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ORIGINAL RESEARCH

Health Care Providers' Perceptions of the Ministry of Health's Organisational Readiness for Change

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Abstract

Background: Whenever an organisational change is mentioned in any research context, the uncertainty concept is usually mentioned as it is or as synonymous with lack of information, ineffective communication, and/or weak feedback. Since no previous studies have investigated the organisation's readiness to change in Saudi Arabia, this study will provide empirical evidence regarding these critical components.
Purpose: The study aimed to explore how healthcare providers in the Ministry of Health perceive the ministry's readiness to change.
Methods: A descriptive cross-sectional correlational design was used for this study. Three public hospitals under the Ministry of Health were involved in recruiting 420 healthcare providers using a convenient quota sampling. A personal data sheet and the organisational readiness for implementing change (ORIC) scale were used for data collection. ANOVA and t-tests were used to analyze the data.
Results: The total response rate was 70%. The participants in the study perceived their organisation to be highly ready to change (3.76±0.73). The organisational readiness to change perceived by nurses (3.86±0.98) was significantly greater than that perceived by physicians (3.56±0.90) and allied healthcare providers (3.61±0.92), with a p-value of 0.001. In addition, the organisational readiness to change was significantly related to the participants' specialty, age, experience, and gender (p<0.05).
Conclusion: The findings showed that participants believed that their organisation was highly ready to change. Participants' specialty, age, experience, and gender were significantly related to organisational readiness to change. This study recommends that leaders need to be proactive in managing changes by assessing the change readiness in their organisation and setting out plans to prepare the organisation.

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1. Introduction

The Kingdom of Saudi Arabia is undergoing a huge strategic change in all government entities. The Ministry of Health (MOH) is seeking to implement several health initiatives related to the National Transformation Program (NTP) 2020 and Saudi Vision 2030. The reform involves all levels of ministry directories, hospitals, specialised clinics, and primary health centres. Moreover, policies are changing and there are new projects to fulfill the vision strategy, like patient-centred care and patient experiences. Hospitals and primary centres are collected into health clusters when preparing for the expansion of the privatisation of health services and reducing the cost of health services. The utilisation of resources will be improved and the use of information technology will become efficient by initiating digital health records for Saudi citizens (Almuqati et al., 2022). Efforts to implement new changes, policies, or practices in health organisations often fail, as the management in most of these settings rarely creates adequate administrative readiness for change. In healthcare organisations, readiness to change has been defined as "capacity to implement change designed to improve performance" (Alharbi, 2018a, pp.45-51). A US study has shown that a previous history of change, culture, and the plan for organisational change influence the organisation's readiness and its ability through its social and technical systems to initiate and sustain that change (Dhingra & Punia, 2016). Moreover, commitment to change was seen as "a mindset that binds an individual to a course of action

deemed necessary for the successful implementation of a change initiative" (Bouckenooghe et al., 2015, pp. 578–595). In 2015, a study to assess readiness to change in 23 Swiss hospitals, where 1,833 nurses filled out questionnaires, showed that nurses were adequately ready for change and that a supportive leadership environment, staffing, and resource adequacy were correlated to readiness to change (Sharma et al., 2018).

Disclosure of information is classified as informational fairness by the organisational leadership, and it forms a critical part of organisational justice. Alharbi (2018a) conducted research in Saudi Arabia involving 18 hospitals and found that transformational leadership and maintaining a close relationship with followers had a significant positive influence on an organisation's readiness to change. Another research has supported the same relationship between the organisation's readiness to change and transformational leadership, in addition to effective communication and organisational commitment (Alharb, 2018a). Based on the argument that "consistent availability of team members can impact teamwork and organisational outcomes," Rodriguez et al. (2016, pp. 286–295) carried out a cross-sectional study using 628 primary care providers to examine the relationship between the availability of team members, teamwork and an organisation's readiness to change. The relationship between organisation type and readiness to change was also investigated in a study in Jordan. This study compared the readiness of four government hospitals and three private hospitals, and showed that government hospital staff and female staff perceived their organisations as more ready to change (Amarneh, 2017). Similarly, the organisations' policies and procedures had a positive or negative effect on the evaluation of task requirements, availability of resources, and situational elements of the members of the organisation (Ahmad et al., (2017).

