

The Identification of Staff Nurses as Organizational Champions

A Dissertation Presented

By

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DEDICATION

This work is dedicated to the champions in my life who have inspired me to embrace my passion and charge at it with reckless abandon. You have inspired me to face each challenge as I have learned to face life... “One mountain at a time.”

-To those who have inspired and supported me to continue on a journey of lifelong learning, I can only hope to honor you with a career that inspires and supports others. To the nurses who have mentored me, I would not be who I am without your expertise and patience.

-To my family, steeped in traditions of lifelong learning, I know that I am standing on the shoulders of those who faced these challenges before me. Without your navigation, I can't say for certain I would have chosen this path. To “Bam”, the first nurse in our family, to my grandfather, the original “professor” and “champion” of lifelong learning, to my grandmother, whose relationship with her students had as much impact on her as it did on them, and finally to my parents who made academics both an expectation and a possibility, I dedicate this work.

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“Oh, and when the kids are old enough we’re gonna teach them to fly”

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Abstract

The characteristics of nurses acting as organizational champions, as well as the ways that clinical leaders systematically harness the energy of these champions in support of innovation, were explored in this qualitative descriptive study. The specific aims were guided by prior empirical evidence and identified research needs. Semi-structured interviews were conducted with 14 formal nursing leaders (e.g. managers, educators, administration) in an academic medical center. This study, including the interview guide, was informed by Kouzes and Posner's (2007) Five Practices of Exemplary Leadership. Two models were developed to describe the data. Overall, participants echoed prior empirical findings identifying a need for organizational champions' support of innovation and explained how some nurses seem to have "innate" characteristics that make them champions. Participants identified the champion as the "go to" person who can see the bigger picture and who seems to "own their own practice". They described the importance of being truly present on the unit in order to harness the energy of these champions. Once champions are identified, leaders match the champions' talents to the innovation planned, secure buy in from the champions, and actively work to support champions and get a culture of innovation "in the drinking water." This work enhances the leader's experience and makes him/her feel inspired and engaged. The two models developed based on the participants' description of their experience working with staff nurses acting as organizational champions provide a framework for clinical leaders to identify and engage organizational champions in their clinical areas in support of innovation.

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Chapter 1

State of the Science

There is a call for cutting-edge solutions to healthcare problems and nurses are being asked to participate fully in innovation in quality and patient safety (Berwick, 2010).

Measurable medical errors are preventable adverse outcomes resulting from improper medical management, costing an average of \$17.1 billion annually (Van Den Bos et al., 2011). Medical errors that are associated with large annual costs (e.g. pressure ulcers and central venous catheter infection) often fit into the category of “nurse sensitive indicators” (National Database of Nursing Quality Indicators [NDNQI], 2012). Nurse sensitive indicators reflect the structure, process, and outcomes of nursing care and are often used to describe quality of care and to measure improvement (Van Den Bos et al., 2011). In addition, these measures are used to determine a hospital’s payment for the care provided to the patient. Good outcomes or improvement in outcomes increases payment (NDNQI, 2012). Making changes to improve these indicators should involve the staff nurse, but identifying the right participants can be a challenge (NDNQI, 2012).

One way that a nurse can participate in improving quality and safety is by acting as an organizational champion in support of change. Organizational champions are opinion leaders, respected by their peers as leaders and experts, who support organizational improvement initiatives by spreading a positive message about change (Greenhalgh et al., 2004). Organizational champions may not always be the first to adopt a new practice (“early adopters”), but they seek out information about an initiative and, once they adopt it, lead others into a new way of doing things (Greenhalgh et al., 2004). Encouraging peer involvement above and beyond formal job requirements is an important function of an organizational champion (Salanova,

Lorente, Chambel, & Martinez, 2011). Champions engage in the innovation through a number of actions (Rogers, 1995; Hendy & Barlow, 2012). They provide education, act as advocates, build relationships with end users, and help navigate boundaries, real or perceived, between groups as a means to enhance the spread of the innovation (Soo, Berta, & Baker, 2009).

