EXPLORING THE ROLE OF REFLEXIVITY IN THE CHANGE PROCESS OF INTERCONNECTED ORGANIZATIONAL ROUTINES

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ABSTRACT
Analyzing the change of organizational routines in a public health care organization, this paper contributes to a better understanding of how organizational routines change when a network of interconnected routines is affected by a change initiative. We focus on the role of reflexivity (Feldman, 2000) and individual as well as collective agency (Howard-Grenville, 2005) in different stages of the change process. We identify the establishment of reflection routines as a key success factor for implementing routine change and enabling continuous adaptation of organizational routines. The process of “routinizing reflection” that we observe in our empirical case explains how collective reflection becomes established within an organization and how it drives the change of organizational routines not only as temporary episodic change but as a basis for ongoing continuous adaptation of routines.
INTRODUCTION

Analyzing the change of organizational routines in a public health care organization, this paper contributes to a better understanding of how organizational routines change when a network of interconnected routines is affected by a change initiative. We focus on the role of reflexivity (Feldman, 2000) and individual as well as collective agency (Howard-Grenville, 2005) in different stages of the change process. We identify the establishment of reflection routines as a key success factor for implementing routine change and enabling continuous adaptation of organizational routines. The process of “routinizing reflection” that we observe in our empirical case explains how collective reflection becomes established within an organization and how it drives the change of organizational routines not only as temporary episodic change but as a basis for ongoing continuous adaptation of routines.

We understand organizations as active accomplishments (Czarniawska, 2008; Feldman, 2000; Hernes, 2008; Tsoukas & Chia, 2002) resulting in temporal social orders based on and shaped by their repertoire of organizational routines (Grand, Rüegg-Stürm, & von Arx, 2010). We use insights on organizational routines and the role of reflective agents in routine performance (Feldman, 2000; Feldman & Pentland, 2003) to explore the role of reflexivity in a change initiative involving the change of several inter-related routines. A change initiative requires not one, but several individuals to perform, reflect upon and adjust their performances (Feldman & Rafaeli, 2002). We focus our research question on how reflective routines unfold over time in a way that they connect periods of episodic and continuous change.

Our research question explores how a bundle of interrelated routines can change in an enduring way. Enduring refers to the successful implementation of change as well as providing mechanisms that facilitate future adaptations of routines and creation of new routines if
necessary in order to adapt to changing contextual factors inside and outside an organization. We identify that a change process of such scale needs to address the overall schema which is the shared frame of reference actors draw on when performing routines. Furthermore, we identified reflexivity as a key driver of successful routine change and creation. The actors performing the routines that are to be changed or created need to act as reflective agents and reflection needs to be formalized in some kind of meta-routines in order to institutionalize reflexivity that assures reflective performance and adaptation of routines.

Therefore, our study furthermore aims at contributing towards a better understanding of the interrelations between episodic and continuous change. Previously often viewed as a dualism, some authors have acknowledged that processes of episodic change in the form of temporal change initiatives interweave with continuous change happening during ongoing daily organizing processes (Langley & Denis, 2006; Orlikowski, 1996; Weick & Quinn, 1999). However, it remains unclear how such interweaving unfolds over time. In our empirical case the change initiative originally designed as episodic change had the purpose of increasing efficiency and service quality in the hospital and this would only be successful in the long-term if the change momentum would be kept up beyond the time of the immediate change initiative.

We draw on data from a 3 year single case study in a public health care organization analyzing how the organization managed to trigger and manifest change dynamics in core organizational routines in the nursing department after a merger of two hospitals. During the observed period between 2003 and 2006 with a direct observation in the field from May 2004 until February 2006, the merged hospitals had started several attempts to initiate changes in the smaller hospital unit in order to improve efficiency of processes associated with better patient care and more cost effective structures in the unit.
As pluralistic organizations, hospital settings seem particularly appropriate in studying the role of reflective change agents because of the relative autonomy of departments and clinics. Due to the knowledge-intensive work of hospital professionals, change initiatives cannot solely rely on coercive forms of implementation, but also require collaborative ones (Denis, Lamothe, & Langley, 2001; Langley & Denis, 2006). Change initiatives in these settings therefore often involve altering professionally attached patterns of behaviour and interaction (Denis et al., 2001). Thus, the role of reflection becomes more salient in order to relate episodic and continuous change (Orlikowski, 1996).

THEORETICAL BACKGROUND

Following a sociological turn on the study of routines (Feldman, 2000) recent routine literature addresses organizational change mostly as continuous change arising within routines through routine performance and reflection upon these performances (Feldman, 2000). Feldman & Pentland (2003), Pentland & Feldman (2008) define routines as generative systems. Taking a process perspective, routines are repetitive action patterns to which multiple actors contribute (Feldman & Orlikowski, 2011; Feldman & Pentland 2003; Pentland & Feldman 2008). The notion of generative system highlights the internal dynamics of a routine that leads to both change and stability as a result from the mutually constitutive relationship of the performative and ostensive aspects of routines.

The endogeneous view complements the widely-held exogeneous one. The exogenous view follows a traditional evolutionary perspective on routines as stable and reproducible constructs crucial for the reproduction of an organization (Becker, 2004; Cohen et. al., 1996; Nelson & Winter, 1982; Nelson, 1994) and highlights change in routines as response to 'external
shocks' such as, for example, technological developments that require adaptation of routines 
(Nelson & Winter, 1982: 130; see also Cohen et al., 1996). Only in 'exceptional' situations does 
an organization realize the need to reflect on a routine, "as long as an existing routine gives 
satisfactory results, no conscious cognitive problem solving is triggered to find another way to 
The problem-solving which might lead to innovation is often initiated by persons which are not 
part of the original routine, but external actors called in (Nelson & Winter, 1982).

A sociological view on routines developed in response to the shortcomings of 
evolutionary routine theory to further explore the full change potential of routines. The 
sociological view shifts the focus away from external shocks as single source of routine change 
and instead promotes incremental continuous change processes within routines thus giving more 
weight to the ability of actors to reflect upon routine performances and initiate changes 
(Feldman, 2000, 2003). Thus, "change occurs as a result of participants' reflections on and 
reactions to various outcomes of previous iterations of the routine" (Feldman, 2000: 611).
Learning in routines occurs because, "people who engage in routines adjust their actions as they 
develop new understandings of what they can do and of the consequences of their actions" 
(Feldman, 2000: 613). Thus, the role of reflexivity is identified as a central change driver. With 
agency, actors expand, repair, or alter their performance that may lead to an adapted pattern of 
practice when repeated (Feldman & Orlikowski, 2011). Howard-Grenville (2005) adds an 
additional layer of individual versus collective performances and points to organizational 
embeddedness of routines influencing performance on both levels of all involved actors. The 
analysis of learning processes in routines thus needs to involve both, individual and collective 
learning processes.
This traditional separation of traditions with two seemingly opposite change perspectives led to dichotomies such as exogenous versus internal change, episodic versus continuous change. However, these distinctions might be more a questions observational perspectives rather than real dichotomies (Weick & Quinn, 1999): looking from far away change appears to occur episodically, while looking from close range, change appears a continuous property of organizing itself. Therefore, there seems to be a need to further explore episodes of deliberate change attempts (episodic change) and their interweaving (Langley & Denis, 2006) with continuous change considering routines and non-routine action as potentially altering organizational routines (Pentland & Feldman, 2008).

The interest in exploring deliberate attempts to alter routines emerged only recently (Pentland & Feldman, 2008) and insights are limited to what promotes failure in changing routines such as a change focus on artefacts and ostensive dimensions of routines that might not always trigger changes in the actual performance. Furthermore, Zbaracki & Bergen (2010) point out that the relatedness of routines to one another may hinder change. Their study analyses how customer routines of taking out trash prevented a change in performances of collecting trash, thus triggering routine change only in relation with other routines.