Previous research involving 41 nurses in Egypt (Abd-Elkawey & Sleem, 2015) also showed that individual characteristics have no significant relationship to readiness to change, unlike their association with organisational commitment. However, organisational readiness to change is positively associated with structure empowerment and negatively associated with high-control organisational climates. On the contrary, another study showed that gender, educational level, and experience are positively related to readiness to change. Job motivation and employee competence are also positively related to organisational readiness to change (Amarneh, 2017).

The Ministry of Health, Saudi Arabia is now working on health reform focusing on sixteen objectives which are challenging. The lack of evidence about the organisation's readiness to change requires this study to be conducted. Since no previous studies have investigated the organisation's readiness to change in Saudi Arabia, this study will provide empirical evidence regarding these critical components. The results will provide leaders in healthcare organisations with suggestions on how to improve their organisation's readiness to change, enhance their employees' understanding of the new strategies, and involve employees in identifying ways to implement strategies. Accordingly, this study was conducted to explore how healthcare providers in the Ministry of Health perceive the ministry's readiness to change.

2. Methods

2.1 Research design

This study was conducted using a descriptive cross-sectional correlational design. This design was selected for the study as it describes the phenomenon, examines the relationship, and does not search for causality. It involves the analysis of data collected from a population, or a representative subset, at a specific point in time, which is cross-sectional data (Polit & Beck, 2017).

2.2 Setting and samples

This study was conducted at three hospitals under the Ministry of Health, Saudi Arabia. The population of the study included all healthcare providers working in the selected settings. According to the specialty classification, the population consisted of nurses, physicians, and allied healthcare professions (AHCP) (pharmacists, laboratory specialists, physiotherapists, and dietitians), with a total accessible population of 5,968.

A nonprobability sample was selected in this study, as they were selected based on convenience and quota. Determining the sample size was done in two steps. In step one, the minimum sample size required was calculated using Slovin's formula (Slovin, 1960). The result of the formula was 375, with addition to 10% to cover the cases of dropout and non-responses, resulting in a sample of 413 participants as a minimum. In step two, a quota sample was calculated

by dividing the accessible population into strata and calculating their proportions of the total population. The quotas of the study participants per health care provider and per hospital are shown in Table 1

Table 1. The quota and target samples

	Quota (%)	Target Samples
Nurses	64.84	268
Physicians	19.98	83
AHCP	15.16	62
Total	100	413
Hospital A	66.00	277
Hospital B	16.40	69
Hospital C	17.60	74
Total	100	420

Participant recruitment was based on the following inclusion criteria: healthcare providers who were employed by the Ministry of Health, presented during the period of data collection and consented to participate in the study. Subjects were excluded from the study if they had been employed in their present position for less than a year, dropped out, or did not complete the questionnaire.

2.3 Measurement and data collection

The questionnaire was composed of two parts. The first part was demographic data, comprising age, gender, nationality, years of experience, specialty, and educational qualification. The Organizational Readiness for Implementing Change (ORIC) (Shea et al., 2014) was the second portion of the complete questionnaire. The scale comprises twelve items, with five measuring commitments to change and seven measuring efficacies. The items are measured on a five-point Likert-type scale (disagree=1, somewhat disagree=2, neither agree nor disagree=3, somewhat agree=4, and agree=5). There are five categories of the organisational readiness based on the mean score, which are very high (mean score of 4.30-5.00), high (mean score of 3.50-4.29), moderate (mean score of 2.70-3.49), low (mean score of 1.90-2.69, and very low (mean score of 1.00-1.89) (Shea et al., 2014). The scale demonstrated adequate psychometrics in the healthcare field and had reliability coefficients of between α=0.91 and α=0.89 (Shea et al., 2014). In this study, a pilot study was carried out on 42 participants to ensure the clarity and applicability of the study measures. No modifications were needed to test the feasibility and applicability of the study tool. Using the Pearson correlation coefficient between the responses on each item and the total score of all respondents on all items, all items showed levels of significance of 0.01 which meant that all items in this instrument were valid. The Cronbach alpha coefficient for the questionnaire was 0.96, indicating that the questionnaire was reliable with high internal consistency.