Organizational champions who identify closely with a small group of similar individuals, such as a workgroup (e.g. staff nurses on a specific shift or unit), play a pivotal role in adoption of a new practice (Hendy & Barlow, 2012). Particularly in the early stages of adoption, champions connect with the new practice and encourage others within the group to connect as well. This connection has been shown to enhance peers' contribution to the practice change process (Hendy & Barlow, 2012). For example, mentoring leadership behaviors has been shown to increase the likelihood that other nurses would feel empowered to demonstrate similar peer leadership behaviors in support of a practice change (Madison, 1994; Wallen, Mitchell, Melnyk, Fineout-Overholt, Miller-Davis, Yates, & Hastings, 2010).

Identifying staff nurses who are organizational champions is a challenge (Soo et al., 2009). A major gap in our understanding is how to best to identify the characteristics of persons who will actively engage in behaviors associated with organizational champions, including supporting evidence-based practice, acting as a peer leader, and supporting and mentoring those interested in such behaviors (Greenhalgh, 2004). If managers could successfully identify these staff nurses, then they could readily elicit their help to support change on a unit to improve quality and patient safety.

Champions motivate others and also experiment with new practices in an effort to improve their work environment (Hendy & Barlow, 2012). They have been shown to help influence adoption of clinical practice guidelines aimed at improving quality of patient care by

educating and mentoring their peers (Ploeg et al, 2010). In addition, staff nurses acting as peer leaders have been shown to be important quality and patient safety advocates by utilizing their experience and skills to flag situations that are risky and advocate for changes needed to improve patient care (Tregunno et al., 2009). Greenhalgh et al. (2004) assert that when the supporters of the innovation outnumber the opponents, success is more likely. Identifying these individuals is critical.

The role of the champion as a supporter of organizational innovation has been studied, but there is a lack of direct empirical evidence about how to identify these organizational champions (Greenhalgh et al., 2004). The purpose of this study was to advance our understanding about how those in leadership positions (e.g. managers, directors, executives, and educators) identify and utilize staff nurse organizational champions. Kouzes and Posner's (2007) Five Practices of Exemplary Leadership were used to guide this study. This research aimed to:

1. Describe how clinical leaders identify staff nurses as organizational champions.
2. Describe how clinical leaders systematically harness the energy of staff nurses acting as organizational champions to support innovations.

Background and Significance

A literature review was conducted to critically appraise the evidence about staff nurses acting as organizational champions. The search was initially limited to articles from the 1990-2012 as this represented the era of modern healthcare quality improvement (QI) in the United States. Articles from service-delivery organizations other than healthcare and from those that were not service-delivery type organizations were included in the review if they (a) provided insight into the characteristics of organizational champions, (b) discussed how organizational

champions' utilization by managers, or (c) were seminal articles in the study of innovation and diffusion of innovations. Reference databases and hand-review of the reference lists of key articles supplemented the computer search.

The final sample of 23 empiric sources included both quantitative (n=9) and qualitative (n=6) research as well as mixed methods research (n=3) and systematic reviews (n=5). The bulk of literature about innovation and characteristics of the stakeholders tends to be older than 10 years, with newer articles (1995-2012) focusing more specifically on ways to affect spread throughout a system. Many of the sources are not data-based studies. Finally, many of the studies that refer specifically to the staff nurses' role in innovation were conducted in countries with social medicine (UK, Canada, Australia) (N=11). Seminal articles in the study of innovation and spread of innovation were included, regardless of age. The review of the literature yielded four main themes:

- Innovation in Healthcare
- Nurses' Role in Innovation
- Leadership Characteristics
- Organizational Champions

Innovations in Healthcare

Greenhalgh et al. (2004), defined innovations in service organizations as “a novel set of behaviors, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users' experience, and that are implemented by planned and coordinated actions.” (pg. 582) Often, innovations come from documentation of best practices or new processes that have resulted in an improvement in another organization (Greenhalgh et al., 2004; Lansisalmi, Kivimaki, Aalto, & Ruoranen, 2006). Despite past

successes in other organizations, when the decision is made to adopt an innovation, it must be made to fit the individual organization's needs. Broadly defined, innovations in healthcare organizations represent any new process or routine to improve the organizations' outputs (outcomes, efficiency, user experience, cost effectiveness) (Greenhalgh et al., 2004). This definition reflects what was found in other literature sources (Hendy & Barlow, 2011; Ploeg et al., 2010) and was used to identify innovations in the literature for this review.

