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ORIGINAL RESEARCH

Perceptions of Organisational Readiness for Change in Nurse- and Midwifery-Led Quality Improvement Initiatives

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Introduction: Perceived organizational readiness is vital to nurses' and midwives' success in leading quality improvement, yet little is known about their perceptions. This study assessed perceived organizational readiness for change among 30 nurse and midwife leaders in leading quality improvement projects following a 9-month academic leadership fellowship with the Global Leadership in Nursing and Midwifery program at the University of Global Health Equity, Kigali, Rwanda.

Methods: Using a quantitative cross-sectional design, we assessed sociodemographic characteristics and perceived organizational readiness of nurses and midwives who had implemented a quality improvement initiative at their workplace following the training. Participants completed the original, validated Organizational Readiness for Implementing Change (ORIC) questionnaire, which assesses perceived readiness, commitment, and efficacy, demonstrating high reliability (Cronbach's α =0.96). Data analysis was facilitated by RStudio and summarized using descriptive statistics. Results were presented in tables and charts to illustrate readiness levels across participants.

Results: Only 50% of the nurses and midwives perceived their organization as being supportive. There was an overall moderately to high perceived readiness score of 49 out of 60, with a higher median perception of change efficacy of 29 out of 35 among the nurses. The nurses had a lower agreement on their organizational motivation, organizational ability to get people to invest in change, and the ability to navigate internal politics. Prior experience with implementing QI in their organization, and perceived organizational supportive cultures were associated with higher readiness scores.

Conclusion: While training enhances nurses and midwifery leaders' confidence in leading QI initiatives, their implementation and sustainability require more than individual capability. Organizational commitment by ensuring supportive structures and resource alignment is essential. Leadership can operationalize readiness by fostering nurse leadership development and supportive environments that address systemic barriers. These findings advance nursing and midwifery leadership frameworks and inform future readiness assessments in healthcare.

Keywords: nurses, midwives, leadership, quality improvement, QI, health services, Africa

Introduction

Being the most abundant professionals globally, nurses have great potential to improve access to high-quality services globally, including contributing to the triple billion targets.[1] The recent State of the world's Nursing Report estimates nurses constitute 57% of the global health workforce and 68% of health professionals in Africa.[2] According to a recent care professionals often serve as the primary interface between patients/communities and health systems, positioning them as critical actors in strengthening health services and advancing quality improvement efforts.[3] Hence, their role in leading quality improvement (QI) initiatives is essential for strengthening service delivery and optimizing health systems goals. Nurse and midwifery-led initiatives are gaining more traction across healthcare systems; however, research that documents what organizational challenges nurses face in leading such efforts remains scarce.[4] For health care workers to

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efficiently lead change initiatives, institutional support, good leadership capabilities, and structures, and organizational readiness to implement change are fundamental. For nurses who are uniquely positioned to identify gaps in care due to their close engagement with patients and frontline processes, a supportive organizational culture empowers nurses to translate their insights and skills into effective QI efforts.[2]

Organizational readiness is recognized in implementation science as a critical mediator between the intent to implement new practices and the eventual observed outcomes.[5] If organizational commitment is lacking, implementation efforts are highly susceptible to failure. Studies have proven that sustained leadership effort is necessary to ensure commitment to sustained QI initiative due to the complexity of systems.[5,6] Tasleem et al emphasized that successful health initiatives require active efficacy—a shared belief among staff that their organization can effectively implement the intended change.[7] Ann et al opined that this efficacy requires the specific resource components, including informational, resource, and human efficacy.[8] However organizational readiness in health care does not constitute a single measure but a state influenced by broader contextual factors, including organizational culture experiences, and past experiences.[5,7,9] Hence, nurse-led initiatives to succeed adequate structural readiness including conducive staffing ratios along with necessary physical and technological resources availability to support and expanded roles or new clinical models are paramount.[5,10] In addition to this, the nurse led initiative must align with prevailing cultural values of the institution. Studies have proven that a lack of cultural alignment negatively impacts the nurses' ability to change the mindset of organizational members and secure the collective commitment needed for implementation.[7] Another key factors that mediates organizational readiness to implement change is the political climate of the organization. Political readiness is often mediated by contextual factors such as policies, procedures, and perceived organizational support.[5,7,11] These determinants are paramount for nurse leaders because they reflect the degree of formal authority, empowerment, and policy backing they possess to drive change.