After achieving the validity and reliability of the instrument, the questionnaire was distributed to the main samples to collect data. English language questionnaires, along with an invitation letter, were distributed by the researchers and the nurses in charge of the respondents in hospitals. Participants were asked to sign the consent forms and complete the paper questionnaires. The questionnaire was distributed and collected during their working shift. Researchers were present during the shift to respond to any questions. The data collection was done within six weeks between 19 March 2019 and 5 May 2019.

2.4 Data analysis

SPSS version 22 was used for the statistical analysis. The statistical test included frequency, percentage, mean, variance, and standard deviation. Analysis of variance one-way (ANOVA) and t-test were used to analyze the relationship between the demographic variables and the organisational readiness to change.

2.5 Ethical considerations

The institutional review board reviewed and approved this study at King Saud University, on 12/03/2019, with a reference number KSU-HE-19-133 and from the Ministry of Health institutional review board (IRB) with number 19-142E. Before participation, the purpose of the

study was explained to the participants on the information page. When a participant checked "I agree" on the informed consent page, they were giving their consent to participate in the study.

3. Results

Of the 600 questionnaires distributed, 447 were returned, and 27 questionnaires were excluded due to incompleteness resulting in 420 questionnaires included in the study. The total response rate was 70%. The response rate for A hospital was 79.14%, while the response rate for B and C hospital was 59.2% and 55.2%, respectively.

3.1 Characteristics of the participants

As shown in table 2, most of the participants were from A hospital (66%), nurses (65%), at the range age of 22-31 years (47.6%), female (72.4%), bachelor (74.3%), non-Saudi (50.5%), and had working experience ranging from 5 to 10 years (40.7%). Furthermore, specialty, age, working experience, and gender were significantly related to the organisational readiness to implement change. The organisational readiness to change perceived by nurses (3.86±0.98) was significantly greater than that perceived by physicians (3.56±0.90) and allied healthcare providers (3.61±0.92), with a *p*-value of 0.001. The older participants perceived their organisation to be more ready to change than younger participants (p=0.010). The participants with more experience perceived their organisation to be more ready to change than those with less experience (p=0.037). Female participants significantly perceived their organisational readiness to change (3.84±0.97) more than male participants (3.56±0.90). In contrast, work setting and educational qualification were not significantly related to the organisational readiness for change (p=0.382 and p=0.639, respectively).

Table 2. Characteristics of the participants (n=420)

Characteristics	f (%)	ORIC Mean(SD)	*F/t*	*p*
Hospital				
A	277(66.0)	3.42 (0.87)	0.964	0.382**
C	69 (16.4)	3.20 (0.81)		
B	74 (17.6)	3.32 (0.84)		
Specialty				
Physician	84 (20.0)	3.56 (0.90)	7.017	0.001**
Nurse	273 (65.0)	3.86 (0.98)		
Others (AHCP)	63 (15.0)	3.61 (0.92)		
Age (years)				
22- 31	200 (47.6)	3.66 (0.93)	3.832	0.010**
32- 41	169 (40.2)	3.80 (0.97)		
42- 51	47 (11.2)	4.01 (1.02)		
52- 61	4 (1.0)	4.18 (1.06)		
Gender				
Male	116 (27.6)	3.56 (0.90)	-3.699	0.0001*
Female	304 (72.4)	3.84 (0.97)		
Experience (years)				
> 5	141 (33.6)	3.71 (0.94)	3.317	0.037**
5-10	171 (40.7)	3.71 (0.94)		
< 10	108 (25.7)	3.92 (0.99)		
Educational qualification				
Diploma	68 (16.2)	3.77 (0.97)	0.564	0.639**
Bachelor	312 (74.3)	3.75 (0.95)		
Master	29 (6.9)	3.70 (1.00)		
Doctorate	11 (2.6)	3.78 (0.90)		
Nationality				
Saudi	208 (49.5)			
Non-Saudi	212 (50.5)			