Innovations are designed and implemented in a coordinated manner (Greenhalgh et al., 2004). Innovation in healthcare includes QI strategies such as implementation of evidence-based practices and behaviors to support learning, either independently as part of clinicians' own improvement or as part of an overarching process improvement project (Fitzgerald, Ferlie, & Hawkins, 2003; Greenhalgh et al., 2004; Lansisalmi et al., 2006). In healthcare, innovations typically relate to larger aims including improving quality, cost-effectiveness, and efficiency (Greenhalgh et al., 2004).

In their systematic review, Greenhalgh et al. (2004) outlined how early research on diffusion of innovations (1966-1995) focused on innovation and adopter attributes that may influence spread of an innovation while later studies (1976-2003) considered context and setting and took a wider view of innovations at all levels within an organization. Early research, primarily focused on medical sociology, communications, marketing, individual adopters, and failed to consider variability of innovations, adopters, and settings (Greenhalgh et al., 2004). Later research addressed emerging areas such as health promotion, evidence-based medicine, the meaning of an innovation to an organization and the "innovation-system fit" (pg. 590) (Greenhalgh et al., 2004). Using this approach supports the idea that diffusion of innovations takes place through careful analysis, multiple stakeholders, and that both organizational change

and individual change are factors in the spread of an innovation (Greenhalgh et al., 2004). The characteristics of the innovation and the system are important to consider when identifying the characteristics of staff nurses who might serve as organizational champions.

Characteristics of the innovation. The key characteristics of an innovation that make it more or less likely to be adopted have been well defined and include (a) relative advantage and (b) compatibility with the system (Greenhalgh et al., 2004). The relative advantage of an innovation is determined by the effectiveness and cost-effectiveness of the innovation (Greenhalgh et al., 2004). If the advantage is not clear to the end-users, there is little chance for widespread adoption occurring (Greenhalgh et al., 2004). Relative advantage can change over time as potential users negotiate the benefits (Greenhalgh et al., 2004). Compatibility with the system is also an important characteristic of the innovation (Greenhalgh et al., 2004; Lansisalmi et al., 2006). When evaluating the innovation, the end-users (the individual adopters) consider the innovation's compatibility with norms, values, ways of working, and needs of the organization to make a decision regarding adoption (Greenhalgh et al., 2004). If the innovation violates a professional norm, for example, a standard of practice or scope of practice, it runs the risk of being rejected by those expected to adopt it (Greenhalgh et al., 2004). In systematic reviews of innovation literature, Greenhalgh et al. (2004) and Lansisalmi et al. (2006) found that innovation characteristics must be considered when planning an innovation. Failure to consider these characteristics has a negative influence on adoption of an innovation.

Characteristics of the system. There are system characteristics that must be considered related to the context in which the innovation is being introduced. (Greenhalgh et al., 2004; Rogers, 1995; Rycroft-Malone, Harvey, Seers, Kitson, McCormack, & Titchen, 2004). Context clues may include: (a) system readiness, (b) system structure, and (c) absorptive capacity for

change. System readiness, including the current working environment, the innovation-system fit, available resources and time, and perceived support for the innovation, contributes to the success of the innovation (Greenhalgh et al., 2004; Rycroft et al., 2004). In addition, the system structure and organization have an effect. If an organization is “large, mature, functionally differentiated, and specialized, with foci of professional knowledge...has slack resources to channel into new projects...has decentralized decision-making structures” (pg. 604), it will adopt innovations more readily (Greenhalgh et al., 2004). Absorptive capacity for change can be assessed by looking at the institution’s ability to identify new information, reframe it to fit the organization, link it to its’ existing knowledge base, and utilize it within the institution (Greenhalgh, et al., 2004). If knowledge is not socialized and added to the knowledge base, to be shared by interpersonal networks, it faces barriers to its spread (Greenhalgh et al., 2004). In healthcare, because of rapidly changing technologies and practice recommendations, this is especially important.