Besides a need to overcome dichotomous views on organizational change, there is an equal need to further explore the concept of reflexivity. While the literature has accepted a view on routines beyond automatic operating procedures but rather involving reflective actors, we know little about different qualities or degrees in reflexivity and how these might be triggered or how these effect routine change. Furthermore, we still know little on how such reflecting and experimenting takes place when several routines are involved and how collective reflection emerges and turns into reflective routines. Therefore, this paper aims to address the need to
further research the creation of routines (Parmigiani & Howard-Grenvill, 2011: 447) to explore how reflection emerges as a collective, organizational phenomenon, e.g. how a shared understanding, or at least a compatible understanding between a collective of actors emerges (Dionysiou & Tsoukas, 2013). This requires to move beyond a focus of studying individual routines but rather considering bundles of interrelated routines to, for example, explore how reflection takes place when the actors are not all present, when the deliberate change concerns several routines, and involves a shift of schema or the shared assumptions according to which organizational members make sense of their routines in practice? In co-presence, two or more involved individuals can develop mutually held expectations and compatible understandings of a routine (Dionysiou & Tsoukas, 2013) as a result of learning about different schemata that routines express (Rerup & Feldman, 2011). Schemas thereby represent shared assumptions and values organizational members hold with regards to their organization (Rerup & Feldman, 2011). An organizational schema serves as a reduction device according to which organizational members interpret the routines and other non-routine action and events they perceive (Balogun & Johnson, 2005: 525) and is defined as a set of “shared assumptions that give meaning to everyday experience and guide how organizational members think and act”(Rerup & Feldman, 2011: 578). Reflecting on and shifting schemata seems a necessity to change routines but is at the same time particularly challenging because of the recursive relationship between schema and routines (Bartunek & Moch, 1987). The proposed new or changed routines are often interpreted within the shared assumptions of the present schema. The result may be that no change takes place in the routines (Pentland & Feldman, 2008), that misunderstanding and conflict emerge and persist (Bartunek & Moch, 1994), that sensemaking fails (Ericson, 2001), or the new routines do not make sense at all within the present schema (Barrett, Thomas, & Hocevar, 1995).
Like an artefact or the ostensive dimension alone, a schema requires to be enacted. Therefore, deliberately creating new or changing routines somehow involves a simultaneous shift in schemata. How do such processes unfold?

Therefore, we formulate the following research questions for this study: How do interrelated organizational routines change over time and why are some change initiatives limited to episodic change while others enable continuous change in order to successfully adapt organizational routines in the future? What is the role of reflexivity and creation of reflective routines in successfully changing organizational routines?

**METHOD**

**Research Setting**

Our study represents a 3 year single case of a public health care organization that tries to implement crucial changes in the hospital routines after a merger of two independent hospitals. This research case seems especially insightful to analyse change dynamics of interrelated bundles of routines for a number of reasons: First, pluralistic organizations, like hospitals, are promising for studying not single, but different types of routines. Their medical and nursing work is quite prominent and involves different organizing routines (Glouberman & Mintzberg, 2001) that relate to different schema within the organization. Second, a restructuring case fundamentally aims to alter both caring and organizing routines and is therefore promising to study the emergence and the deliberate change and emergence of routines (see also Denis et al., 2001; Jarzabkowski, Le, & Feldman, 2012). Third, the prolonged and open access of our research partner over a considerable period of time enabled us to generate real-time data and to closely follow the initiative (Langley, Mintzberg, Pitcher, Posada, & Saint-Macary, 1995). Such
real-time data helps to what Pettigrew (2012) calls catching reality in flight and thereby provides rich data and insights.

**Data Collection and Analysis**

Our data set includes real-time observations, semi-structured interviews, and documentary data to allow for triangulation (Eisenhardt, 1989; Yin, 2009). The field phase dated from April, 2004 until February, 2006. Data was gathered by a team of two persons including the first-author to allow for triangulation. A journal contained our field notes on observations, of meetings as non-participant observers, our own interpretations and numerous informal conversations. Seventy-three observations were made, including ward meetings, meetings of nurse leadership and a one-week ethnographic visit on a ward of surgery and of internal medicine in both hospitals. These observations were validated by participants in 28 feedback sessions. We conducted 80 semi-structured interviews of one to two hour length regarding the interviewees’ understanding of the hospital merger in their work and organizational context. The interviews encompassed different professions involved and all hierarchical levels. Interviews with key informants were repeated between two and six times. All interviews were transcribed. Access was granted to 69 documents including conceptual papers, minutes, annual reports and email correspondence.

Data was analysed taking a process perspective (Langley, 1999): First, we developed a case history making use of visual mapping. After analyzing the documents, we incorporated our field notes to connect events, decisions and on-going developments. In order to understand the arising case history from the practitioners’ perspective, the informal conversations and interviews were incorporated in order of occurrence.
Second, applying temporal bracketing, we identified three distinctive episodes of change. For each episode we analysed key events and actors and explored the different levels of individual and collective reflectiveness in the light of changes in performative and ostensive aspects of routines. It was at this stage that organized reflection and reflective routines emerged as important in our analysis. Furthermore, we identified the professional understanding and underlying assumptions of nurses with regards to caring and organizing routines by analyzing their daily work with patients, supported by literature on pluralistic organizations in general (Denis et al., 2001; Jarzabkowski & Fenton, 2006; Denis & Langley, 2007), and on hospitals in particular (Glouberman & Mintzberg, 2001) because our data suggested the importance of the embeddedness of routines within the organizational context (Howard-Grenville, 2005). As to the routines themselves, we coded the data in terms of who does what, when, and how.

Insert Table 1 about here

The third phase was to validate the findings with peers and practitioners. Workshops with the practitioners of the three professional domains were organized to enhance the reliability of our findings.

Case Context

Our case analyses the integration of the nursing department of a small regional hospital (Reho) into that of a large hospital (Laho). As a measure to enhance economic efficiency the public owner announced to integrate Reho and Laho, the process of which ranged from 2002 until 2007. The integration mainly involved Reho departments and clinics to adapt to those of Laho located in the state capital with ca. 70,000 citizens. Reho is situated 20 KM apart in a rural
city of 9,000 inhabitants. Together, both hospitals are among the ten largest providers in Switzerland. In 2005, 445 medical doctors, 964 nurses and 884 support staff members treated ca. 60,000 patients in residence, and 70,000 in day care with 753 beds overall. Budget-wise, Laho is about nine times as large as Reho. Reho is an acute hospital, whereas Laho additionally offers special services in treatment, research and education, similar to a university hospital.

During the observed episodes between 2003 and 2006 the merged hospitals had started to initiate changes in the organizational routines in the smaller hospital unit in order to improve efficiency of processes associated with better patient care and more cost effective structures in the unit. The goal of this episodic change process was to transform care and organizing routines in the hospital unit and replace established inefficient processes with a new set of organizational routines. This initiative was triggered by the critique of the head surgeon at Laho regarding lacking nursing professionalism at Reho. The group of surgeons at Laho had identified deficiencies with regards to the nursing services at Reho and found it challenging to initiate changes in order for Reho nursing standards to live up to procedural standards at Laho. What seemed especially challenging was to create awareness for the need to change and to involve nursing staff at Reho actively in implementing changes.

“The really difficult step was the nursing unit. How to, if I may say so, wake them up from their state of sleeping beauty and to force them into our procedures.” (leading surgeon at Laho)

**FINDINGS**

After initial challenges to initiate changes at Reho we observe multiple interrelated care and organizing routines that are changing in the nursing department. We structure our analysis of the observed change process into three episodes: (1) The first episode represents a failed attempt
to impose change on the hospital by external change agents. (2) In a second episode a head nurse from the large hospital becomes part of the actors at the smaller hospital as the “Director of the wards”. In this stage routine change starts to pick up primarily on a performative level. (3) In a third episode, the director of the wards becomes the regional nursing director. Routine change is on-going involving both changes in the performance of routines as well as changes in the ostensive aspects of routines.

The interrelated routines are associated with a particular schema (Rerup & Feldman, 2011; Feldman, 2004; Bartunek & Moch, 1987). The schema expresses the way caring and organizing routines are performed before and after the change initiative. They provide different shared frames of reference and meanings to the professional actors in terms of a “family” schema before and a “professional” schema after the change initiative. Changing the overall schema seemed central in implementing change that goes beyond adjustments of single routines. Implementing the change rather manifests in a dynamic involving an ongoing assessment of many interrelated care and organizing routines which required the collective of actors involved in performing these routines. Therefore, the shift in the overall frame of reference (schema) goes along side changes in the performative as well as ostensive aspects of existing care and organizing routines including the creation of new routines. Such new organizing routines specifically encouraged reflection upon the operational routines in place.