Note. *t-test, **ANOVA

3.2 Level of perceived readiness to change in organisation

Table 3 illustrates the organisational readiness to implement change (ORIC) perceived by healthcare providers. The total mean score of ORIC was 3.76±0.73, meaning that the participants in the study perceived their organisation to be highly ready to change, as a greater score would have indicated greater change readiness. The mean score for the change efficacy subscale was 3.75±0.75, where the item "people who work here feel confident that they can coordinate tasks so that implementation goes smoothly" had the highest mean score (3.81±0.89) and the item "people who work here feel confident that they can manage the politics of implementing this change" had the lowest mean score (3.66±0.93). In addition, the mean score for the change commitment subscale was 3.79±0.76. In this subscale, the item "people who work here want to implement this change" had the highest mean score (3.90±0.89), while the item "people who work here are motivated to implement this change" had the lowest mean score (3.72±0.95).

Table (3). Organisational readiness to implement change (ORIC)

ORIC items	Mean	SD	Rank
Change Efficacy		3.75±0.75	
People who work here feel confident that the organisation can get people invested in implementing this change.	3.77	0.97	4
People who work here feel confident that they can keep track of progress in implementing this change.	3.75	0.95	5
People who work here feel confident that the organisation can support people as they adjust to this change.	3.70	1.00	6
People who work here feel confident that they can keep the momentum going in implementing this change.	3.77	0.87	3
People who work here feel confident that they can handle the challenges that might arise in implementing this change.	3.78	0.90	2
People who work here feel confident that they can coordinate tasks so that implementation goes smoothly.	3.81	0.89	1
People who work here feel confident that they can manage the politics of implementing this change.	3.66	0.93	7
Change Commitment		3.79±0.76	
People who work here are committed to implementing this change.	3.83	0.90	2
People who work here will do whatever it takes to implement this change.	3.73	0.97	4
People who work here want to implement this change.	3.90	0.89	1
People who work here are determined to implement this change.	3.76	0.89	3
People who work here are motivated to implement this change	3.72	0.95	5
Overall ORIC		3.76±0.73	

4. Discussion

The current study aimed to explore how healthcare providers in the Ministry of Health perceive the ministry's readiness to change. Overall, the study's findings showed that organisational readiness to change is highly ready across hospitals. The mean score of all items of the ORIC was 3.76±0.73, which meant that the participants in the study perceived their organisation to be highly ready to change, as a greater score indicates greater change readiness. There was agreement from the participants in general about all items of (ORIC) since the value of the standard deviation was less than two. The finding of the study showed that the change efficacy subscale in ORIC was moderately high, where the item "people who work here feel confident that they can coordinate tasks so that implementation goes smoothly" was the highest and the item "people who work here feel confident that they can manage the politics of implementing this change" was the lowest. The finding of the study also showed that the change commitment subscale in ORIC was moderately high, where the item "people who work here want to implement this change" was the highest and the item "people who work here are motivated to implement this change" was the lowest.

Readiness to change is a multilevel and multifaceted construct. In this study, the readiness to change was examined at the organisational level by measuring shared change commitment and shared change efficacy. Organisational readiness for change reflects members' commitment to change and change efficacy in carrying out organisational change. It shows how favourably the organisation appraises the three key determinants of change implementation ability: task demands, resource availability, and situational factors. When organisational readiness for change is high, members are more likely to initiate change and display more cooperative behaviour and, in turn, effectively manage the change (Billsten et al., 2018). Another study investigated factors associated with Egyptian nurses' readiness for organisational change using a descriptive exploratory design and a convenience sample of 179 nurses. The samples showed moderate readiness and low resistance to organisational change. Also, nurses' readiness for organisational change correlated positively with the professional nursing practice environment (PNPE) and structural empowerment and negatively with dispositional resistance to organisational change and the emotional climate (El-Sayed et al., 2018).

The findings of this study were similar to those found by Alharbi (2018b) in an analysis of the Saudi health system and readiness for a transformation plan. The analysis concluded that as the resources are available, contextual factors are aligned, organisation members will employ maximum effort demonstrate greater engagement and commitment to the plan, and the readiness will be high, enabling the Saudi transformational plan to be implemented with less resistance. In this study, participants acknowledge the need for change, enhancing the organisational readiness. In our finding, the item linked to "want to" has higher agreement among the commitment items. People usually want to implement the change for different reasons, which make them committed to the change and show enhanced organisation readiness. This finding was supported by that found by Alharbi (2018b). When resources are available and situational factors aligned, employees will take the initiative to change and engage in more cooperative behaviour that can lead to the efficient and effective implementation of change.

