20% improvement in the safety climate of the hospital (Gupta *et al.*, 2015).

3.4.4 Mainstreaming

Following implementation of the TeamSTEPPS change strategies and Action Plan, it is important to continuously monitor the impact that this new program is having on the patient safety culture in the hospital. This is the only way the organization's management can ensure that the change strategies will become a permanent part of the organization. In the absence of evaluation of outcomes, the team and the organization's employees will very soon lose the motivation to keep working on the Action Plan. Evaluation will also help identify if there are any problems with the implementation of the plan that need to be addressed early on to avoid major problems in the future.

The most common method by which organizations ensure that the Action Plan is being strictly adhered to is by conducting pre-developed surveys once before the implementation and then at regular intervals after the implementation. These results are then extrapolated in a graph to measure the level of patient safety before implementation and the improvement of patient safety at specific timepoints after implementation. The resulting curve will give insights into the rate at which improvement has occurred and the percentage of improvement in specific areas of the organization (Siddons and Potter, 2016).

Another method is to check for documented patient safety errors and medication errors before and after the implementation of TeamSTEPPS strategies. In one of the hospitals, team training programs were implemented for the staff of the operating room to promote patient safety in the organization. It was identified that the number of occurrences where foreign objects were retained in the patient body was considerably lesser when compared to data before TeamSTEPPS implementation. Also, there was an increase in the timely administration of prophylactic measures to patients. Overall, the rate of avoidance of errors was significantly improved when checked after implementation. This data points to the fact that the implementation of team training in the hospital was a success and it can lead to a permanent shift in the hospital's practices (Coburn and Gage-Croll, 2013).

Some of the ways in which hospitals can achieve permanent solutions for their organization is through assigning strategic leadership roles and empowering employees. They also need to constantly review the implementation of TeamSTEPPS in other organizations and

learn from their positive outcomes and mistakes. A lot of hospitals report that they lack the time and resources to go through with these types of implementation programs. Hence, these organizations need to be empowered in allocating time and resources for improving the patient safety culture at their hospital (Natafqi *et al.*, 2017).

3.5 Ethical Considerations

Ethical considerations are considered to be major aspects in implementation of change management within an organization. One of the most important ethical aspects of research involving human subjects is to gain their informed consent before the study. No part of the process and objectives of the research can be hidden from the participants. Explicit permissions need to be obtained for every part of the project in which the participants are directly or indirectly involved. Also, the risks and benefits of the study need to be evaluated. Through this study, no participant can be harmed physically, mentally, or emotionally, and their jobs at the hospital cannot be put at risk. Participation in this study should not have any adverse effects on the personal and professional lives of the participants (Emanuel *et al.*, 2000).

In projects involving the collection of opinions from human subjects, it is empirical to maintain data confidentiality. Access to data by people not involved in the study should be strictly restricted. Maintaining confidentiality is also a sign of respecting the participants' privacy which is of utmost importance in a research study. Participants should be allowed to opt out of the study any time they wish. If any new information regarding the study comes up during the course of the project, it needs to be promptly informed to all the participants. If any of the participants faces any untoward situation as a result of participation in the research study, appropriate support should be provided (Emanuel *et al.*, 2000).

3.6 Summary and Conclusions

This chapter identifies and analyses the organizational development process that is needed to be implemented in the chosen hospital. It has been established earlier that certain reforms in the patient safety culture of the chosen hospital are necessary to bring about a positive shift in the organization. This chapter discusses the various models of change that can

be implemented in the hospital and provides a rationale for selecting the Appreciative Enquiry model for implementation in the chosen hospital. It also applies the HSE 2008 model of change and describes the various processes in initiation, planning, implementation, and mainstreaming of the change implementation process. The TeamSTEPPS strategies are used to address the issues of communication and punishment among the employees after conducting a thorough SWOT analysis of the organization. Based on research evidence, it is expected that the use of this framework will lead to a positive change in patient safety culture in the organization.

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