Greenhalgh et al. (2004) and Lansisalmi et al. (2006) conclude that organizational characteristics affecting diffusion of innovation (in addition to innovation characteristics) are often the focus of innovation research. The gap identified is how to maximize the spread and sustainability of an innovation (Greenhalgh et al., 2004; Lansisalmi et al., 2006). The common factor known to enhance spread of an innovation through an organization, is the presence of an organizational champion, often a staff nurse in the healthcare setting, working to support the innovation’s success (Greenhalgh et al., 2004; Hendy & Barlow, 2012; Lansisalmi et al., 2006; Patrick et al., 2011; Soo, 2009; Weingart et al., 2009; Zrelak et al., 2011).

Nurses' Role in Innovation

Nurses, regardless of role, are important participants in quality improvement initiatives in healthcare (Kirchner et al., 2010; Ploeg et al., 2010; Soo et al., 2009; Zrelak et al., 2012). The addition of frontline staff to planning an innovation such as a QI project has been shown to enhance the peer acceptability of the innovation (Kirchner et al., 2010; Soo et al., 2009). Champion roles include advocating for the innovation, building relationships, and navigating boundaries (Soo et al., 2009). A need for further research about nurses' involvement in the planning and dissemination of innovations, such as QI strategies, has been identified as a priority in the IOM (2010) "Future of Nursing" report.

Nurse-sensitive outcomes, such as pressure ulcer and healthcare-associated infection rates, affect hospitals' payment for care provided (CMS, 2012; NDNQI, 2012). These problems within healthcare are often addressed using evidence-based protocols and "bundles" that are dependent on nursing interventions to carry out, and in some cases, initiate interventions (NDNQI, 2012; CMS, 2012; Institute for Healthcare Improvement [IHI], 2012). Measures such as catheter-associated infection rates (including urinary, venous, and arterial catheters), pressure ulcer rates, and patient satisfaction with staff nurse-patient communication, pain management, and response to concerns are directly dependent on engaging frontline staff to address these problems consistently and in a somewhat standardized manner (IHI, 2012).

Staff nurses that act to improve patient, organizational, and system outcomes by championing innovative best practices can influence peers, disseminate information through education and navigate the context in which the practice is being introduced (Ploeg, Skelly, Rowan, Edwards, Davies, Grinspun, Bajnok, & Downey, 2010). In a mixed method sequential triangulation study, key informants were interviewed (n=23) and a separate group of champions

of best practice (n=232) and administrators (n= 41) were surveyed to identify the role of the champion (Ploeg et al., 2009). The survey used a five-point Likert-type scale to assess the success of strategies identified during interviews and the practice changes that occurred as a result of the practice champion strategies (Ploeg et al., 2009). No significant differences were found between the scores of champions and administrators related to raising awareness, sharing information, providing education, integrating best practice goals into staff orientation and integrating best practice goals into ongoing education. However, the study showed the diversity of the role of the nurse championing best practices. It also linked the ability to influence practice at the local level to the ability to act as a peer leader and impact change at the system level (Ploeg et al., 2009).