In the following paragraphs we will first compare the “family” and “professional” schemata. In a second step we will explore how the change process evolved from one schema to another by focusing on the enhancement of reflection by changing existing routines and by creating new routines. Table 2 provides a summary of these findings.
The Performance of Care and Organizing Routines under the “Family” Schema

Particularly during the beginning of the change process, the nurses enacted a family schema. Caring within the family schema meant that sick people should “feel good around here”. Nurses used phrases like “cosy”, “snugged in here” and “family” to describe the atmosphere on the wards. According to the nurses, the “family” atmosphere is what their patients favoured. The work on patients was prioritized before all other tasks including organizing ones. Some nurses even reported a tendency for “self-sacrifice” in order to make patients feel good. To illustrate the family schema, the first author observed the following incident:

On a busy day in late November, I rush after a senior nurse along the hallway who gathers blood samples of various patients, checks medications, and tries to reach a colleague on the phone to help out the next day, while her co-workers distribute dinner to the patients. Stopping short in front of one patient room, she slows down, and quietly opens the door. We enter the darkening room. The nurse greets the middle-aged lady in her pyjamas by name in a low voice. She sits down gently besides her on the bed, the dinner tray in front, and begins feeding her calmly small portions of mashed potatoes and cooked vegetables. No word is spoken, and after a while the lady puts her bald head on the nurse’s shoulder and sighs. Feeling like an intruder I leave the room. After her return, the nurse explains that the lady suffers from the ultimate stage of cancer. She dies a week later. (Observation note)

The relation of nurses and their unit expressed the family schema in two ways. Relations among nurses and between the different wards were rather informal so that people found the time to chat with each other and visit friends of other wards for coffee during the day. Also, work shifts were structured towards work-family compatibility, called a “portioned” shift. Here, a nurse worked in the mornings, and early afternoons with a three hour break at midday, which
was particularly convenient to “go home, cook for the children and then come back to work”. Likewise, the afternoon shift was portioned so that a nurse worked on midday for three hours, and returned to work after her morning colleague had left in the afternoon. At night, a reduced number of staff performed the so-called “night watch” monitoring patients.

In relation to medical doctors, the family schema emphasized close cooperation and subordinate support. One needed to be “friendly with the clinics”. Close cooperation was considered a sine qua non as the regional nursing director explained: “you have to cooperate closely. If not, everything goes down the drain”. In daily work on the wards, such close cooperation meant that medical doctors not only gave instructions to nurses with regards to specific patient treatment, but also on organizing topics including schedules for their ward visits, admission of additional patients, etc. Overall, the “family” of nurses were considered an important but subordinate support function to the medical doctors.

Caring routines followed a so-called “functional nurse concept”. The nurses focused on particular tasks, like checking the vitals of patients (pulse, blood pressure, and pupil reaction to light changes), taking blood samples or body secretions for analysis, treating wounds, besides supporting patients in their daily hygiene activities, in eating, or by taking time for conversations. A nurse explained the downsides of the functional nurse concept: first, there was a risk of losing information over the numerous handovers from the outgoing to the incoming nurse. Second, the patients sometimes did not know who was responsible for them since they interacted with a number of different nurses, medical doctors and other healthcare professionals during the day. Third, when a nurse could not immediately respond to a patient’s question but had to confer with colleagues, “patients gather the feeling [they] are incompetent”.
The focus on making the patient feel good in a family like atmosphere had consequences for organizing routines including documentation tasks, planning processes or other so-called “administrative” routines. “Administrative” work was a devaluing phrase on the wards because this type of work was not considered “real” work. Instead, nurses understood “administrative” routines taking time away from doing the real care work. As a result, “administrative” work was often postponed to overtime hours. Head nurses reported that they often planned the staffing for shifts at home. Such man-power planning was referred to as the “wish plan”, aimed to address the preferences of the nurses to handle family issues for example. Likewise, documenting nursing activities consistently and timely in order to generate internal billing to clinics and to provide information on the nursing unit’s work capacity and performance, was rather perceived as an unwelcome distraction from patient care.

“When I work with the computer, my team does not consider that work ... they think that I am not really working”.

“They do not see much sense in such things as documenting their care activities.” (nurse expert sent to evaluate Reho)

“I have the feeling: I do something, and I need to document it, again and again. The documenting takes more time than the doing”. (Reho nurse)

“I don’t like all this organizing and coordinating people because it keeps me away from spending time with the patients on the ward.” (vice head nurse at Reho)

While nurses emphasized the positive aspects of performing under this family schema they also recognized disadvantages and inefficiencies generated in the way nursing and documenting routines had been performed. For example, inefficiencies were connected with time for chatting. Chatting could lead to gossiping as a nurse recalled: “There is less time for sitting around and chatting now [after the change initiative]. But the gossiping became also less.”
The priority to caring also affected feedback routines. First, the functional care concept diffused the personal responsibility of a nurse towards an individual patient because her responsibility lay in performing a specific function. Therefore, as a nurse explained informally, the nurses could “hide” behind the team. Furthermore, feedback on performing caring routines was not an integral part: “we hardly have the situation that we are two people at the bed and then provide each other feedback on what went well and what each of us could improve.” Such feedback happened on rare occasions, ad-hoc and on an individual. As organizing routines, a continuous and integral feedback would have been considered a distraction from the “real” work to care for the patient.

In order to enhance the importance of organizing routines and the space for feedback or reflection on the operational tasks the change initiative required to shift towards a “professional” schema. The challenge was to convince the collective of actors that an increased focus on organizing routines including designated room for feedback discussions and reflection on operational routines would not necessarily happen at the expense of care quality but in contrary help to provide better care.

**The Performance of Care and Organizing Routines under the “Professional” Schema**

According to the Laho nursing director the key goal of the integration was to “professionalize nursing” at Reho. Within a “professional” schema, caring routines should meet state-of-art medical and nursing science standards. Professional caring involved work with patients, continuous administrative work and on-going improvement of nursing standards as well as development of administrative and leadership expertise.

The professional schema substituted the “functional nurse concept” with a “primary care concept” by assigning nurses responsible for specific patients. This meant that a nurse looked
after her patients from the moment they entered the hospital up to ensuring necessary after-treatment or care with their departure. The primary care nurse coordinated the professional treatment activities of anamnesis, diagnosing, and caring with the different medical and nursing professionals. Assigning specific responsibility for patients and related actions was central to primary care.

“they cannot hide behind the team anymore when something goes wrong, but have to stand up to their responsibility individually.” (nursing director of Laho)

“[Nurses] become a sort of control also of our therapy decisions. Four eyes see more than two. Also, I focus on the physiological aspects and the nurses look after all the psychological and other such issues.” (medical doctor)

“Overall, the medical doctors of course give us the medical instructions on particular patients, like medication or taking blood samples and the like. But, first, there are care functions like food provision, hygiene support, and patient mobilization that are purely up to the nurses. Here, the medical doctors are not allowed to give orders, also not on how we organize ourselves. That is entirely in our responsibility. They cannot just go to ward and say: I want this and that done differently.” (nursing director of Laho)

Furthermore, the leadership responsibilities of head nurses increased in contrast to the distributed responsibility under the family schema:

“With primary care, the head nurse has to be the head of her team. She has to assume the responsibility, and stand in front of her team and tell each nurse: ‘You are now responsible for this patient over the next five days.’ But many find that difficult to do because they are so used to working with the whole team assuming the responsibility collectively. And now, the nurse responsible for the patient has to decide with the patient, what is best for him, and then ensure that this is done that way even when she is not at work. And the head nurse needs to look after her team members doing this.” (director of the wards)

The professional schema affected the way organizing routines were perceived and performed. Administrative work on the ward was now seen as integral to running a ward. Accordingly, head nurses were granted one full work per week to use for administrative routine tasks. Documenting care activities timely and consistently, for example, “helps to demonstrate all the work we do for the patients” (nurse). The collected data was fed into a monthly report for
the nursing director about the overall care activities providing the bases for billing the clinics internally. This data also offered a consistent overview of the patient population, entries and exits. Finally, the monthly report held insights to the degree of workload, important when arguing for new nursing positions in the hospital’s annual budgeting. This new understanding and valuation of nursing work was significant in times of resource constraints because personnel costs associated with nursing made for a large portion of overall costs.

Professionalization was also visible in manpower planning routines which were oriented towards the needs of the nursing department and less towards the personal wishes of nurses which had previously been considered a form of compensation for the hard labour but also led to inefficiencies in workforce planning. The professional understanding of man-power planning was supported by re-structuring work shifts that reduced the number of handovers, a known source of potential errors. The 3 shift work days replaced the previous portioned shift structure. The new structure contained a morning, afternoon, and night shift, reducing the number of handovers and allowing for only a 45 Minute lunch break.

The man-power planning routines are an excellent example of showing conflicts that arise based on the family-schema guiding Reho nursing. For a head nurses, man power planning was complicated because team members had a lot of over time to compensate, different degrees of part-time contracts, already granted vacation etc.

“I have to do the [staff plan] now. But many of my team request vacation and there are so many individual wishes. ... But it is just impossible to plan the month to everyone’s liking.” (head nurse)

“There is no clear line. Everyone does whatever he or she wants because nobody feels responsible. Head nurses need to jump in when others don’t want to work. For example she doing a night shift because nobody else is ready to do so, then she takes a day off to come in another day again because she had filled another gap in personnel, then she
works 10 days in a row. You know, that does not work. You can’t lead in this way.”
(Director of the wards)

In alignment with the previous family schema man-power planning traditionally reassembled a wish-list trying, for example, to accommodate every nurses preferred working and vacation schedule. The situation escalated during our observation period in July, 2004, and 2005, when the wards lacked personnel during summer vacation due to these planning routines. This meant that all change efforts during these periods were suspended and everyone on the ward helped to assure operations at Reho. Consequently, stricter controls and double checks on staff-plans were introduced to avoid similar situations in the future.

Change Episode 1: A Failed Attempt to Impose Change

The following account of episode 1 begins with the event triggering the change initiative at Reho in May, 2003 (the head surgeon critique on Reho nursing) and ends in June, 2004. The integration of Reho’s nursing into that of Laho started out by aiming to copy Laho’s professional standards. This process was led by the nursing director of Laho complaining about inadequate professional standards at Reho and carried out by two specifically assigned nursing experts send to Reho. On Reho’s side, the regional nursing director was sceptical towards the planned changes, and so were the head nurses:

“At first the surgeons assured us that there were not too many changes. But then it became more and more. We felt like being eaten alive.” (Reho head nurse)

In consequence, two nurses from the surgical department of Laho were sent as nursing experts to visit their colleagues at Reho for ten days. The nursing experts participated in daily work and felt “heartily welcome, even though [we] were the outsiders” (Laho expert nurse) and found that the Reho nurses “were happy [we] came.” During their visit, the nursing experts focussed mainly on the caring routines, like patient mobilization or wound treatment.
Additionally, the two expert nurses assessed other organizing aspects of the work such as the handling of patient information in patient files or the ordering of material, and managing bed capacity to evaluate documentation procedures and information flow at the Reho nursing department.

Based on their analysis, the nursing experts prepared a report which they presented to the nursing directors of Reho and Laho in August, 2003. The report – headed “measure catalogue” and written in passive voice - contained a list of required changes in nursing standards. For example, the wound treatment and the pain treatment were to be “removed” and “replaced” with the ones practiced at Laho. Topics of organizing like changing the schedule of ward rounds were to be “discussed” and missing pieces of equipment to be purchased. While the Laho nursing director seemed to expect that Reho would make these changes to comply with the standards at Laho that were perceived as superior, the nursing director of Reho took notice of the results as recommendations rather than instructions by the superior Laho director: “The suggestions were helpful for me to see what we could use for our development.”

In fall, 2003, the Laho nursing director and the nursing experts provided a “feedback” to the Reho nurses who they summoned in the meeting room of Reho, distanced from the wards. One of the nursing experts:

“There we told them of all the caring topics and honestly told them all what did not work and were they had deficits”.

According to this nursing expert, the reaction of the Reho nurses was two-fold in that some Reho nurses thanked them for their work, while others were startled by the magnitude of deficits in nursing standards.

In January, 2004, the Laho nursing director sent another nursing expert for two months to Reho. His role was to support the implementation of the new or changed nursing standards. He
understood his task as to implement the Laho “folder of nursing guidelines” at Reho. He engaged with the daily work on the wards, and the Reho nurses appreciated his support, asking numerous questions.

“\textit{He came for quite some time, really trying to help us out and he did a lot of teaching on the job.}” (head nurse on the surgery ward)

Besides working on the wards, this nurse met weekly with the leading surgeon to “\textit{discuss how it is going, how to handle specific problems and such things}” (leading surgeon). Between the two, they decided on how to proceed in implementing the guideline folder.

At the end of this period, the Laho nursing director and the three nursing experts summoned the Reho nurses again for a feedback in the meeting room, displaying an excel-sheet on the overhead projector stating what remained to be changed. The Reho nurses felt intimidated and angry:

“\textit{It was almost like they were threatening us: ‘You must change this and that, and if you don’t, then…’... It was like all we had done so far was worth nothing. All of us were furious’}.”

Likewise, their Laho colleagues became angry:

“\textit{It was difficult to change anything particularly in those aspects in which the Reho nurses think they do them well. This was really challenging. But thank God, we then received the results of the external evaluation, and then it was clear. It proved that at Reho nursing really lags behind.”} (Laho nursing director, in a debrief later)

The results of this patient satisfaction survey were based on data from the previous fall and showed (according to a head nurse attending the presentation of Laho nursing director) that the patients did not consider the Reho nurses to be very competent and caring. The Laho nursing director presented her interpretation of these results to the Reho nurses in a third feedback meeting in June, 2004. The Reho nurses were shocked and confused by this critique.
Why did this apparently well planned change initiative by the Laho nursing director not generate the results she hoped for? This first attempt of changing care routines was very much perceived by the targeted staff at Reho as a top down imposed change. Staff themselves perceived that they had little say what and how to change. Outsiders from Laho come in and defined what had to be done. Furthermore, the Reho nursing department had the impression that the Laho assessment team were only focusing on negative aspects without acknowledging anything good about Reho. Reho nurses felt disappointed trying their best to create a family atmosphere and give their best care to patients without any acknowledgement or even worse with creating a narrative of malfunctioning.

They did the presentation saying this and this needs to be improved at Reho. This and this does not work on a slide on the projector. I found this horrible. And when we ask them if they had anything good to say about Reho as well or if everything was just bad they reacted annoyed. (head nurse Reho)

Many of our patients tell us they are fortunate to be at Reho and not at Laho. Despite Reho having a worse infrastructure they have the feeling of being in a more family-like and cosy atmosphere ....One of the new nurses also noticed: 'This is the way you are treated here, all you get is a kick in the back. You can sacrifice yourself and only receive negative feedback in return. (head nurse Reho)

It seemed that the nurses at Reho felt taken by surprise, not having been involved in the assessment and being judged by outsiders imposing of changes without respecting the efforts of the Reho nurses. It was the way the feedback was delivered which created much resistance and frustration.

We do not need somebody who only comes for a presentation and tells us that most of what we do is bad. We need someone who is here, who helps us, who shows us how things could be different, and what could be better. I think the way of making these points did not come across in a very humane way. (vice nursing director Reho)
How this intervention was designed as a one-directional top-down approach to assessment and feedback allowed for little reflective involvement of affected staff at Reho. It created a resistance to change because the Reho nurses found their work ill represented and de-contextualised as the outside experts claimed to impose Laho comparison standards to a distinctively different Reho context in their perception.

As to the process, feedback meetings were orchestrated as official formal meetings in contradiction to the informal communicative practices common within the family schema. Reho nurses expected help but experienced rather externals telling them what to do in an imposing and threatening manner:

*Someone from Laho came that was supposed to optimise our care. But somehow all this came across very differently. We perceived it as: ‘You have to do this and if you do not then…’, it was like a threat (head nurse Reho)*

In episode 1, the feedback of the nursing experts focuses on the structural level of the routines referring to guidelines, standard operating procedures, or checklists. Feedback remains abstract and only identifies what requires adaptation, but not how that may be done. Pointing out deficits without support resonates with the wording in the report talking about “removal” or “replacement” of certain procedures. Instead of triggering changes this intervention deepened the differences between Laho and Reho.

**Change Episode 2: Initiating Performative Change through Small Wins**

With the conflict at the end of episode 1, the Laho nursing director appointed a head nurse of Laho to be responsible for all wards at Reho (referred to as “Director of the wards” in the next paragraphs) to handle the integration. Her task was to conceptualize the implementation of nursing standards; to assess the level of personnel qualification as well as leadership; to develop a concept for advanced training; and to assist the wards in planning and organizing their
daily work. At the end of this second episode the director of the wards became the new regional nursing director.

On June 28th, 2004, the newly appointed director of the wards introduced herself at the monthly meeting of head nurses at Reho. When she arrived a week later to start working on the Reho wards, however, nobody seemed to know of her official role and she was without access to documents like the staff plan, the monthly report, the guidelines, checklists and nursing standards which were important for her to pursue her tasks.

“We thought, she comes, looks at what we can improve. That she comes to help us. ... We have not been told what her official position was, that she is our superior now.” (head nurse at Reho).

After the difficult start, the director of the wards immersed into the family schema and related everyday practices at Reho to gain legitimacy and trust of the ward nurses that she was there to help. She tried to engage Reho nurses, encouraged them to take responsibility and initially implemented small performative changes to demonstrate the impact of seemingly little changes, thus aiming to convince the nurses that change efforts would lead to an improvement of their situation. Furthermore, missing time allocated to reflect upon the procedures on the ward was identified as a key factor for triggering change. In periods of high workload nurses had less time to ask questions but rather aimed to “get the job done somehow”. A head nurse added that she would like to have a time out “with someone who reflects with us this whole situation.” Everyday care routines and the lack of supporting organizing routines did not allow to analyse and reflect upon necessary changes that could improve managing the everyday work. Therefore, providing time for reflection would be key for the director of the wards to get nurses on her side, raise awareness for the need to change and mobilize nurses to participate in the change needed.
To begin with, the director of the wards visited each team in their monthly team meeting to introduce herself and to explain the planned changes within the coming months. At the same time, she interviewed all nurses to identify main topics, worries and expectations of the nurses at Reho. The interviews were intended to

“see what the situation is, how they think about it, what are their challenges in their daily work on the wards with patients, with getting things organized and all that. ... it is important to get their point of view, also how they feel right now, what are their worries and fears, and hopes.”

Simultaneously, she visited each ward talking to head nurses and nurses alike in the morning and in the afternoon, to check “How are things going?” The ward daily visits allowed her to make her own observations complementary to the insights from her interviews. She sought to keep the head nurses by her side and explained:

“I want the head nurses to have a different, a more important position. I need them to be responsible for their ward, and they are my primary contact when I communicate with the ward. I want them to know what is going on in their team and when I need to know something I want to ask them and not anybody else.”

Ward visits were complemented by explicitly keeping her office door open. Employees were to feel free to approach her at any time. We observed that she often referred the nurses back to their head nurse and explained the respective jobs and responsibilities to the nurse to reinforce the role of head nurses. The new director of the wards furthermore gained trust by helping out with operational tasks whenever possible. Fast support helped to establish her role as someone who takes care of the nurses’ problems. She was granted an assistant nurse helping out in caring for patients, with documentation, gathering care material or equipment. A lot of these unfulfilled tasks required the support of the director of the wards were related to a lack of clear responsibilities, for example:
“they [referring to nursing staff at Reho] basically only re-act to things. But nobody acts out of own impulses. Everything is just accepted but not questioned. A typical example: they have been waiting to get a new blood pressure gauge for half a year. Well, I got on the phone and within five minutes I got a new device”. (Director of the wards)

In part, the lack of initiative can be ascribed to time conflicts arising from the previous family schema. For example, when staffing problems arise in high peak times due to the “wish list” staff planning routines a head nurse explained that

“if there are only a few people on the ward, then you want to ask as little as possible. You focus on getting things done, that you can provide support somehow and not only stand around the whole day asking questions. On the other hand, you don’t want to do anything wrong.” (Reho head nurse)

One of the key issues identified by the director of the wards was a lack of ward leadership caused by unclear responsibilities and missing initiative of nurses and head nurses to take charge and responsibility:

“There is no leadership. It is all wishy-washy. Everybody does what she wants. And then it is not done, because nobody within the teams feels responsible.”

In consequence, she confronted the staff with this issue during the monthly team meetings of each ward and encouraged the teams to discuss, decide and implement certain topics collectively. In this way, she aimed to make the tasks explicit and urged the wards to adopt their responsibility.

Furthermore, the director of the wards initiated the so-called “leadership conversations”. These were meetings of her with a single head nurse to discuss of running her ward. These leadership conversations became a newly created weekly routine by October 2004, and were officially included in the nurse unit’s structure in February, 2005. These routines allowed for open reflection on challenges of the everyday ward operations that previously got lost in the daily routine. For example, one of the head nurses recounted from her first “leadership
conversation” that the director of the wards was surprised that head nurses struggle with the duty roster, did not plan their budget, nor did they ensure the documentation of nurse activities. Later in the year, further topics were included like running team meetings, or handling specific personnel issues. The newly established leadership conversation routine became an important source for identifying necessary changes in other care and organizing routines, or triggering the creation of new organizing routines. The “leadership conversation” thus provides an example to address the lack of formal organizing that had been previously considered as being against the family schema.

In September, 2004, a Nurse Developer began her work as a professional expert in working with nurses to adapt their professional standards continuously. Her task was to revise and adapt the caring routines jointly with the nurses, following a professional understanding. Shortly after her arrival, she began to assess various care standards by looking at the standard operating procedures and by accompanying nurses in performing them. In consequence, nursing routines were adapted or redesigned. For some routines including waste disposal, modifications on surgical patient care regarding pain treatment and support in digestive relief, it was sufficient to adapt the documentation of these routines, published on the intranet in December 2004. For more complicated care standards, the nurse developer set up project teams to collectively discuss and revise such standards like wound treatment or food provision and support, or hygiene. Again, the nurses were encouraged to reflect upon existing routines and contribute towards identifying necessary changes. The project teams consisted of nurses of different wards that worked collectively to adapt the standards, changing forms or written instructions. The nurses of the project team communicated the changes in their ward’s monthly team meeting, sometimes
accompanied with a specific training session for all nurses to attend. Besides these measures, the nursing expert accompanied nurses in their daily work:

“I accompany nurses in their work with the patients, and then we document afterwards on how they actually do the standards so that I can give direct, concrete feedback what went well and where to improve. This can be an intensive and longsome task. But, I cannot just hold a meeting and say: This is how we do it from now on, here are the forms and checklists, go for it.”

While changes to care routines by that time seemed to be accepted and welcomed, organizing routines remained a problematic issue. The nurses still considered them a distraction from the caring routines as in the family schema. Among the organizing routines, documenting nursing activities gained priority to be practiced in a way that allowed comprehensive and timely data on nurse activities. Head nurses needed these data for planning, budgeting and handling different workloads between the wards. Documenting however was considered critical by the nurses who give priority to caring. A head nurse remarked:

“We are supposed to document everything, in the patient file and in the computer to document our activities more comprehensively and timely so that we do not forget it. But how should I do that in such a bee-house?”

Similar to the man-power planning, documenting nursing routines remained a difficult issue, and was discussed and reported on in official meeting minutes during the year of 2005 in February, April and June. It was only by November 2005 that the head nurses announced that documenting care activities worked comprehensively and timely.

Why were nurses at Reho more receptive to changes in the operating routines in this episode? Opposite to episode one, the director of the wards sent from Laho starts to address change attoque and in situ at an individual level and only after having received a certain insider
status within Reho and being accepted as member of the team losing the outsider status of her colleagues during episode 1. Furthermore, change is not directly targeting to overhaul the family with the professional schema as well as imposing changes on the material aspects of routines. Rather, change began with addressing seemingly small adaptations and changes on a performative level. Improving the actual performing of routines helped to convince the nurses that changes would improve operations and enable nursing staff at Reho themselves to initiate further changes addressing the conflicts arising from operations under the family schema. For that to happen, it is important to encourage reflection, for example with the newly established leadership conversation routine. The actions taken in episode 2 slowly help establishing a culture of taking responsibility and increasing reflexivity of all involved actors that are no longer passive recipients and implementers of imposed changes. Rather, they begin to become active reflective change agents. The emergence of new routines supporting reflection resonates with the existing ones practiced as part of the family schema which increases acceptance on behalf of the nursing staff. Ward visits and open office doors invite informal conversations similar to the informal character of existing practices like the morning coffee and private conversations. Organizing routines gain importance for the nurses as they do not perceive them contradictory to providing good care but supportive to improving care routines. For example, the changes in the man-power planning procedures helped to handle future staff shortages which previously made it difficult at peak times to provide the high quality care.

**Change Episode 3: Stabilising Routine Change and Creation through Routinized Reflection**

The third and last episode began with the new nursing director of Reho (and former director of the wards) conducting her first head nurse meeting in February, 2005. We ended our field observation in February 2006. In episode 2 the new nursing director had started to use
adjusted or newly created meeting routines as a means to actively engage nursing and clinical staff in the change process. This practice continues in episode 3 and we observe a shift towards a collective change dynamic. It is now more and more the collective of nurses that evaluates established routines and initiates changes often triggered in the new meeting routines and their collective discussion and decision making involving nursing teams across the wards in close coordination with the department of nursing quality and development of Laho.

A key change involved the structure of the monthly head nurse meeting. The nursing director appointed in episode 2 summarized her motivation for this change as follows:

“Here, we can talk about problems on the wards or within the nursing unit as a whole. And I can gather opinions of the head nurses on the head nurses’ perception of how work is coming along. Another thing is that we can discuss how we can help one another, so that the wards think more in relation with each other. And, when we discuss the projects or changes, we can share the experience, like the challenges each ward encounters and how they handled them. At the end, I want that the head nurses engage themselves in the changes we pursue.”

Accordingly, the meeting rhythm increased to twice a month; the agenda and minutes were distributed timely to the participants and to the wider audience of clinic and department heads, the Laho nursing director and Reho’s hospital management. Guests were invited on certain topics or could attend the meeting voluntarily. The new meeting sequence of agenda items fostered collective reflection and decision making. There were agenda items for the Reho nursing director passing on information to the head nurses; for jointly discussing topics; for decisions of the entire group or of the nursing director; followed by a round of the head nurses passing on and discussing topics emerging from the ward teams. According to our field notes, the changes in the meeting structure took until May, 2005, to bear the effect that head nurses engaged more actively in the discussions of topics with a clearer focus on the nursing unit as a whole throughout the meeting whereas prior ones tended to drown in operative details, like
broken sinks, or missing equipment. Together with other changes the emerging practice in the head nurse meeting seemed to contribute the nursing staff taking responsibilities. This observation was confirmed by the new nursing director and a head nurse:

“There are more questions and suggestions coming. Somehow I get the impression that they [the nursing staff] have more courage to ask questions. They do no longer apologise for asking questions ‘Sorry, just a question...’. And there are also more requests: Why do we not get this? They leave their humble attitude behind.”

“I see myself not only in working with patients and in pushing the interests of my team within the unit. I try to approach things now sort of more global if you like. I have now also to really see that I do all the documenting and plan the work load better. And also with personnel decisions, the nursing director includes us in the hiring process which I really appreciate because I can check if someone fits into my team or not.” (head nurse)

The invitation of guests to the meetings encouraged the collaboration between departments and started in the first head nurse meeting in February. The head of kitchen attended because the nursing unit wanted to change the meal times to better fit the 3-shift structure. The head of kitchen explained the implication for his team and the decision was reached that the ward teams would support the kitchen by returning the trays after lunch themselves as a change in the food distribution routine on the wards.

Not all collaborative efforts passed without conflict. Problems arose with medical doctors. Several times in 2005, the Reho nursing director decided and communicated via the meeting minutes that the wards had to avoid accepting medical doctor’s instructions regarding organizational changes, but instead referred these topics to the Reho nursing director. She explained that

“I have to be so careful that those medical doctors do not just order my people around as they please. I have to be alert all the time, and pick a fight sometimes, so that it is clear that the medical doctors approach me first when they wish organizational changes on the wards.”
This routine aimed at reinforcing a professionalization of the ward operations created conflict with the medical doctors as the head of inner medicine summarized:

“That I have first to talk to [the nursing director] before being able to approach the wards. This did not exist before in this place. We now have to follow the chain of command, but that is not helpful to handle issues as they arise.”

Apparently, there was no designated space for medical doctors and nurses to discuss such issues. In July, 2005, The Reho nursing director agreed with the heads of surgery and inner medicine to meet every week to handle emerging issues in daily collaboration. Simultaneously, the minutes of the head nurse meeting contained the instruction to head nurses to refer medical doctors to the Reho nursing director on doctors’ requests on topics of ward organization. Despite instructions and the weekly meeting with clinic heads, the relation between the nursing unit and the clinics remained a contested topic. At the end of 2005, even some employees within the nursing unit still criticised this new routine in interviews. The former Reho nursing director stated:

“The collaboration has become more difficult. Each party (clinics and nursing department) insists on their view with the result that the Laho Nursing Director has to handle the issue, and that occurred now a couple of times.”

A head nurse was more ambiguous:

“In general, I do not quite like the idea to separate the nursing department so strongly from the clinics. But, at the same time, the experience we have sometimes is also true that the medical doctors just intrude in our work all the time. Sometimes, we have to distance ourselves a bit ... But, we and the clinics should stay in the same tune.”

Another new routine was the “morning meetings” that aimed at fostering support between the wards within the nursing department. Together with the head nurses the nursing director observed differences in work load between the ward teams in March, 2005, and also a certain “victim” attitude among nurses:
“One of the wards has the feeling to be left behind and complain that they have too few nurses in their team but the highest workload. To me, they consider themselves victims. And my colleague tries to motivate her team to be more open and to leave that victim attitude. But it is not easy.” (head nurse)

After assessing the work load of the ward and conducting a workshop on managing for the a head nurses, the “morning meeting” routine started in May, 2005. Every morning at 7am the night shift nurses, the nursing director, and all the nurses responsible for the ward teams gathered for about 15 minutes to share “remarkable events during the night”, reported to each other what they expected for the day on each ward, and could ask other wards for support by shifting personnel. As stated in the minutes of the head nurse meeting (March, 24th, 2005) these meetings aimed to: “become faster in reacting to unexpected increase in work load.”

Overall, these new routines encouraging collaboration and reflection seemed to help shifting the schema. A head nurses remarked in May, 2005:

“I have the feeling that now the nurses can admit when an error occurred. They can stand there and say: ok, that happened. But also, they can stand their ground more firmly and argue. In total it has become more friendly and appreciative in our talking with each other on work issues on the ward. It is not with everybody, but I see it growing now”.

At the same time, the first author observed the afore-mentioned change in the mode of discussion within the head nurse meeting. In caring routines, the nurse developer reported on several revisions of nursing standards, including the creation of a so-called “short file”, a patient file designed for short hospital stays. This new short file practice was adopted by the wards of Laho, the hospital that was considered superior in their organizing and care routines.. Also, the documentation of nursing activities improved as nurses reported in November, 2005 in the head nurse meeting. However, man-power planning remained challenging during the observation period.
Over the year, we observed the consistent use of the minutes to the head nurse meeting to document the progress of the change process within the nursing unit. The minutes mention changes in caring and in organizing routines, besides providing explanations as in the case of the morning meeting. This documentation in the official minutes provided a continuous feedback, when accomplishments are congratulated, as well as critical feedback, when for example the documenting routine is still not observed to be practiced professionally. In our view, documenting the changes may provide acknowledgement and reinforcement to members of the nursing department to keep on developing their practice of the routines in question. Furthermore, and extending the boundaries of the nursing department, the documentation of topics regarding collaboration makes these issues a more public affair within Reho. This may have contributed to enhance the collaboration of the nursing unit with other departments and clinics.

While episode 2 was all about generating an awareness for the need to change and convincing actors to change routine performance by making specific suggestions often initiated by the placed head nurse, reflexivity takes on a new level in episode 3 and is less about convincing actors to change but more about the collective of actors taking charge of identifying and initiating changes themselves. The change of the head nurse monthly meeting structure, for example, is another important moment where the intention of the new nursing director to reinforce reflexivity of all involved staff rather than directing in a top down fashion becomes obvious. She perceives the key to successfully implementing the changes and initiating further needed changes in the organizational routines in the turning staff from passive change recipients into active change agents and taking responsibility to evaluate procedures on the ward, identify need for change, come up with solutions and implement the change in routines. The changed organizing routines including for example the new meeting structure of the monthly head nurse
meetings and the creation of other routines that provide deliberate space for reflection reinforce
this development and help institutionalizing reflectiveness. Therefore, this is the episode where
structural change starts at a collective level and manifests in changes in the ostensive routines
including the creation of new routines that provide routinized space for reflection.

DISCUSSION

We set out to analyse the interconnections between episodic, externally initiated change
and continuous change based on internal dynamics of change within organizational routines. In
the organizational change literature, episodic and continuous change (Weick & Quinn, 1999) are
often viewed as dualistic. While the literature on routines and continuous change (Feldman,
2000; Orlikowski, 1996) has a tendency to downplaying the role of episodic change (Tsoukas &
Chia, 2002), other views focus on episodic and continuous change as a duality (Langley &
Denis, 2006; Farjoun, 2010). Relating the two often involves improvisation (Orlikowski, 1996),
or individual reflection (Feldman, 2000), or relational spaces (Kellogg, 2009) in which
organizational members join informally to make sense and act upon episodic change initiatives.
The emergence of reflective routines that we explore in our study contributes to these insights by
addressing the central challenge (Bartunek & Moch, 1994) of new routines being interpreted
from the perspective of the existing or old schema, which often leads to confusion,
misunderstanding and conflict. Our empirical findings illustrate the evolution of a change
process involving a bundle of interrelated care and organizing routines in a hospital unit after a
merger. We illustrate that bundles of related routines are connected through schemas that guide
routine performance. In order to successfully implement change the overall guiding schema
needs to change. However, as our empirical case demonstrates, changes in schemata cannot be imposed but rather evolve through initial changes on a routine level triggered by individuals that develops into a collective change efforts affecting related routines and finally results into a chance of schema that will then allow for future adjustments of routines. In compliance with Pentland & Feldman (2008), we find that the emergence requires performing routine rather than focusing on reconfiguring its ostensive components (see also Jarzabkowski et al., 2012).

Defining what needs to be changed in terms of altered artefacts and pointing towards the ostensive dimension of routines does not suffice. It is within the performative dimension where change becomes possible, if connections and compatible expectations can emerge that foster the new by handling problems associated with the old schema (Barrett et al., 1995; Reay, Golden-Biddle, & Germann, 2006).

We identified three key aspects central to the observed change process: First, resourcing (Feldman, 2004) was essential in order to build relations and positions that provides the grounds to act, and relies initially on small wins (Reay et al., 2006). Second, collectivizing means to move from individual reflective settings towards involving all employees systematically across the nursing department to become involved in designing and implementing change. Third, creating collective reflective routines foster collective reflexivity during the change process and beyond for future adaptations of organizational routines. We label this process of moving from individual reflexivity to collective reflexivity and the stabilization of reflection through formal reflection routines as a process of “routinizing reflection”. Routinized reflection enables to change routines and develop a new understanding of the organization simultaneously. This reflexive layer helps to develop and stabilize new care and organizing routines in the nursing unit.
associated with the “professional” schema. Here, introducing formal reflection routines provides a structure for actors to enact reflection in their everyday praxis continuously.

Our detailed account of the three change episodes involved in the observed change process revealed that externally initiated change efforts were unsuccessful because change was imposed by external parties leaving the actual change agents, the nurses that have to implement the change process, in the role of implementers and not designers of change. Leaving nurses outside the identification of change needs and designing necessary changes meant that the nurses disagreed with imposed changes. In this episode daily operational tasks where designed in a way that they left little room for the change agents to reflect upon necessary changes. Low degree of reflexivity hindered that change initiatives by individuals were taken on at a collective level as it would be necessary for successful routine change (Howard-Grenville, 2005). Furthermore, the imposed new schema and its related routines were understood in terms of the presently enacted schema (Bartunek & Moch, 1994). In consequence, this led to misunderstanding and opposition due to conflicts with the existing schema in place (Barrett et al., 1995; Ericson, 2001).

In episode 2, therefore, changes were not externally imposed as in the first episode. Rather the lead change agent (the Director of the wards sent from Laho to Reho) tried to initiate change from within the routines performed in Reho by indulging in the processes and gaining trust and legitimacy as a change agent as well as by observing the daily organizing and caring routines not only from the perspective of the attempted professional schema but equally understanding their origins in the present family schema. This initial stage of observing that triggered change, differed between the episodes 1 and 2 in several ways that help explain why episode 1 failed in changing caring and organizing routines: First, the nursing experts during episode 1 focused on the deficits at Reho in comparison to the professional schema practiced at
Laho, thus omitting the specific situation the Reho nurses found themselves in. In comparison, the observations by the nurse taking over the role as director of all wards were more concerned with the problems and challenges of the Reho nurses in their daily work practice.

Second, the immersion into the local context differed in a way that fostered or hampered acceptance through understanding the situation at Reho. The director of all wards engaged in detail with the daily work of the nurses. As her colleagues in episode 1, she observed caring and organizing by accompanying her subordinates, but complemented these observations with interviewing all employees to understand their perspective, and to understand “how they feel right now, what their worries and fears, and hopes [are].” Immersion in the context not only means to understand a situation, but also that others form compatible expectations (Dionysiou & Tsoukas, 2013).

Besides informal conversations, the director of all wards enacted routinized interactions of “visiting wards” and “open office door”. Doing so allowed to detect and to handle arising problems of Reho’s performing caring and organization. Even when such problems appeared trivial like a broken hair dryer, solving them herself or showing a nurse how provided solutions to problems of the Reho nurse. Such small wins are known to gain acceptance and legitimacy (Reay et al., 2006), so that Reho nurses observed that the director of all wards fulfilled the expectation of “someone who comes and helps us”. Such compatibility of expectations helped to legitimize the professional schema by pointing out and handling problems associated with the family schema (see also Barrett et al., 1995). Initially, it is through small performative changes that other actors start following proposed changes and building an increasing awareness of a necessity for change by seeing small improvements. This helps to overcome the opposition to change and increases the awareness or reflexivity for how organizational care and organizing
processes can be improved. Individuals were supported of carrying out the performative changes initiated by the change agent due to a more inclusive change approach. While in episode 1, affected actors rather fulfilled the role of change recipients (Bartunek, Rousseau, Rudolph, & DePalma, 2006), they now became actively engaged in the change process.

In episode 3, however, the performative changes are initiated not only by the change agent but by the collectivity of actors with a higher degree of reflexivity. It is now all nurses on the wards that are encouraged to reflect upon how organizational routines are performed and to initiate changes not only on a performative level but also on an ostensive level. The involved actors initiate changes themselves and push the change process. This creates a new change dynamic that moves the process forward and sets the fundament for ongoing performative and ostensive improvements not only limited to the present change initiative but beyond. One set of new routines created during the change process was related to reflexivity of actors and the institutionalization of reflection by scripting reflection into specific newly created routines that serve as some kind of meta-routines or second-order routines to the primary nursing and organizing routines that guide everyday operational praxis on the wards. These reflective routines emerged over time in response to handling emerging systematic topics within the nursing department (Barrett et al., 1995; Reay et al., 2006) and were not only key to successfully undergoing the observed chance process. But they seem also central to future change and adaptation of routines to adapt to continuously changing contextual factors. The increased level of reflexivity is supported by the creation of reflection routines and helps to build up the new nursing structures, to implement and stabilise them. At the same time change becomes integral to the overall schema. Actors now have structures and routines in place that enable them to keep
reflecting about their everyday practice. Our findings are summarized in the following conceptual model.

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Insert Figure 1 about here
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The issue of shifting schemata and routine change has been explored recently by Rerup & Feldman (2011) and Bresman (2013). By showing how and why reflective routines emerge over time, our study connects with and extends these works. Bresman (2013) highlight the process of shifting and adapting routines by means of learning routines that are already performed and embedded within the organizations. Our study shows how such routines in which participants reflect upon their routines emerge. Thereby we address the call to further explore the birth of routines (Parmigiani & Howard-Grenvill, 2011). In Rerup & Feldman (2011) a shift in schema arises from handling problems associated with an existing (or enacted) schema. By considering different types of routines, such as caring, organizing and reflecting, we further extend the knowledge of routines and schemas during organizational change. Routines express schemas while schemas help to make sense of the routine both in their ostensive and performative dimension. We also show that the relation between different types of routines alters with the shifting schemas. Within the family schema, caring routines were central, while organizing and reflecting routines were peripheral (Gersick & Hackman, 1990) performed sporadically and informally or not considered “real work” as for organizing routines. Central routines are those that lie at the core of what an organization is about, like caring routines in a nursing department. Peripheral routines are considered less important and less embedded, as the organizing and reflective routines within the family schema. In our case, the peripheral routines of organizing were difficult to change, precisely because they were considered subordinate to the central caring
routines. This is why man-power planning or documenting took a long time, until they were at least somewhat performed differently. Within the professional schema, both gain importance in that they provide the pre-conditions to ensure the continuous performing of caring routines. While organizing routines concern the ensuring of the present performing of caring routines, reflective ones aim towards ensuring caring routine performance in the future. Thus, shifting schemas not only involve changing routines, but the relationship between routines.

With these insights, our study contributes insights to both changing routines and schemas and to how routines emerge. Triggered by individual observation on the performative dimension (Pentland & Feldman, 2008) repeated and coherent interacting enables connections and compatible expectations on reflective routines to emerge. They differentiate to reach across the organization and are documented in terms of their declaration and effects. Together with routinized boundaries, these three components embed the reflective routines in the organization.

As for pluralistic settings, our study re-emphasizes the importance of knowledge-intensive work as a central activity in such settings (Denis et al., 2001; Denis, Langley, & Rouleau, 2007; Jarzabkowski & Fenton, 2006). More specifically, how members of the nursing unit understand their department impacts on the sense-making of enacted routines, as illustrated by the different interpretations with regards to organizing routines as peripheral under the family schema and a more balanced view under the professional schema.
REFERENCES


TABLE 1
Visualizing the Evolution of the Change Process

Episode 1

<table>
<thead>
<tr>
<th>Time</th>
<th>May ’03</th>
<th>Aug. ’03</th>
<th>Fall ’03</th>
<th>Jan. ’04</th>
<th>Feb. ’04</th>
<th>April ’04</th>
<th>June ’04</th>
</tr>
</thead>
</table>

**Legend:**

- **Schema**
- **Incidents outside organization’s control**
- **Actions / activities**
- **Communicative Event**
Episode 2

- **Laho Nursing Director (L-ND)**
  - Send HoW (April '04)
  - Suspends changes

- **Nurse Experts (NE), Head of all wards (HoW)**
  - HoW: interviews with all nurses

- **Reho Nurses**
  - Leadership conversation weekly with each head nurse: situative
  - Leadership conversation weekly with each head nurse: weekly
  - Ward visits: twice a day
  - Support nurse of Laho helps out on wards for 3 months with caring and organizing routines
  - Nurse Developer (ND) arrives at Reho

- **Reho clinics and support departments**
  - HoW requests performance of documenting routine
  - HoW observes difficulties in manpower planning
  - HoW decides to change to 3-shift structure
  - HoW is appointed new rND
  - One Reho ward participates in primary care

**Legend:**
- Schema
- Incidents outside organization’s control
- Actions / activities
- Communicative Event
<table>
<thead>
<tr>
<th>Schema &amp; Routines</th>
<th>Family Schema</th>
<th>Professional Schema</th>
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| Core idea and associated structure | *Core Idea:* Caring is a comforting, family-like atmosphere for a sick person, emphasizing to accompany the patient during his hospital stay.  
*Associated Structures*  
- Portioned Shift with large breaks for a nurse in between (either at noon or early evening) to accommodate family needs of nurses with relatively high number of handovers  
- Nurses: subordinate to medical doctors with regards to medical, nursing, and organizing topics | *Core Idea:* Caring is a professional service (May, 2005) that continuously applies the state-of-the-art in medicine and nursing science to the patient who knows his nurse responsible for him or her.  
*Associated Structures*  
- 3-shift structure (October 2004) of morning, afternoon, and night shift to reduce number of hand-overs and nurses looking after designated patients  
- Nurses: partner to medical doctors who receive instructions on treatment issues only and who help to control medical treatment (4-eye-principle)  
- Leadership day for head nurses to perform organizational routines (February 2005)  
- Position of professional nurse developer to enhance caring routines (September 2004) |
| Caring concept and routines | *Care concept:* Functional Care of nurses specialized on tasks without individually specified responsibility for particular patients  
*Caring Routines (examples):*  
- supporting patients in hygiene, food provision, mobilization, conversation  
- Collecting medically induced data, e.g. vital signs, blood samples  
- Patient treatment of providing prescribed medication, wound treatment, pain treatment | *Care concept:* Primary Care of nurses individually designated responsibility for certain patients acting as “case managers” from entrance to exit; combined with their functional expertise  
*Caring Routines (examples):*  
- supporting patients in hygiene, food provision, mobilization, conversation  
- Collecting medically induced data, e.g. vital signs, blood samples  
- Patient treatment of providing prescribed medication, wound treatment, pain treatment  
- Coordinating entrance, diagnostic and therapeutic actives during... |
### Organizing concept and routines

**Concept of organizing**: “Administrative” work is subordinate to caring and not considered “real work”, but an obligation that has to be performed even though it distracts from direct patient care.

**Organizing routines (examples)**:
- **Documenting** care activities often performed at the shift end, in overtime and non-comprehensive
- **Man power planning** is a complicated monthly task because of differing degrees of part-timers, high-overtime and employees’ preferences (“a wish plan”), at times requiring the head nurse to work when her team members are not willing to attend work. Man-power planning is regularly performed in overtime or at home.

### Reflecting concept and routines

**Concept of reflecting**: Feedback is informal and based on the premise to consider each other good nurses (“I am OK – you are OK”)

**Reflective routines (examples)**:
- Chatting while having coffee: Informal and idiosyncratic visits of nurse friends which also involve gossiping
- Morning breakfast of the team: Informal conversations among present team members on patients, medical doctors, the nursing department and the hospital

### Reflecting concept and routines

**Concept of reflecting**: Reflection and feedback are integral to professional nursing in order to maintain on professional state-of-the-art, and systematically concern caring and organizing routines that are discussed in a planned repetitive manner.

**Reflective Routines (examples):**

1. **Reflection on caring routines**:
   - Nurse developer accompanying nurses in performing caring routines (September 2004)
   - Cross-ward project teams to discuss, and revise caring routines systematically to apply the current state of the art (September 2004)
   - Discussing difficult care cases (November 2005) to weekly reflect on difficult cases within the team with the nurse developer in a
structured and documented process

2. **Reflection on organizing routines:**
   - Ward visits and open office door (July, 2004) of the nursing director twice a day to observe and handle emerging issues while demonstrating roles of head nurses
   - Head nurse meeting (February, 2005) of head nurses and nursing director on issues of the nursing unit with invitation and participation of guests, including ongoing documentation of change progress
   - Daily Morning meeting (May, 2005) of nursing director and ward members to ensure daily overview on activities and mutual support
   - Weekly meeting clinic heads (July, 2005) weekly to handle doctors’ requests on organizing topics and potential problems in collaboration via the nursing director timely
FIGURE 1
Conceptual Model

Organizational Unit

Schema 1

↓

Ostensive

Performative

Operational routines

Resourcing & Trust building

↓

Small wins & Change awareness

Collective change efforts

Schema 1

reflection routines

Operational routines

Schema 2

reflection routines

Operational routines

Schema 2

Ostensive

Performative

Individual

Degree of Reflexivity

Collective