Experiment Workplace Innovation in Elderly Care

Three teams developing and implementing their own organizational model

Empirical results

Abstract

By order of the Dutch national association for long term care, ActiZ, the Utrecht University of Applied Science has carried out an Experiment of Workplace Innovation for elderly care to develop a ‘smart’ (Christensen, 2009) innovative organizational model that is intended to improve the quality of care, work and efficiency. BrabantZorg, a large care provider in the South of the Netherlands, was the pilot organization for the experiment. The result is a general methodology that should enable other care providers to initiate a similar innovation process in their own organization (Offereins & Fruytier, 2013). The experiment has finished in the summer of 2013.

The experiment of workplace innovation is unique as the innovation is initiated and developed bottom up by the care professionals themselves together with the clients and/or their families. While working on innovation, they applied the required design principles unintentionally. Managers, board and back-office are required to react on the change process started from the work floor and need to reflect upon their role and adapt it accordingly in order to facilitate the process. The project combines organizational design with change and implementation. The project consists of three nursing teams of BrabantZorg in The Netherlands.

Keywords: Elderly Care, Workplace Innovation, Organizational Design

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Introduction

The Dutch elderly care is changing rapidly in order to bring necessary reforms into force, alike other post-industrial welfare states in Europe (Actiz 2010, Helderma e.a. 2013, Bonoli 2006, Taylor-Gooby 2004, Van Dalen e.a. 2011, Min. Van VWS 2013). Several causes explain both the necessity and impact of the transition. Firstly, there is the demographical cause (CBS...
Our society is ageing rapidly due to the ‘baby boom-generation’. Secondly, the average life expectancy of men and women has increased as well as the prosperity (Poos 2013). Due to these developments it is expected that the demand for care is going to increase rapidly in the near future. Thirdly, the way people look at healthcare and what they consider to be good quality have altered as well. People make high demands on healthcare and living conditions in nursing homes (Wolf 1994). Therefore, it implies not only an increase in volume, but also higher demands on the quality of care. Fourthly, the aversion to the Tayloristic way of organizing the elderly care in order to reduce the rising healthcare costs (i.e. Ipenburg 2011). In elderly care, a strong standardization of care processes and task division have been carried through on the assumption that the care processes could be organized more efficiently. As a response to Taylorism, we currently see a tendency towards small scaled and decentralized organization structures, in which teams are responsible for a broad range of tasks, often in cooperation with clients and their families (Actiz 2010). A final cause is the financial implications of the economic recession and the high urge for retrenchment in order to keep elderly care affordable (RvZ 2012).

Western societies are challenged to preserve elderly care accessible, affordable and of high quality now and in the near future. In order to accomplish this, fundamental reforms and transformations are required. In the Experiment of Workplace Innovation that has been conducted by by order of the sector association ActiZ, the Utrecht University of Applied Science (HU) worked on transformation of the elderly care together with three teams at three different locations of BrabantZorg, a large care provider in the Southern part of The Netherlands.

Researchers and teachers of the HU developed the experiment and facilitated the three teams. The researchers specialized in designing an appropriate organization structure, facilitating the change process and to hand over the initiative to the teams (Kuipers e.a. 2010: 43). The experiment has been conducted between April 2011 and July 2012. In 2013 the effects were measured on the quality of care, quality of work and the efficiency. The experience and lessons learned have been used to develop a universal methodology in the form of a guidance for workplace innovation. In this way, other care providers can learn from the experiment and initiate their own innovation process.

Fundamental to the approach was the fact that care professionals themselves reshaped their organization model and the corresponding way of working. According to Kuipers et al (2010) this is essential to achieve success in organizational change. “In our opinion the organization designs

2010).
its own redesign in the ideal situation. This offers two benefits: in the first place, it will provide more commitment for change and in the second place it gives the opportunity to utilize local knowledge from different parts of the organization in order to shape the new organization model” (idem 43). The executive management needs to trust and let go of control in order to provide as much as autonomy as possible to work on the innovation of care.

Scientific studies on both organizational design and change have been used in the experiment. It was an important objective how to integrate these theories in the approach of the experiment. The question was what the priority should be in organizational change: should the emphasis be placed at the existing organization structure that influences the mindset and behavior of employees, or should it be placed on the mindset and behavior of employees by means of which the design obtains its shape? What do these insights imply for the development of a methodology for organizational change? This is also referred to as the scientific discussion that is called ‘Breaking the code of change’ by Nohria & Beer (2000).

New insights are important to this debate, as it is predominantly the organization structure that forms the impediment for most care providers that have the ambition to innovate. Traditionally, care providers have strongly fragmented care processes. They lack the flexibility to adapt the processes to respond to unexpected problems. Nowadays, the unexpected is the rule rather than the exception in elderly care (Westerberg, 2004, p.p. 67).

Research question

Within the context of the debate about change and design, more knowledge about how to break the code of change can help care providers to successfully design and implement work innovations that improve the quality of care, quality of labor and the efficiency. Therefore, this conclusion results into the following research question:

“What insights does the experiment of work innovation bring forward about a proper fit between change and design in the development of a methodology by means of which an integrated improvement of the elderly care can be achieved?
2 Conceptual background

Exploration of scientific literature

An exploration of theoretical perspectives regarding change and design is necessary in order to compose a conceptual model by means of which the research question can be answered.

If we look at organizational change, three dimensions are relevant according to Achterbergh & Vriens (2010): the functional dimension, the social dimension and the infrastructural dimension (see figure 1).

![Change process](image)

*Figure 1 Dimensions of organizational change (Achterbergh, Vriens en Doorewaard, 2010)*

The functional dimension concerns the actual change of the way work is organized (the ‘organization’), the care professionals who carry out the work (‘human resources’) and the technological resources that they use (‘technology’). This change process passes through the stages of a regulative cycle in a schematic way (Vennix 2004): the diagnosis of the problem, the design of the solution, the implementation and the evaluation.

With regard to design theories the ‘Socio-technical Systems Theory’ and subsequent the ‘Modern Socio-technical Design’ (De Sitter 1994) forms the most important theoretical framework. The reduction of organizational complexity and the minimalization of the need for coordination
by decentralization of tasks and corresponding decision-making at the lowest organizational level (i.e. de teams) is the most important design principle. Key notions in the redesign are autonomy by means of local decision-making, responsibility at team level and coaching instead of hierarchical steering.

The social dimension concerns the internationalization of change by care professionals in terms of their attitude and behavior. This change process passes through the stages unfreeze, change, refreeze in a schematic way (Lewin, 1951):

• Unfreezing – stage of awareness of the problem (‘problem ownership’) and the acknowledge and acceptance of the urge to change.
• Moving of Changing – the change processes at cognitive and emotional level that result into new and altered behavior (and vice versa).
• Refreezing – stage of integration by means of experiencing the new situation.

The most important change principle is the participation by care professionals from the beginning of the organizational change process. Participation is indispensable to pass through the stages that continuously overlap and repeat in a successful way (Lewin 1947, Schein 1987).

The infrastructural dimension finally is not concerned with the achievement of results in change and design, but regards the approach of organizational change in order to achieve the functional and social objectives. This can be the alteration of the organization structure, the intervention in Human Resource-measures or the intervention regarding the use of technology (Achterbergh, Vriens & Doorewaard 2011).

The most important question, however, is how organizational change should be approached in a way that both the functional and the social dimension get the attention they need in order to make the organizational change a success. This is the key question that scientists struggle with for a long time (e.g. Mintzberg 1979).

This scientific discussion leads to the following conceptual model that contains the most important notions:
<table>
<thead>
<tr>
<th>Interventions</th>
<th>Functional dimension ('design'): Diagnosis, design, implementation, evaluation</th>
<th>Social dimension ('change'): Participatory change</th>
<th>Result: Quality improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructural dimension:</td>
<td>• Organization structure</td>
<td>• Reduction of organizational complexity</td>
<td>• Unfreeze, change, refreeze</td>
</tr>
<tr>
<td>• Human Resources</td>
<td>• Minimalization of need for coordination</td>
<td>• Decentralization of authority</td>
<td></td>
</tr>
<tr>
<td>• Technology</td>
<td>• Autonomy</td>
<td></td>
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</tbody>
</table>

Figure 2 Conceptual model for the approach of organizational change
3 Method
Design and sample

Care professionals at three nursing homes of BrabantZorg have been given the full autonomy to discover and develop their dreams and ambitions for future geriatric care together with clients and their family. These dreams were rough sketches that proved to be relevant as connecting threads during the whole experiment.

The Utrecht University of Applied Science (HU) supported the translation of dreams into a design for the new organizational model. The teams put in the details gradually by means of which the design obtained its shape. Besides, the HU observed the change process and committed it to paper. These observations provided a lot of useful information about the team development and the change process.

The effects of the experiment were measured by means of quantitative research based on the nationwide benchmark on elderly care (Actiz 2012) and by means of qualitative research based on interviews with care professionals, clients and their family, volunteers and managers. In addition, during the experiment the change process was monitored, described and filmed on a regular basis.
4 Results

In this section the results of the experiment will be discussed in two ways: firstly, the results of the three pilots will be presented as well as the effects on the quality of care, work and organizational management. Secondly, the insights that contribute to the discussion about the appropriate balance between design and change in the methodology will be explained.

Results of the Experiment

The experiment of workplace innovation produced three new organizational models that have been developed and implemented by the three nursing teams: one team developed the concept of family participation by means of which they provide the care for clients in close cooperation with their families. They use a digital community to keep them involved. Another team started working in autonomous teams that each had the responsibility for a small group of clients. They introduced iPads to simplify administrative tasks and to spend more quality time with the clients in their apartments. Finally, the third team decided not to make use of positions and levels of professionalism, but to focus attention on team member’s individual qualities and creativity.

Effects on quality of care, quality of work and efficiency

One year after the experiment was completed, changes are clearly noticeable. Care professionals seem more self-confident and show entrepreneurial behavior. They communicate and consult with families of clients more often. Clients experience the nursing home to be more quiet and peaceful and notice that care professionals get in touch with them more often. They give a higher rating to the quality of care and indicate that they have a greater say in the care they receive. They absenteeism of all three teams decreased considerably in two years’ time: the absenteeism of one team even decreased from 8,66% in 2011 to 0,25% in 2012. The autonomous teams indicate that they now have more time to pay attention to clients and to improve their well-being. This seems to imply that these teams now work more efficient compared to the situation before the experiment.

Insights in the fit between change en design

In order to set up the experiment, researchers choose the intervention through Human Resources. The emphasis was placed on team development, not on organization structure or technology. The approach was characterized by a participative way of change and design that was executed by
care professionals themselves. There was no top down coordination that determined the content or direction. It was the teams’ initiative from the beginning till the end. The experiment provides essential insights in the fit between change and design that has been the result of the choice for the intervention through this type of intervention.

In the first place, it became apparent that loosen up care professionals from their daily routine was necessary to utilize their creativity (unfreeze). It took several months to let go of old patterns and to be able to think without any limitations. Subsequently, the teams became aware of their shared values and corresponding behavior that they expected from each other. This change process became necessary to go on with the design process. The design process was relevant for determining the collective goal and ambition: a rough sketch containing all of their dreams that was indispensable to hold on to the enthusiasm and to hold into sight their common objective.

The second insight is the observation that regulative cycle proved its value predominantly in the practical realization at small scale: the cycle was passed through by the teams innumerable times by dividing big ambitions in well-organized small parts, after which the teams developed the plans and completed the details. Realizing the plans, making the results directly visible, discussing the process and move on to the next ambition: it was a process of learning by doing and personal growth of the care professionals. It required intensive support by experienced facilitators and coaching by team managers. They managed to facilitate the design and change process by asking questions, stimulating care professionals to find their own solutions for problems and by placing the decision-making in the teams. In this way, by working on the design of their new organizational model, they simultaneously worked on the change of their knowledge, attitude and behavior.

A third insight is the relevance of the facilitator’s expert role in making the translation of the team’s ambitions and dreams into design principles for the new organizational model. For example, the team that had a common dream to work in autonomous teams, needed support and guidance from an expert: their current organizational model hampered the team in realizing their dreams. The facilitator reduced the complexity of the organization structure by reviewing their organizational model and subsequently interfering in their way of working. He suggested to start working differently, but gave back the initiative to the team immediately. In this way, the facilitator gave the initial impetus to form the autonomous teams, but left the composition of teams to the care professionals.
Finally the insight that care professionals are only ready for utilizing the autonomy to work on their dreams and take on the responsibility for the realization, when they experience full ownership for the workplace innovation. Situations of setbacks and subsequent resistance to the change and design process appeared to be a useful and valuable experience. It became apparent that the care professionals were able to make great progress with regard to the care processes as well as their personal growth. The three teams showed impressive results with concern to the organization structure and the use of technology, whereas these instruments have not been used as an intervention itself. Technology was implemented because it was the teams’ ambition, not a managerial decision. As a result, there was a rapid adoption of iPads and a digital community.
5 Conclusions and discussion

In this paper we have discussed the insights in change and design processes that the experiment of workplace innovation put forward. Our research question was whether these insights contribute to the discussion about change and design in order to develop a general methodology for workplace innovation.

One of the most important implications of this experiment is the finding that the intervention by means of human resources may reap success, but that you cannot work without either the organization structure or the change process. There was a continuous interaction between the change of mindset and behavior on the one hand and the design of new organizational and labor configurations on the other hand.

The change process however, was most fundamental to initiate the design process for the new organizational model. It facilitated the care professionals to let go of their working routines and to create and adopt new ideas, new ways of working and taking the ownership for the innovation process. In order to do this, they first had to alter their mindset, values and behavior.

Moreover, it became apparent that the teams were not able to reduce the organizational complexity on their own. They needed a strong facilitator who supported the change process but who also was expert in making the translation from the care professionals’ dreams about their nursing home into design principles. By working on their dreams step by step they made themselves familiar with the new organizational model and corresponding ways of working. Only then they were able to take full ownership and effectively use their autonomy.

The study emphasizes the need to conduct a thorough study of scientific literature on change and design processes by means of which these results can be explained and takes a position in the scientific debate on organizational change in elderly care. This will be initiated in the PhD-study by the researcher in the next years.
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