The Organizational Readiness for Implementing Change (ORIC) instrument, which measures change commitment and change efficacy, is a valid instrument that has been used in high- and low-resource settings.[12–14] Organizational readiness to implement change is defined as the extent to which a healthcare organization is prepared, both psychologically and behaviorally, to adopt and implement a new initiative or change.[15] Perceived readiness reflects how members of ana organization view or interpret that capacity, including their confidence in collective commitment and efficacy. The organizational readiness framework serves to identify barriers and facilitators to implementation.[9] Thus, it is a crucial concept for successful healthcare transformation, as it impacts how effectively new practices are adopted and sustained. Studies have highlighted the role of perceived readiness as an aggregate measure of different health care professionals within organizations in shaping implementation outcomes.[12–14] This approach sidelined the perspectives of frontline nurses who are directly involved in leading Quality improvement interventions or other change initiatives.

This study addresses this gap by examining individual perceptions of organizational readiness among nurse and midwife fellows who participated in the Global Leadership in Nursing and Midwifery (GLNM) Fellowship Program at the University of Global Health Equity's Center for Nursing and Midwifery (UGHE-CNM). According to the WHO, leadership development opportunities for nurses and midwives remain uneven globally, with only 25% of low-income countries offering leadership development opportunities.[1] This disparity underscores the importance of the GLNM fellowship program, which aims to strengthen the leadership capacity of nurses and midwives. The fellowship aims to enhance nurses' and midwives' capacities in system leadership and improvement through critical thinking, problem-solving, self-reflection, confidence-building, decision-making, and quality improvement (QI). As part of the program, each fellow implemented a QI project within their place of work. The program provided didactic training in QI, mentorship, leadership development, and access to QI resources and toolkits. Fellows who successfully completed the program received a certificate of completion. This study thus offers a unique lens into how nurse and midwife leaders perceive their organization's readiness to implement change. This approach can inform strategies to better support midwife/nurse-led QI initiatives, particularly in Africa. Despite their critical role in driving change, nurses are often excluded from strategic decision-making processes, which may impact their motivation and ability to lead.

Research Objectives

1. To assess the perceived organizational readiness for change in institutions where fellowship students implement QI projects.
2. To identify demographic and organizational factors affecting the implementation of nurse-led QI project.

Materials and Methods

This was a descriptive cross-sectional study with a total of 30 nurses and midwives (census sampling) from different organizations participated in the 9-month-long Global Leadership in Nursing and Midwifery (GLNM) program at the Centre for Nursing and Midwifery (CNM) at the University of Global Health Equity (UGHE), Rwanda. These individuals received hands-on training and mentorship to lead and execute a quality improvement project at their respective facilities/ institutions. Using a cross-sectional design, quantitative data were collected using the 12-item Organizational Readiness for Change Survey (ORIC) instrument, along with data on participants' demographic, professional, and leadership information. The instrument was administered electronically via KoboCollect (May 29- June,13 2025), 1 week after completion of the fellows' QI project. Given the exploratory nature of the study, no formal power calculation was conducted; the full cohort of 30 eligible fellows was included.

The ORIC is designed to measure two dimensions of organizational readiness: change commitment (motivation) and change efficacy (capacity).[13] Studies have shown that ORIC is a validated and reliable instrument in the African healthcare context.[13,14] However, it has been mostly used for multiple respondents per facility and assessment of inter-rater agreement.[13,14] Our study adopted respondents as key informants per facility reporting their individual perception of their organization's readiness to implement change. The instrument demonstrated high reliability (Cronbach's α =0.96) within this sample, supporting its use for capturing individual perceptions of readiness.