Furthermore, organisational readiness for change is linked to leadership capacity, which means the skillful involvement of staff in the work of leaders (Nilsen et al., 2018). Effective top management helps employees to implement their creative ideas and effectively manage organisational change (El-Sayed et al., 2018). Leaders should focus on the timing of the change, the amount of information disseminated, and training on change management. This will have a positive influence on employees' attitudes toward organisational change (Nilsen et al., 2018). Open communication and training help employees to accept and integrate change successfully (Sharma et al., 2018). In this study, the change commitment level is higher in comparison with change efficacy. The pattern of greater change commitment than efficacy may be due to the perceived need for change and improvement in a busy and stressful environment (Storkholm et al., 2019). Even though the three hospitals in this study are in different stages of change and in implementing the National Transformation Program (NTP) objectives, they have approximately the same level of readiness. Other research findings were different and revealed that readiness varies between hospitals and departments based on the type of leadership, staffing, culture, training opportunity, and resource availability (Sharma et al., 2018). The finding of this study shows that employees' characteristics influence readiness to change. As an individual factor, readiness for change is associated with people's characteristics, attitudes, and preferences in terms of organisational readiness for change (Nilsen et al., 2018). As an organisational factor, readiness for change refers to job characteristics that empower employees with the attitudes, skills, and opportunities to manage change. In addition, it focuses on emotional climate and structural empowerment. Emotional climate helps to provide a structure for assessing the role of emotion in organisational readiness for change. Structural empowerment is an organisation's ability to give access to information and resources as well as supportive work environments (Nilsen et al., 2018).

Currently, various organisations consider models like the McKinsey 7-S approach and the ADKAR model as pivotal pillars for facilitating their workplace transitions. McKinsey 7-S Model, as its name suggests, sets on seven stages when handling organisational changes. These include strategy, structure, systems, shared values, style, skills, and staff. The planning strategy encompasses the tactics relied on upon developing and upholding a framework. The structure, on the other hand, includes the manner in which an organisation's elements are consolidated or the structure used for achieving the desired outcomes. Systems define the necessary regulation

activities that ought to be undertaken regularly to meet the sought-after results; it also includes the processes in which such activities have to take place for changes to be managed with efficacy. At the same time, shared values are the core value that is expected to safeguard an organisation. The style encompasses the technique adopted in leading the development, implementation, and maintenance of changes, while the staff features the labor force relied upon by an organisation in terms of its availability, numbers, or potential. Lastly, the skill includes the competence and expertise possessed by an organisation's staff. The seven steps are further classified as either soft or hard based on their levels of significance and ease of identification (Perez, 2015). The second model is the ADKAR approach. This change management model gives much credit to the key steps that will lead to the attainment of the desired change. With ADKAR, an organisation must focus on achieving simpler goals as they are interlinked to the overall objectives of a change cumulatively. Therefore, it serves as a suitable change approach in scenarios where an organisation seeks to detect flaws or incompetence in the awaiting changes, therefore seeking ideal methods of alleviating or counteracting them. ADKAR approach comprises five steps, namely awareness, desire, knowledge, ability, and reinforcement (Perez, 2015).

In this study, the organisational readiness to change was influenced by employee specialty, whereas nurses had more collective readiness than other specialties in this regard, which meant that the organisational readiness to change perceived by nurses was more than by physicians and allied healthcare providers. The result contradicts those found in another research, where physicians had more readiness to change (Rodriguez et al., 2016). Organisation readiness to change was affected in this study by participant experience, as more experienced employees had more collective readiness to change. This means that the participants who had more experience perceived their organisation to have more readiness to change than participants who had less experience. This result was different from Khammarnia et al. (2014)'s study, which reported that employees who had more experience had lower readiness to change. The study locations and methodological approaches may play a crucial role in explaining why different results were obtained. When faced with organisational change, people may also feel anxious, and they will have a tendency to adhere to their own beliefs due to poor communication, insufficient information, and a lack of involvement in the development of any change program. Additionally, employees who have been in their positions for a longer period are satisfied. The longer they have worked there, the more favorable their opinions of magnet hospital aspects were. Moreover, female and older employees in this study had more collective readiness than others. These results contrast other studies that revealed that gender, age, and profession had no impact on organisation readiness to change (Abd-Elkawey & Sleem, 2015; Rodriguez et al., 2016; Storkholm et al., 2019). The sample size, study settings, methodology, and population characteristics may all play a significant role in explaining why results from the studies turn out differently. According to the researchers, female nurses are more emotionally stable than male nurses, more satisfied and committed because of their financial burdens and family responsibilities, and they have good and positive relationships with their supervisors and peers, all of which help them to be more open to change. Likewise, younger workers are more likely to welcome organisational change and are also less resistant to it. Therefore, in contrast to older employees, they were prepared for and amenable to organisational change.

5. Implications and limitations

The need to stay at a high level of readiness for change is important in the age of agile organisations and competitiveness. The results of this study could be used by healthcare organisation leaders to encourage readiness for change in the healthcare sector. Leaders need to be proactive in managing change by assessing the change readiness in their organisation and setting out plans to prepare the organisation, which can be done using change management models such as the McKinsey 7-S Model and ADKAR Model. Organisation administrators should also pay more attention to making the resources to support reform available to all staff in implementing change.

Even though the results of this study contribute to the field of change management in healthcare, it is important to consider some limitations of this study. First, there is the question of whether the results from this study on change readiness in the Ministry of Health can be generalised to other organisations. Second, since our research was investigated in the healthcare sector, its outcomes are not represented by all healthcare professionals; thus, consideration is

required to generalise our findings. Third, data from the sample was gathered at just one point in time. Because of this, there should be caution in making claims about the directionality of the relationships between variables in this study, limiting our ability to make causal inferences. Fourth, the hospitals were at different phases of change. Employees' changing attitudes may alter over the change phases. Fifth, because all of the measures used were self-report, objective understanding of strategy by employees was not evaluated, although it is reasonable to assume that such a measure would be important.

6. Conclusion

The findings of this study showed that participants believed that their organisation was highly ready to change. The ORIC efficacy dimension was reasonably high, with greater values indicating more change efficacy. As for the differences between demographic characteristics regarding organisational readiness to change among healthcare providers working for the Ministry of Health, it was discovered that organisational readiness to change was positively affected by specialty, age, experience, and gender. However, participants' work settings and educational qualifications were not related to readiness to change. The need to stay at a high level of readiness for change is important in the age of agile organisations and competitiveness. In conclusion, future research may include research that uses a mixed-methods design. Finally, employees need to take an active approach to implementing the plan to enhance their perception of the ability to implement the change. This study also recommends that leaders need to be proactive in managing change by assessing the change readiness in their organisation and setting out plans to prepare the organisations, which can be done by using change management models such as the McKinsey 7-S Model and ADKAR Model.

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Author contribution

JA developed the conceptual framework. MA and AA developed the methodological design. JA contributed to data collection. JA and MA analysed the data and drafted the manuscript. All authors contributed to the final version of the study.

Conflict of interest

No conflict of interest in this study.

References

Abd-Elkawey, H., & Sleem, W. (2015). Factors affecting nurses' readiness for change in health care organizations. *International Journal of Advanced Research*, *3*(11), 1330–1343. https://www.journalijar.com/uploads/873_IJAR-7847.pdf

Ahmad, M. H., Ismail, S., Rani, W. M., & Wahab, M. H. (2017). Trust in management, communication and organisational commitment: Factors influencing readiness for change management in organisation. *Proceeding of International Conference on Applied Science and Technology, 1891*, 1. AIP Publishing. https://doi.org/10.1063/1.5005352

Alharbi, M. F. (2018a). An investigation of the Saudi healthcare system's readiness for change in the light of vision 2030: The role of transformational leadership style. *Journal of Health Specialties*, *6*(2), 45–51. https://doi.org/10.4103/jhs.JHS

Alharbi, M. F. (2018b). An analysis of the Saudi healthcare system's readiness to change in the context of the Saudi National Healthcare Plan in Vision 2030. *International Journal of Health Sciences*, *12*(3), 83–87. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5969787/pdf/IJHS-12-83.pdf

Almuqati, M., Althomali, S., Alfaki, M., Alkrani, A.S. (2022). Examine the relationship between transparency, strategic understanding, and organisation readiness to change among healthcare providers working in The Ministry of Health. *Bioscience Research, 19*(3), 1615.