Leadership Characteristics

Regardless of a leader's level or role within an organization, characteristic leadership behaviors such as mentoring positive or desired behaviors and supporting the innovation has been shown to facilitate its' implementation across an organization (Ploeg et al., 2009; Wallen et al., 2010). In a mixed-methods intervention study targeted at staff nurse clinical leaders acting as mentors to enhance implementation of evidence-based practices (EPB), post-intervention surveys showed increased implementation of EBP (Wallen et al., 2010). Survey scores, using the EBP Implementation scale (Cronbach's α 0.92-0.94), an 18 item, five-point Likert-type scale, increased more in those that participated in the mentoring program. Evidence-based implementation in the intervention group (N=54) increased by 6.6 points as opposed to only 3 points in the non-intervention group (N= 35) (Effect size 0.57). Beliefs about EBP were assessed using the EBP Beliefs scale, a 16 item five-point Likert-type scale (Cronbach's α 0.90-0.92) (Wallen et al., 2010). Beliefs increased post-intervention (N=56) (+5.4) and only slightly

increased in the non-intervention group (N=40) (+ 0.2) (Effect size 0.52) (Wallen et al., 2010).

A positive correlation was noted between EBP beliefs and EBP implementation ($r=0.36$, $p<0.01$) (Wallen et al., 2010).

Two themes emerged from the literature review relevant to leadership characteristics' impact on the spread of innovation: leadership roles (formal vs. informal) and transformational leaders. A review of these themes and their impact on the nurse's role in innovation will be discussed in the following sections.

Leadership roles. In a healthcare organization, nurses often act in both formal (e.g. managerial) and informal (e.g. peer) leadership roles (Downey, Parslow, & Smart, 2011; Patrick et al., 2011). A term sometimes used synonymously with "informal leader" is "clinical leader." For this review clinical leader will be identified as either "formal" (e.g. nurse manager) or "informal" (staff nurse acting upon peers). Articles using "clinical leader" or "clinical leadership" are careful to delineate the difference between the formally-appointed clinical leader and the staff nurse demonstrating clinical leadership in a more informal capacity (Davidson, Elliot, & Daley, 2006; Patrick et al., 2011).

While formal leaders are often recognized for their effect on change and patient care; it is often the informal clinical leader, who has the greatest impact at the local level (Greenhalgh et al., 2004; Patrick et al., 2011). In a focus group study of 188 staff nurses and managers (31 focus groups), the informal leader acted in a similar role as the organizational champion, presenting a positive outlook on a change to his or her peers (Tregunno, Baker, Jeffs, Doran, McGillis Hall, & Bookey Bassett, 2009). In addition, the informal nurse leader was described as the "go to" (p. 336) person for information, the one "on the ball" (p. 336) to identify potential threats to patient

safety, and the one to “keep the ball rolling” (p. 336) to encourage change to improve quality of care and patient safety (Tregunno et al., 2009).

Informal leaders can act as mentors, both in day-to-day interactions with peers (informally) and as formal preceptors (Downey, M., Parslow, S., & Smart, M., 2011). The mentoring relationship has a personal meaning for the mentee, which helps to personalize the support, and can influence adoption of a new practice as well as enhance feelings of group cohesion (Wallen et al., 2010). Mentoring leadership behaviors can encourage informal (staff nurse) clinical leaders to emerge. In addition to validating the psychometric properties of a measure of staff nurses’ clinical leadership, the importance of the leadership network in allowing informal clinical leaders to emerge was shown by Patrick et al. (2011). When formal nurse leaders demonstrated positive behaviors, the direct effect was that structural empowerment, a measure of work effectiveness, was increased ($\beta=0.69, p<0.05$) (Patrick et al., 2011). In turn, when structural empowerment was increased, staff nurse clinical leadership behaviors were increased ($\beta=0.29, p<0.05$) (Patrick et al., 2011).

Transformational leaders. A transformational leadership style supports inspiring those being led to both achieve desired outcomes and to grow as leaders themselves (Bass, 1985; Bass & Riggio, 2006). Bass and Riggio (2006) state that “transformational leaders motivate others to do more than they originally intended and often even more than they thought possible...they set more challenging expectations...empower followers and pay attention to their individual needs and personal development” (p. 4). Leaders, both formal and informal, demonstrating positive leadership behaviors associated with a transformational leadership style are defined in the literature as a positive influence on the nursing workplace for both staff and patients (Cummings, MacGregor, Davey, Less, