The journey of a teaching hospital to become a learning organisation

Stuart D Rowley

Abstract

This paper describes how an acute tertiary referral hospital moved away from a "culture of blame", using change management principles aligned with the concept of the learning organisation. I outline the process of change, and describe its outcomes. The result is summarised as an improvement in desired attributes of the organisation's culture, as evidenced by consistent improvement in the results of a proprietary staff survey. I conclude that the concept of the learning organisation is a useful one for hospitals that seek to improve the organisational culture.

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What is known about the topic?

The effectiveness of efforts by hospitals and health services to enhance their performance through changing the culture is controversial, and evidence of practical results is scarce.

What does this paper add?

This case study documents the progress made by one acute hospital, in improving the commitment and satisfaction of its staff with the hospital's leadership and approach, using the principles of the learning organisation.

What are the implications?

The use of a more open and participatory style of management, together with a focus on enhancing and recognising performance, can assist health services to improve staff satisfaction and commitment. ◆

The context: pressure for change

Hospitals are complex, sociologically rich places which are hard to read and even harder to change. The literature lacks detailed, empirical case studies of culture change and organisational learning processes in large acute settings, with only occasional exceptions.[1] This paper seeks to redress the imbalance in the literature by presenting the aspirational journey of Mercy Hospital for Women in Melbourne, Australia, from 1999 to 2005, in cultural and organisational learning terms.
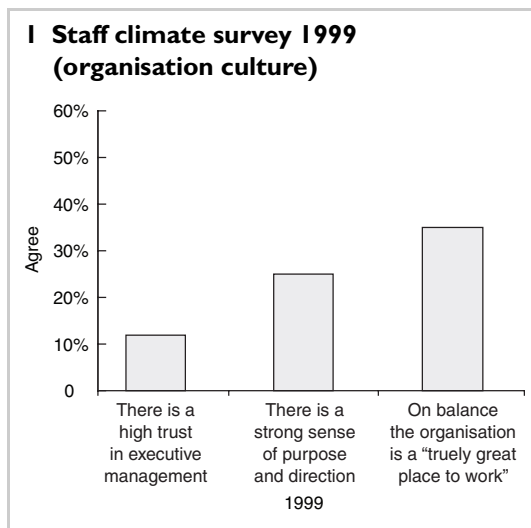
Acute public hospitals in Victoria have characteristics of M-form (command and control) organisations.[2] They exhibit traditional hierarchical management structures and function in the

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highly bureaucratic environment of indirect government control through funding and policy guidelines. While these traditional management models have been successful in the manufacturing environments of the industrial revolution, there is a substantial body of evidence indicating that they are limited in their ability to respond to the rapidly changing environments of today — in the information age.[3]

The Victorian health care system has been through more than a decade of significant financial and structural change including the introduction of casemix (a new system of funding) in 1992, and a major review of metropolitan health services in 1995 by the Metropolitan Hospitals Planning Board.[4] This resulted in the introduction of Metropolitan Health Care Networks in 1996, their subsequent dissolution in 2000 and the establishment of Metropolitan Health Services.[5] Each of these changes was used to drive efficiency and cost containment in the health care system at a time when there was increasing demand for services, for quality improvement

1 Staff climate survey 1999 (organisation culture)

and greater accountability. These changes have had a major impact on hospital management.

The ability of management to be responsive to the environment has also been affected by the characteristics of the health care professionals employed in hospitals.[6] The approach of medical and other professionals, who have traditionally enjoyed substantial practice autonomy, are not always compatible with hospital management structures.[7]

The hospital

Mercy Hospital for Women (MHW) is one of two free-standing tertiary women's facilities in Melbourne. It provides specialist obstetric, gynaecology, and paediatric services and is a major referral centre for Victoria. The hospital employs in excess of one thousand employees and has an annual operating budget of $75 million. The organisational structure of MHW was designed on the traditional hierarchical tripartite management model of medical, nursing and general administration. While MHW is government funded, the hospital is owned and operated by Mercy Health and Aged Care (MHAC) on behalf of the Sisters of Mercy.

Consistent with other acute hospitals in Victoria, MHW had been significantly impacted by the turbulence of casemix funding and numerous reviews. In the late 1990s, while the current facility was being scheduled to relocate to a new site in 2005, there were a number of senior staff changes, and concern about direction and leadership. This, coupled with the uncertainty of the funding environment, contributed to a troubled management system.

In 1999, MHAC engaged Best Practice Australia Pty Ltd to conduct a staff climate survey in all of its facilities, including MHW.[8] This survey revealed a very poor climate, and low trust in executive management. The results indicated a 12% positive response to the statement "There is a high trust in executive management" and an equally low response to the statement that "There is a strong sense of purpose and direction". Employees also gave low scores in response to the specific statement that, "On balance, the organisation is a truly great place to work", with only 35% of staff agreeing with the statement (Box 1).
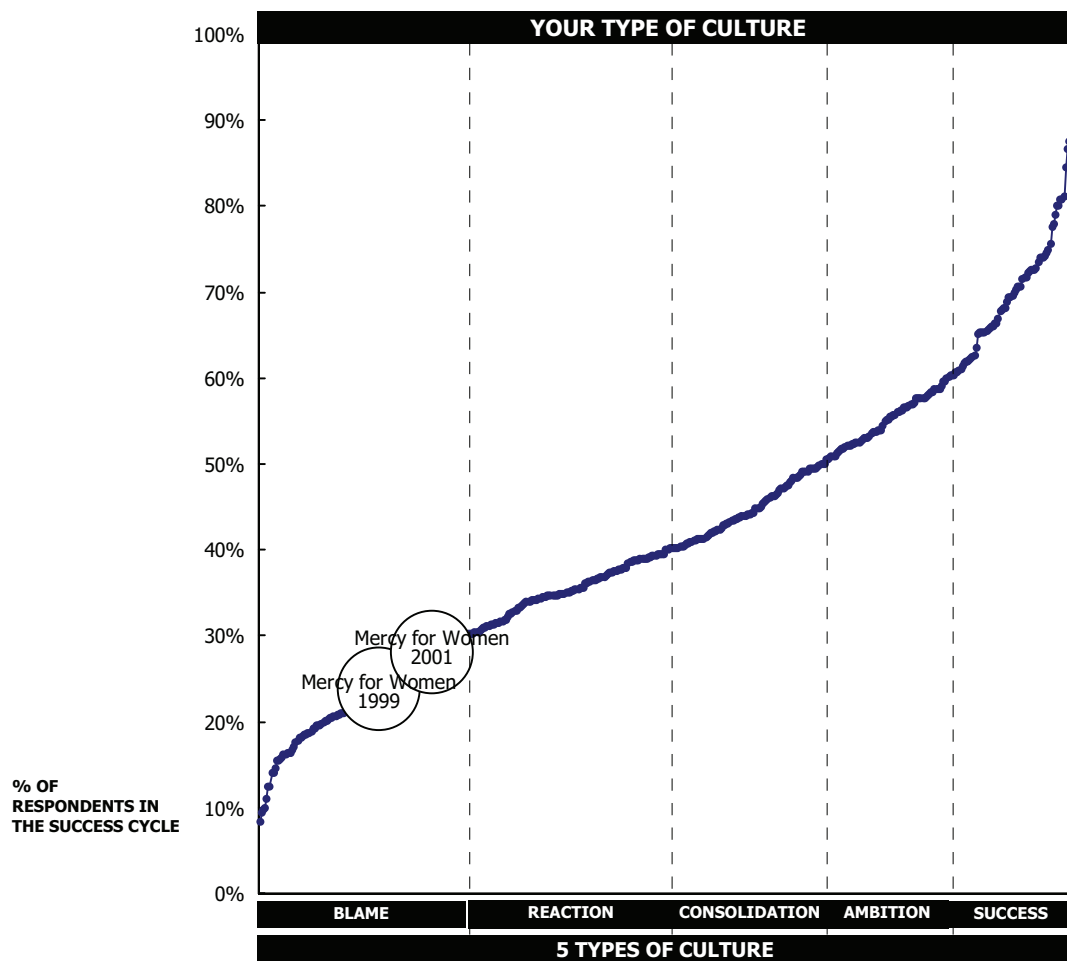
The survey also collects answers to a series of specific questions which are used to assess the climate of an organisation. Each organisation can be located across a continuum of cultures from a "culture of blame" through cultures of "reaction", "consolidation" and "ambition" to a culture of "success".[9] The results of the survey indicated that MHW sat clearly in the section referred to as the culture of blame in 1999 (Box 2).

A new vision for the hospital

A new senior management team (a new director of nursing and myself as chief executive officer) was appointed to MHW in late 2000, as part of the response by MHAC leadership to the results of the survey. We endeavoured to implement a new management approach, based on the belief that successful change and improvement had to emerge from within the organisation and that solutions to the organisation's problems would primarily be identified by the staff, if given the opportunity and support.

The management team adopted a democratic and inclusive set of management principles which included:

2 Organisational culture — Mercy Hospital for Women 1999

YOUR TYPE OF CULTURE

% OF
RESPONDENTS IN
THE SUCCESS CYCLE

Mercy for Women
2001

Mercy for Women
1999

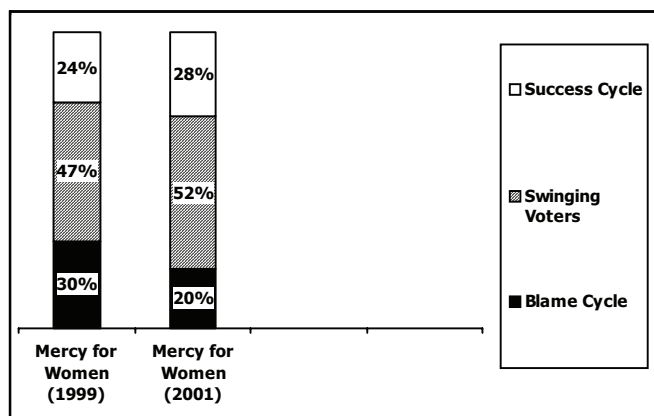| BLAME | REACTION | CONSOLIDATION | AMBITION | SUCCESS |

5 TYPES OF CULTURE

Percentage of respondents who are:

... Experiencing a Success Cycle (either personally or throughout their work unit). They are openly positive, optimistic and engaged about the organisation's future.

... Experiencing a Blame Cycle (either personally or throughout their work unit). They are openly negative, pessimistic and disengaged from the organisation's future.
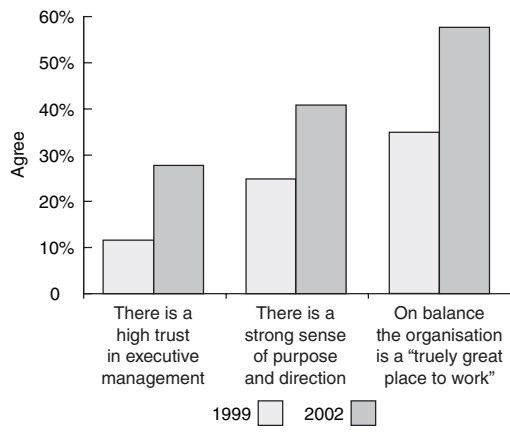
... Swinging Voters. They sit on the fence and are neither openly positive nor openly negative - they just want to come to work to do their job.

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☐ Success Cycle

▨ Swinging Voters

■ Blame Cycle

	Mercy for Women (1999)	Mercy for Women (2001)
Success Cycle	24%	28%
Swinging Voters	47%	52%
Blame Cycle	30%	20%

For a full explanation of the model "5 stages of culture (from blame to success)", see <http://www.bpanz.com>. ◆

3 Staff climate survey 2002 (organisation culture)

isational performance would stem from a positive organisational culture and staff alignment with a clear vision and strategic direction.

The vision was initially developed by the senior managers and Clinical Directors and then presented at open staff forums seeking input and contribution. This input was accepted and responded to in a way that recognised its importance. I believe that the vision had a great impact on the majority of staff, as it had relevance to them, and this resulted in a feeling of ownership; and that this would not have been the result had a vision simply been imposed on staff. The vision statement resulting from the consultative process is:

> "To be the recognised leading provider of women's health in clinical service, teaching, training and research."

To move towards achievement of this vision, it was agreed that a number of key aspirations or goals would need to be achieved. These were developed and refined following a number of discussions with staff. This vision was then operationalised into the final aspirations or goals:
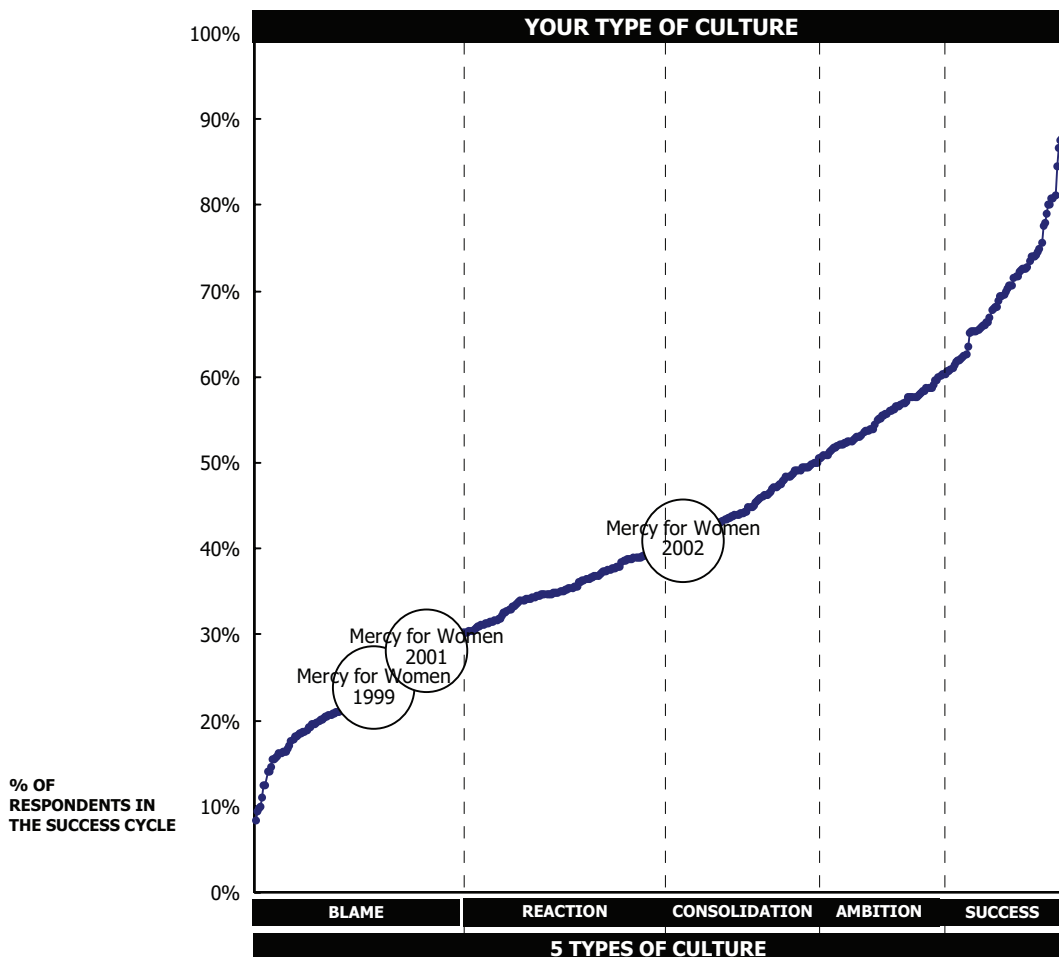
- to live the Mercy Mission and values (compassion, respect, innovation, stewardship and teamwork);
- to be the service provider of first choice;
- to be the employer of first choice;
- to provide quality services;
- to develop and maintain a national and international reputation; and
- to build a sustainable base.

The result was a clear, one page Strategic Direction document which I presented at every orientation program and which was referred to at most management meetings. Positive feedback from these presentations indicated that the document had the support of staff, was seen as clear and precise, relevant and easy to read and understand.

- clear direction setting by leaders and creation of a shared vision for MHW;
- obtaining staff input into the strategic direction-setting process;
- greater alignment of individual and departmental/organisational goals;
- an emphasis on quality improvement and learning from external reviews of other organisations;
- greater staff involvement in resolution of issues; and
- acknowledging weaknesses in physical work environments and establishing priorities for improvement.

We supported this approach with:

- open communication and easy access to senior management;
- regular open forums and educational sessions for staff;
- physically attending departmental meetings and gatherings; and
- acknowledging and celebrating achievements.

In the first instance, a participative approach that engaged staff in the development of a clear vision for the organisation was commenced. We wanted to achieve commitment to a vision for the organisation, not simply compliance. This approach was implemented because the new executive team held the belief that positive organ-

Moving the hospital

Formal acceptance of the vision and goals was followed with the development of many strategies

4 Organisational culture — Mercy Hospital for Women 2002

YOUR TYPE OF CULTURE

% OF
RESPONDENTS IN
THE SUCCESS CYCLE

Mercy for Women
2002

Mercy for Women
2001

Mercy for Women
1999

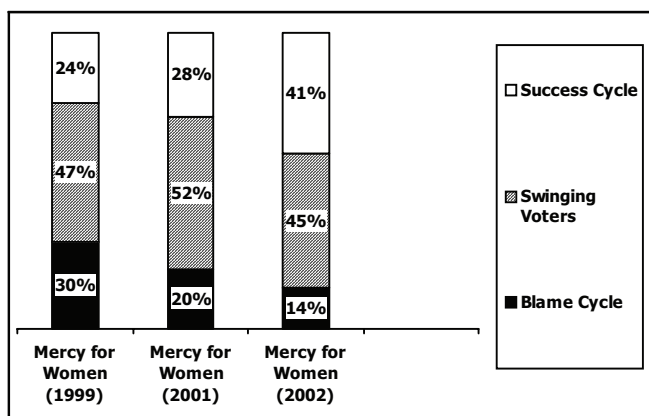| BLAME | REACTION | CONSOLIDATION | AMBITION | SUCCESS |

5 TYPES OF CULTURE

Percentage of respondents who are:

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... Experiencing a Blame Cycle (either personally or throughout their work unit). They are openly negative, pessimistic and disengaged from the organisation's future.

... Swinging Voters. They sit on the fence and are neither openly positive nor openly negative - they just want to come to work to do their job.

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	Mercy for Women (1999)	Mercy for Women (2001)	Mercy for Women (2002)
Success Cycle	24%	28%	41%
Swinging Voters	47%	52%	45%
Blame Cycle	30%	20%	14%

For a full explanation of the model "5 stages of culture (from blame to success)", see <http://www.bpanz.com>. ◆

in the hospital. In this paper, the focus is on applying the vision and goals to the approach we took to relocation of the hospital to a new site in 2005. This major organisational change provided a unique opportunity for individuals and the organisation to substantially expand their capacity to create the hospital of the future that they desired.

There is little literature on the involvement of staff in similar major organisational changes involving relocation to new or different facilities. This made it difficult to learn from the experience of others. However, we set about the planning and subsequent organisational change associated with the relocation of MHW to a new purpose-built hospital in 2005, with the intention of using it as a catalyst for innovation.

A significant investment in staff development commenced, giving staff the opportunity to become involved in several projects and planning activities associated with the relocation. Staff were provided with project management training to assist them in their specific tasks. Additional support was also provided through workshops on diverse topics such as writing for publication, conducting literature reviews, and research and development programs. We also supported the development of a journaling club, and a history and memorabilia project.

The use of team processes was introduced very early in the planning for the new hospital. It was recognised that the best outcomes for the new departments, including layout, interrelationships and functionality, would come from an inclusive approach. Staff were provided with support and time to develop new models of care. Architectural and design support was also provided.

We recognised that the formal learnings from relocation would come from the experiences of staff through their involvement in all aspects of relocation, commencing with planning of the new facility, to the eventual occupation of it. A project structure named "Chrysalis" was developed to engage staff in the process of action learning.[10,11] An arrangement has been established with a major university, offering individuals the opportunity to gain formal qualifications and facilitate sharing of knowledge throughout the organisation using learning to reach their goals.

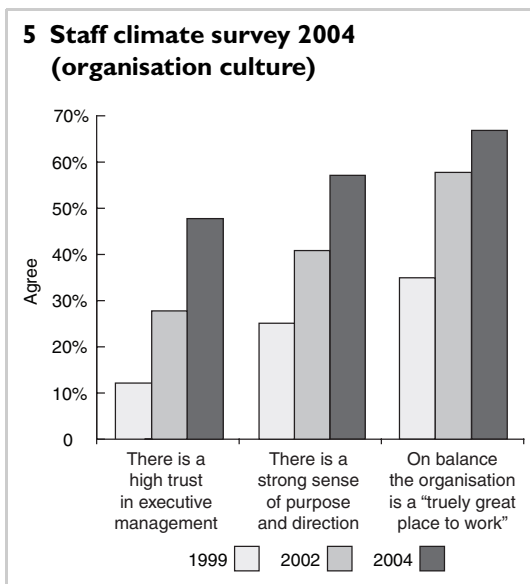## Repeat surveys: improved results

Best Practice Australia replicated the staff climate survey in 2001 and 2002. The 2002 results were very encouraging, particularly in the responses to the question relating to staff trust in executive management. Equally, there had been a very positive, and statistically significant, improved response to the statement that "the organisation is a truly great place to work" with 58% of staff supporting the statement, an increase of 50% since the 1999 survey (Box 3).[8] Of the 350 hospitals in their database, the norm for all public hospitals of 100 to 300 beds surveyed by Best Practice Australia Pty Ltd is 40% of staff agreeing with the same statement. Staff morale had clearly improved.

Best Practice Australia plotted the scores of the organisational culture questions against the scores for the same questions in 1999. These results showed that the organisation had moved away from the culture of blame that was present in 1999, through the "culture of reaction" and into the "culture of consolidation" (Box 4).[8]

A learning organisation

For organisational theorists, a learning organisation is one that has a strong sense of direction, a focus on individual performance and encourages continuous development of the staff.[12] Furthermore, a learning organisation is able to continuously evaluate its performance and look towards further improvements.[12] We found that many of the approaches adopted initially, which were seen at the time as an intuitive or natural approach to dealing with the issues facing the organisation, were consistent with the concept of a learning organisation.

Many authors have described the concept of a learning organisation.[13-19] However, I found little Australian literature that applies this concept to acute health care organisations such as public hospitals.

5 Staff climate survey 2004 (organisation culture)

Although Senge's explanation of the learning organisation appeared early in the development of this literature,[13] the most appropriate description for this hospital of the characteristics of a learning organisation is a summary provided by Kerka.[17] She explains that learning organisations:

> provide continuous learning opportunities . . . use learning to reach their goals . . . link individual performance with organizational performance . . . foster inquiry and dialogue, making it safer for people to share openly and take risks . . . embrace creative tension as a source of energy and renewal . . . [and] are continuously aware of and interact with their environment.

Our management team found that these characteristics fitted very neatly with our management approach and provided a meaningful theoretical framework to underpin our management philosophy. As the management team further explored the concept, it served to reinforce and give clarity to our approach, and strengthen our motivation.

This work continued over the next 18 months with considerable emphasis on providing a continuous learning environment and using this learning to reinforce our goals. We endeavoured

to implement a comprehensive organisational and individual performance management program in specific areas of the hospital, and this approach was well accepted by staff who stated this at open forums.

Final survey results

In order to measure progress, the Best Practice Survey was conducted again in September 2004 and the results continued to improve. I believe that the use of the learning organisation model was fundamental to this continued and sustained improvement in measurement of the organisational culture over a period of 4 years (Box 5).

The latest results show continued improvements across all departments with an overall move through the culture continuum from blame (1999) to consolidation (2002) and most recently to a culture of ambition (2004), moving towards a culture of success (Box 6).
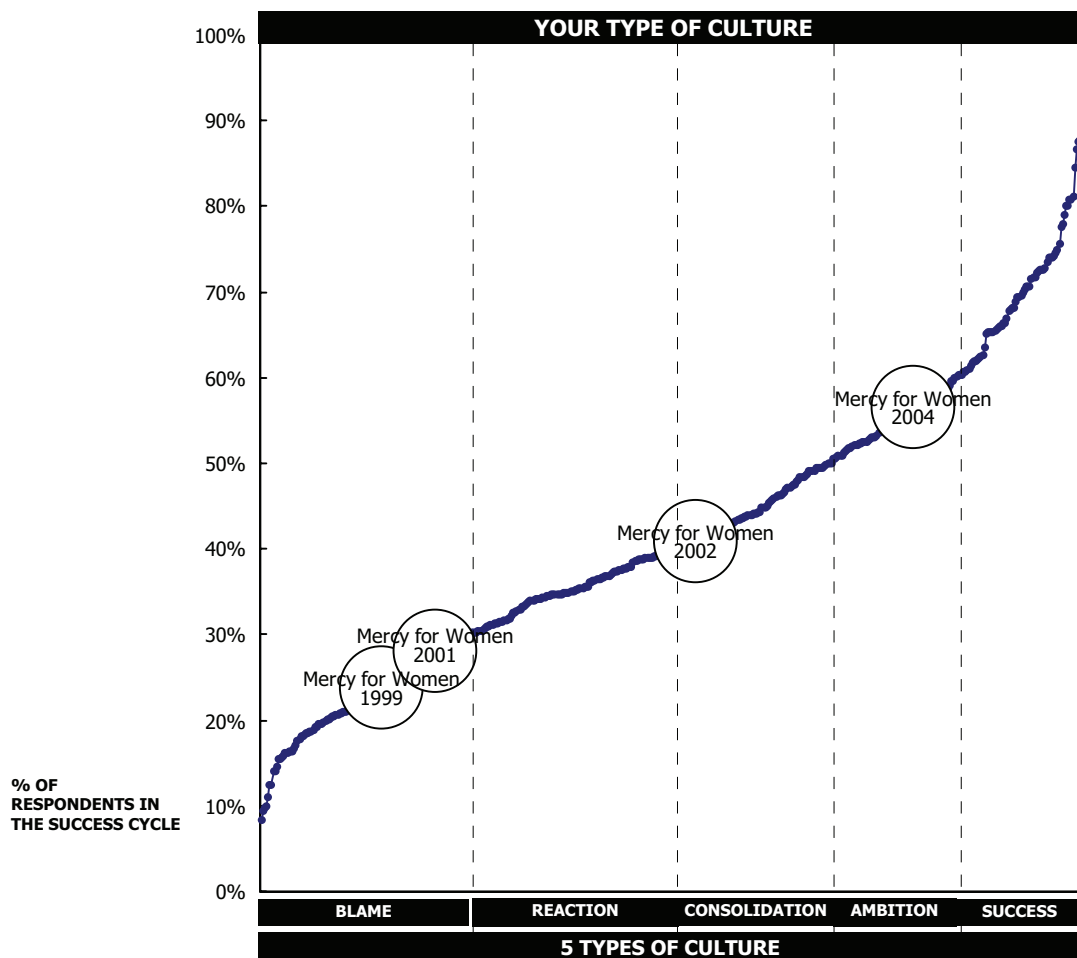
Conclusion

The results of the staff climate survey were both telling and reassuring. It is acknowledged that there is still much improvement to be made in all key performance indicators.

The next steps involve reinforcing the roles of staff, and providing further direction for senior staff. Top leaders and managers should serve as learning role models, sharing their own learning goals and encouraging others to learn, while providing incentives for and rewarding learning and personal growth. Procedures and policies that aim to ensure ongoing and timely re-evaluation of changing job skill-sets and requirements are also needed. Furthermore, individual employees should be encouraged to accept responsibility for their own careers and their own personal learning, as well as being held accountable (and being rewarded) for their performance.

The senior management of the hospital found that the concept of a progressive cultural journey, measured at regular intervals, using the principles of the learning organisation provided a very rich theoretical framework upon which to base our

6 Organisational culture — Mercy Hospital for Women 2004

YOUR TYPE OF CULTURE

% OF
RESPONDENTS IN
THE SUCCESS CYCLE

Mercy for Women 2004

Mercy for Women 2002

Mercy for Women 2001

Mercy for Women 1999

BLAME · REACTION · CONSOLIDATION · AMBITION · SUCCESS
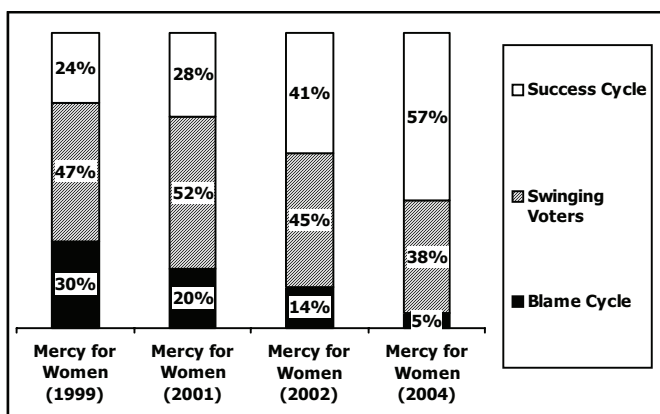
5 TYPES OF CULTURE

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	Mercy for Women (1999)	Mercy for Women (2001)	Mercy for Women (2002)	Mercy for Women (2004)
Success Cycle	24%	28%	41%	57%
Swinging Voters	47%	52%	45%	38%
Blame Cycle	30%	20%	14%	5%

For a full explanation of the model "5 stages of culture (from blame to success)", see <http://www.bpanz.com>. ◆

approach to change. We moved from an initial organic/intuitive approach to issue resolution, to using the concept of a learning organisation to develop a more formal approach to thinking about and leading change. As part of our journey, we found that we understood the theoretical models better after we had grappled with the challenges we faced. Sometimes you have to live the experience before you can make sense of the theory.[20] This is the essence of learning after all.

Note

The data used in this case study were used with permission from Best Practice Australia Pty Ltd.

Competing interests

The author declares that he has no competing interests.

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