Amarneh, B. H. (2017). Nurses' perspectives on readiness of organizations for change: A comparative study. *Nursing: Research and Reviews*, 7, 37–44. https://doi.org/10.2147/NRR.S126703

Billsten, J., Fridell, M., Holmberg, R., Ivarsson, A. (2018). Organizational Readiness for Change (ORC) test used in the implementation of assessment instruments and treatment methods in a Swedish National study. *Journal of Substance Abuse Treatment, 84,* 9–16. https://doi.org/10.1016/j.jsat.2017.10.004

Bouckenooghe, D., M. Schwarz, G., & Minbashian, A. (2015). Herscovitch and Meyer's three-component model of commitment to change: Meta-analytic findings. *European Journal of Work and Organizational Psychology*, *24*(4), 578–595. https://doi.org/10.1080/1359432X.2014.963059

Dhingra, R., & Punia, B. (2016). Impact of organizational culture on employees' readiness to change a study in Indian perspective. *Journal of Management Research*, *16*(3), 135–147.

El-Sayed, F., Seada, A., El-Guindy, H. (2017). Factors associated with nurses' readiness for organizational change at Beni Sueif University Hospital. *Egyptian Nursing Journal*, *14*(2), 141-151. https://doi.org/10.4103/ENJ.ENJ_24_17

Khammarnia, M., Ravangard, R., & Asadi, H. (2014). The relationship of psychological empowerment and readiness for organizational changes in health workers, Lorestan, Iran. *Journal of the Pakistan Medical Association, 64*, 537–541.

Nilsen, P., Wallerstedt, B., Behm, L., Ahlström, G. (2018). Towards evidence-based palliative care in nursing homes in Sweden: a qualitative study informed by the organizational readiness to change theory. *Implementation Science: IS, 13*(1), 1. https://doi.org/10.1186/s13012-017-0699-0

Perez, A. (2015). *Healthcare staff readiness for change based on EHR implementation: An exploratory qualitative inquiry* (Order No. 3718650) [Doctoral dissertation, Capella University]. ProQuest Dissertations & Theses Global.

Polit, D. F., & Beck, C. T. (2017). *Nursing research generating and assessing evidance for nursing practice* (10th ed.). Wolters Kluwer.

Rodriguez, H. P., Chen, X., Martinez, A. E., & Friedberg, M. W. (2016). Availability of primary care team members can improve teamwork and readiness for change. *Health Care Management Review*, *41*(4), 286–295. https://doi.org/10.1097/HMR.0000000000000082

Sharma, N., Geest, S. De, Herrnschmidt, J., Claes, V., Bachnick, S., & Simon, M. (2018). Organizational readiness for implementing change in acute care hospitals: An analysis of a cross-sectional, multicentre study. *Journal of Advanced Nursing*, *74*, 2798–2808. https://doi.org/10.1111/jan.13801

Shea, C. M., Jacobs, S. R., Esserman, D. A., Bruce, K., & Weiner, B. J. (2014). Organizational readiness for implementing change: A psychometric assessment of a new measure. *Implementation Science*, 9, 7. https://doi.org/10.1186/1748- 5908-9-7

Slovin, E. (1960). Slovin's formula for sampling technique. Prudence. https://prudencexd.weebly.com

Storkholm, M. H., Savage, C., Tessma, M. K., Salvig, J. D., & Mazzocato, P. (2019). Ready for the triple aim? Perspectives on organizational readiness for implementing change from a Danish obstetrics and gynecology department. *BMC Health Services Research*, *19*(1), 517. https://doi.org/10.1186/s12913-019-4319-3112