Study Location

The study was carried out at the University of Global Health Equity, Rwanda, Centre for Nursing and Midwifery. The university's main campus is located in Butaro in the Burere district in the Northern Province of Rwanda. The Center of Nursing and Midwifery offers the Global Nursing and Midwifery program to nurses and midwives from different parts of the world. The program aims to empower nurses with the voice to reshape healthcare leadership across the continent and beyond, emphasizing equity and empowerment. The University of Global Health Equity (UGHE) is ranked among the top universities in Sub-Saharan Africa by Times Higher Education (THE).[16]

Data Analysis and Measurement

Data was analyzed using RStudio. Due to the small sample size and the non-normal distribution of the variables, nonparametric test were used.

The dependent Variable was perceived organizational readiness for change, measured using the validated Organizational Readiness for Implementing Change (ORIC) questionnaire. It included two sub-dimensions: change commitment and change efficacy. The independent variables included demographic and professional characteristics of the nurses and midwives, including: gender, age, highest educational level (diploma, bachelor's, master's), job role (administrator, nurse clinician, supervisor/manager, or other), Categories with fewer than three respondents (dispenser and teacher), were grouped as "other, and years of experience within the organization". Organizational type (government, private, NGO), the number of employees, the employment type (full-time or contract), and the perceived organizational commitment (resistant, neutral, supportive). Prior exposure was assessed through previous experience with QI projects and previous training on change implementation provided by the organization. Continuous variables were presented using median score and interquartile range, while categorical data were presented in percentages. The ORIC instrument assessed the outcome variables change efficacy (CE):

- ORIC1: People in my organization felt confident that the organization could get people to invest in the QI,
- ORIC2 people in my organization felt confident that they could keep track of the progress in implementing the QI,
- ORIC3 people in my organization felt confident that the organization could support people to adjust to the change,

- ORIC4 people in my organization felt confident that they could keep the momentum going in implementing the QI,
- ORIC5 people in my organization felt they could handle the challenges that arose in implementing the QI,
- ORIC6 people in my organization felt they could handle the task so implementation goes smoothly,
- ORIC7 people in my organization felt they could handle the politics of implementing the QI.

And change commitment (CC):

- ORIC12 people in my organization were motivated to implement the QI,
- ORIC11 people in my organization were determined to implement the QI,
- ORIC10 people in my organization wanted to implement the QI,
- ORIC9 people in my organization did whatever it took to implement the QI and
- ORIC8 people in my organization were committed to implementing the QI).

Each response option for ORIC was assigned a numerical value as follows: Disagree = 1, Somewhat Disagree = 2, Neither Agree nor Disagree = 3, Somewhat Agree = 4, Agree = 5. The overall ORIC score was calculated by summing the numerical ratings for all 12 items in each response giving a possible score of 60. CC scored a total of 25, and CE scored a total of 35. A bivariate analysis was done to identify what demographic, leadership, and professional factors significantly affected ORIC, CC, and CE using the Mann–Whitney test (U), Kruskal–Wallis chi-square, and Spearman correlation for continuous data. Dunn's post hoc test was used to identify which specific perceived organizational culture had a significant relationship with ORIC, CC, and CE. Significance thresholds was set a $p < 0.05$.

Data from this study were collected as part of the routine program monitoring of the Global Leadership in Nursing and Midwifery (GLNM) Fellowship program with the aim of informing curriculum and coaching practices. Ethical clearance was obtained for the University of Global Health Equity Institutional Review Board (UGHE-IRB) (Ref: UGHE-IRB/2025/431). All participants were informed of the study purpose and provided informed consent prior to their involvement in the study. Pseudonyms were used, and data were de-identified to protect participant confidentiality. Participation was entirely voluntary, and individuals could decline or withdraw at any point without consequence. The study was conducted in full compliance with the ethical principles outlined in the Declaration of Helsinki.

Results

The median age of the nurses and midwives' leaders was 36.5 years (IQR: 30–41.75), with over 60% (18) being female. Most respondents held a bachelor's degree (56.7%), with a median of 12 years of experience as a nurse and midwife, and a total of 5 years (IQR: 3–12) spent in the organization where the QI was implemented. Most respondents practiced as midwife/nurse clinicians (36.7%), with 83.3% being employed as full-time staff. Up to 60% (18) worked in government institutions.

Up to 63.3% had previous experience with QI projects. Half of the participants indicated their organization had provided training on change implementation (see Table 1).

Up to half of the respondents described their organizations as being supportive, 36.7% as neutral, and 13.3% as resistant to change (see Figure 1).

Figure 2 illustrates the distribution of respondents' perceptions of their Organizational Readiness for Implementing Change (ORIC) and its two domains: Change Commitment and Change Efficacy. Change Commitment scores ranged from 5 to 35, with a median of 18, indicating a moderate to high level of Change Commitment. Change Efficacy scores ranged from about 10 to 30, with a median of 29, indicating high Change Efficacy. The Total ORIC score ranged from around 17 to 60, with a median of 49, indicating a moderately high overall readiness for change across respondents.

In Table 2 participants who have previous QI experience reported a significantly ($U = 56.5$ $*p < 0.05$) higher median score for perceived change efficacy in their organization compared to those without. Similarly, participants' previous QI experience showed a significantly higher ORIC median score (Statistic = 58 $*p < 0.05$).

Kruskal–Wallis *H*-tests indicated statistically significant differences across categories of perceived organizational commitment for all three outcome measures (see Table 3).

Table 1 Demographic Characteristics of Respondents N=30

Variable	N(%)/ Median (IQR)
Demographic characteristics	
Age (years)	36.5 (IQR: 30–41.75)
Age	
Under 40	18 (60%);
40 and over	12 (40%)
Gender	
Female	18 (60%)
Male	12 (40%)
Highest Educational Level	
Diploma	10 (33.3%);
Bachelors	17 (56.7%)
Masters	3 (10%)
Professional Background	
Number of years of experience as a nurse	12 (IQR: 5–15)
Years of experience in the Organization	5 (IQR: 3–12)
Number of employees in the organization	78 (IQR: 46–201.5)
Job Role	
Others (dispenser, teacher)	4 (13.3%);
Administrator	6 (20%)
Midwife/Nurse clinician	11 (36.7%)
Supervisor/manager	9 (30%)
Employment Type	
Full time	25 (83.3%)
Contract/Part time	5 (16.7%)
Organization	
Government	18 (60%)
Private	5 (16.7%);
NGO	7 (23.3%)
Organization Size Category	
50 people and below	12 (40%)
Over 50 persons:	18 (60%)

(*Continued*)

Table 1 (Continued).

Variable	N(%)/ Median (IQR)
Quality Improvement and leadership experience	
Previous training on Change Implementation by the organization	
No	15 (50%)
Yes	15 (50%)
Previous experience with QI in organization	
No	11 (36.7%)
Yes	19 (63.3%)

Post hoc pairwise comparisons showed that perceived supportive organizations had significantly higher ORIC scores, change commitment scores, and change efficacy scores than those with perceived Neutral cultures and perceived Resistant cultures.

Figure 3 presents the distribution of responses across the 12 ORIC items, capturing measures of both the change commitment domain and the change efficacy domain.

Participants reported high agreement on *change efficacy* items, particularly ORIC5 (confidence in handling implementation challenges, 76.7%), ORIC3 (confidence in organizational support, 73.3%), and ORIC4 (confidence in sustaining momentum, 73.3%). Lower agreement was observed for ORIC1 (confidence in securing investment in QI, 55.6%) and ORIC7 (confidence in managing politics of change, 59.0%).

For *change commitment* items, the highest agreement was for ORIC8 (commitment to implementing QI, 66.7%) and ORIC10 (desire to implement QI, 66.7%), with lower agreement for ORIC12 (motivation to implement QI, 50%).

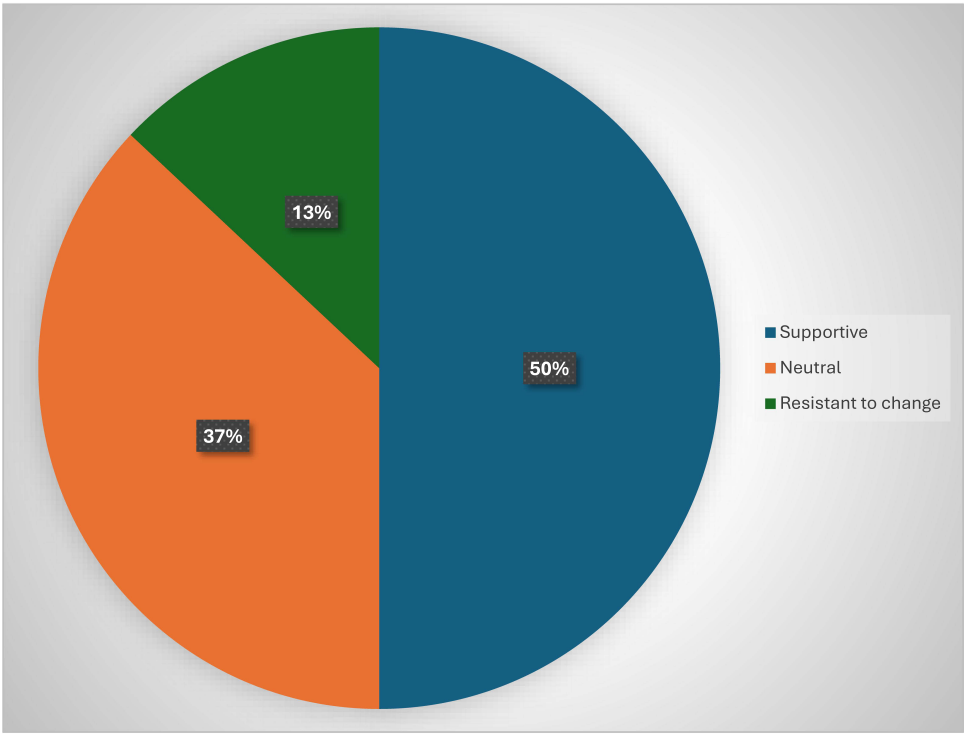

Figure 1 Distribution of perceived organizational culture.

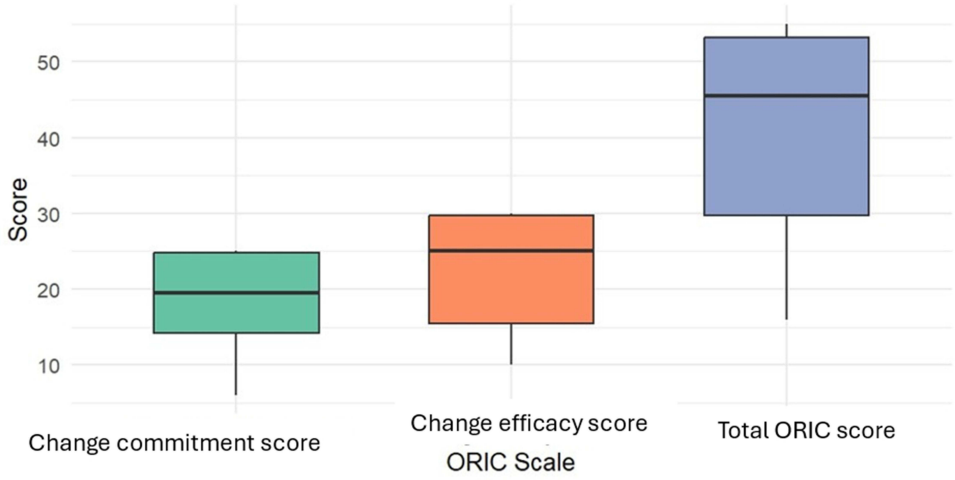

Figure 2 Box plot Distribution of perceived ORIC scores and domains (CC and CE).

Discussion

Using the 12 Organizational Readiness for Implementing Change (ORIC) instrument, this study assessed the perceived organizational readiness to change from the perspectives of 30 nurses and midwives who had attended a 9-month leadership fellowship and had led a QI project at their places of work. Findings showed the nurses and midwives perceived a moderate-to-high organizational readiness for change, along with moderate-to-high perceived change commitment and high change efficacy of their organizations. Further analysis confirmed that previous QI experience

Table 2 Demographic, Leadership and Organizational Factors Against CC, CE, and ORIC Scores N=30

	CE Scores			**CC Scores**		**ORIC Score**	
	Categories	**Median**	**Test Stat**	**Median**	**Test Stat**	**Median**	**Test Stat**
Gender	Female	24.00	99.50′′	18.00	66.00′′	42.00	92.50′′
	Male	25.50		21.00		46.00	
Age in years			0.11′		0.18′		0.149′
Highest Educational Level	Diploma	24.50	3.12′′′	21.00	4.86′′′	45.50	4.051′′′
	Bachelors	23.00		17.00		40.00	
	Masters	30.00		25.00		55.00	
Job Role	Others	27.00	3.255′′′	23.00	3.50′′	50.00	3.26′′′
	Administrator	18.50		16.00		34.50	
	Nurse clinician	25.00		21.00		46.00	
	Supervisor/manager	27.00		20.00		47.00	
Years of Experience in the Organization			0.108′		0.17		0.149
Organization	Government	23.50	1.179′′′	18.00	1.66′′′	42.00	1.57′′′
	Private	29.00		25.00		54.00	
	NGO	26.00		23.00		49.00	

(*Continued*)

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Table 2 (Continued).

	CE Scores			CC Scores		ORIC Score	
	Categories	**Median**	**Test Stat**	**Median**	**Test Stat**	**Median**	**Test Stat**
Number of employees in the organization			0.06		0.02*		0.03*
Previous Experience with Qi Projects	No	17.00	**56.5´´***	15.00	61.00´´	32.00	**58´´***
	Yes	26.00		21.00		47.00	
Previous training on Change Implementation by the organization	No	22.00	88.50´´	18.00	89.50´´	40.00	83.00´´
	Yes	27.00		20.00		47.00	
Employment Type	Full time	25.00	67´´	20.00	70´´	46.00	67´´
	Contract	25.00		19.00		44.00	
Perceived org commitment	Resistant	11.50	**17.25´´´****	8.00	**19.52´´´****	19.00	**18.54´´´****
	Neutral	17.00		15.00		32.00	
	Supportive	29.00		25.00		54.00	

Notes: ´Spearman's rho. ´´Mann–Whitney *U*-test. ´´´Kruskal–Wallis *H*-test. *p < 0.05 (shown in bold). **p is <0.001 (shown in bold).

Table 3 Dunn's Post Hoc Pairwise Comparison

		Z	P
ORIC Total scores	Neutral-resistant to change	0.76	0.99
	Neutral – Supportive	3.59	**<0.001**
	Resistance to change - Supportive	3.33	**0.003**
CE scores	Neutral-resistant to change	0.69	0.99
	Neutral – Supportive	3.50	**<0.001**
	Resistance to change - Supportive	3.18	**0.004**
CC Scores	Neutral-resistant to change	0.721	0.99
	Neutral – Supportive	3.73	**<0.001**
	Resistance to change - Supportive	3.38	**0.002**

Note: Values in bold represent results that are statistically significant at p<0.005.

was reported to have significantly higher median scores for perceived change efficacy and overall ORIC. Also, participants who perceived their organizations as supportive had a significantly higher perceived ORIC, Change Commitment, and Change efficacy compared to those with perceived neutral or resistant cultures. Generally, participants expressed high agreement on items related to handling challenges and supporting adjustment to change, while lower agreement was observed in their organizational motivation, ability to get people to invest in change, and the ability to navigate internal politics.

Generally, there was a moderate-to-high perceived organizational readiness to change, with high change efficacy scores. This implies that within these organizations, most of the nurses and midwives leaders collectively believe in the shared ability of people within their organization to implement a change. These leaders especially indicated a high perceived efficacy for people in the organization's ability to handle, adjust to, and sustain change. However, there was low agreement regarding the support and efficacy of organizations in handling internal politics, which are factors

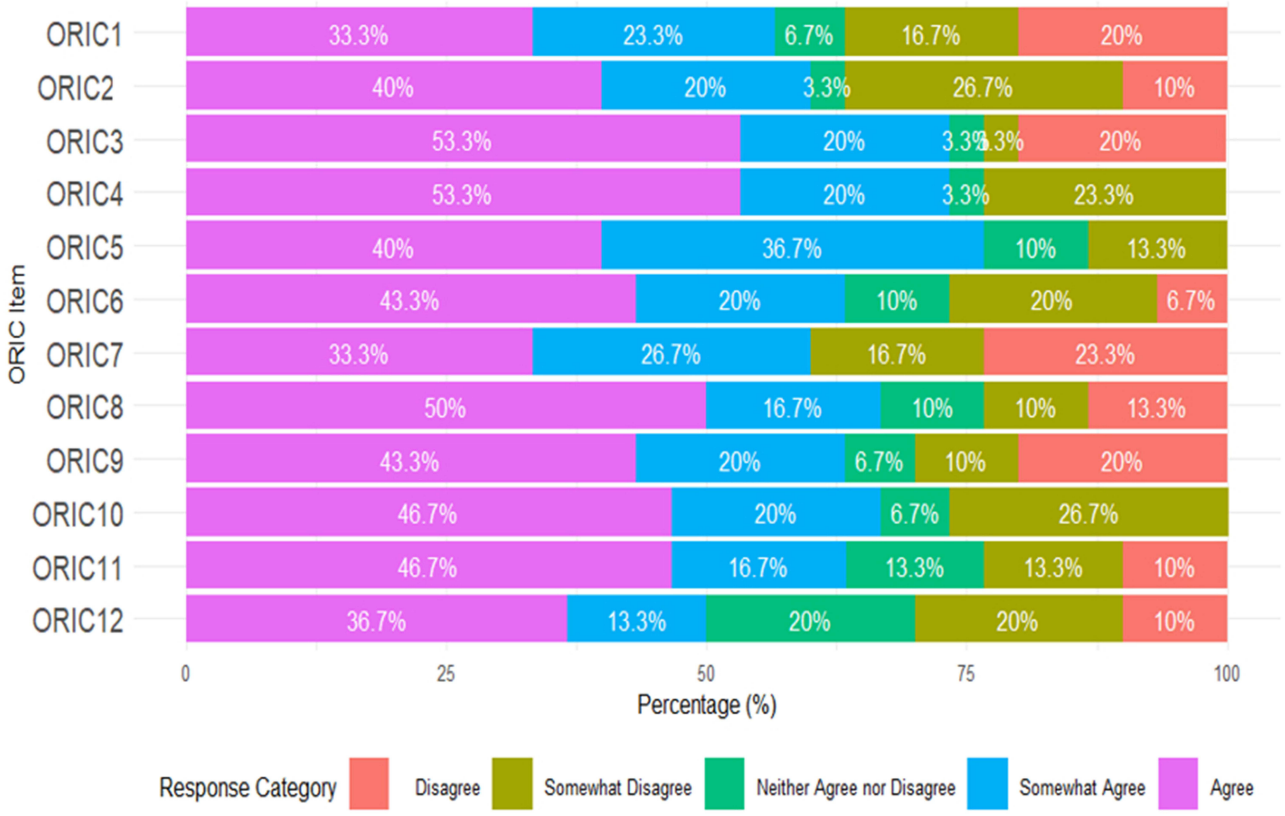

Figure 3 Change efficacy items ORIC1-7 change commitment ORIC (8–12).

necessary to ensure a sustained quality improvement (QI) initiative. This perception may be tied to the insufficient inclusion of nurses in key committees and strategic decision-making processes.[17] When nurses are excluded from policy development and planning efforts, internal decision-making can appear opaque, hierarchical, and politically driven, contributing to a sense that organizational politics are a barrier rather than a pathway to change.[17,18] Research highlights that engaging nurses in leadership and governance not only empowers them but also improves the legitimacy and perceived fairness of change processes.[17]

The study's findings further highlight the complexity of organizational change, where general support does not always translate to universal enthusiasm or smooth political navigation. Hence, while nurse and midwife leaders are willing to lead change, systemic challenges such as a lack of leadership buy-in and other bureaucratic constraints may exist. Prior research shows that while nurses and midwives are skilled at addressing healthcare challenges and improving care quality, their capacity to lead change is often constrained by limited leadership support, competing priorities, and unsupportive organizational environments.[19] This further aligns with the assertion in other studies that leadership support for nurses needs to be strengthened, especially due to the lack of structural power for them to drive change independently.[12] However, challenges can be overcome if Organizations should commit to change management capacity building and the cultivation of collaborative environments, enabling nurse and midwifery leaders to effectively lead transformation efforts.

Additionally, the respondents reported a moderate-to-high perceived organizational commitment to the change initiative, with the majority wanting the change initiative. However, there was a low perceived motivation for people to act on their commitment to implement change. This suggests that leadership training and structured mentorship may have helped boost the participants' confidence; however, they did not change the organizational culture. Highlighting that within the organizations, people may be on board with the idea of change, but the system around them needs to support it too. As stated in previous studies, systemic and external factors, such as a stressful work environment, obstruction of career goals, lack of support from colleagues, and problems with management, may dampen motivation for change10,17. Addressing these motivational barriers will be essential to translating readiness into sustained action.

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The high correlation between participants' previous QI experience and higher perceived change efficacy and overall ORIC scores suggests that prior engagement in QI projects builds confidence in both individual capacity and the organization's readiness for new initiatives. Studies have shown that past successes and experiences contribute to higher self-efficacy and collective efficacy.[18] This study also confirms that when an organization is perceived as supportive, it naturally fosters greater commitment and a belief in its capacity to manage change.[20] Other studies have proven that self-efficacy and perceived organizational support have been shown to significantly influence the employees "responses to change readiness".[21] The high rating of efficacy over commitment items may suggest the need for capacity building in these organization to motivate commitment to change. Hence, strengthening readiness for nurse-led changes, interventions should not only build individual confidence but also enhance the organizational environment through visible support, inclusion, and leadership engagement.

Limitations

In this study, the ORIC instrument captured the nurses and midwives' perspective of their organization's readiness to implement change, limiting assessment on shared readiness, and inter-rater agreement of organizational readiness.

The single-institution fellowship context (UGHE-CNM) and the small sample size (n = 30) limit the generalizability of the findings beyond the fellowship cohort and limit transferability of findings to other healthcare or cultural settings.

The use of a cross-sectional design restricts the ability to infer causality between perceived readiness and organizational or leadership factors.

Self-reported data may be subject to response and social desirability bias, especially since participants recently completed a leadership fellowship.

The study did not include objective organizational performance metrics such as QI project outcomes or policy adoption rates to validate perceived readiness scores.

Potential confounding variables such as institutional size, resource availability, and management structure were not controlled for in the analysis.

The study relied solely on the ORIC tool, which, though validated, may not fully capture contextual nuances of leadership, motivation, or political dynamics in low-resource healthcare settings.

Conclusion

This study provides insight into how nurse and midwife leaders perceive their organization's readiness to implement change initiatives. While nurses and midwifery training generally improve nurses' and midwives' confidence in leading change, structural support and commitment are crucial. The study highlights the role of organizational support as an influential factor in ensuring change efficacy and commitment. This emphasizes the need for leadership development programs for nurses and midwives to go beyond empowering nurses with strategic communication skills and building multidisciplinary teams. They must also understand organizational behavior and navigate institutional politics to ensure nurses are better prepared to influence policy, navigate institutional dynamics, and drive sustainable improvement. For nurse-led initiatives to succeed, health organizations must foster a supportive culture, involve nurses in decision-making, and integrate QI leadership modules into organizational development frameworks. This will enhance nurse and midwife leaders' ability to navigate organizational politics, mobilize support from colleagues, and confidently lead and advocate for nurse-led change initiatives. Leadership can operationalize readiness by investing in nurse and midwife leadership development and cultivating supportive environments that address systemic barriers. These findings strengthen nursing and midwifery leadership frameworks and provide a foundation for future readiness assessments in healthcare.

Recommendation

Future studies should consider the perspective of nurses and other stakeholders involved in the project to provide a more balanced view. Adding a qualitative component to explore the low motivation and concerns around internal politics would add an additional understanding of the structural or cultural factors behind these perceptions. We recommend the use of a mixed-methods approach in future studies to explore and uncover what political and organizational barriers nurses and midwives face in leading change.

Disclosure

The authors report no conflicts of interest in this work.

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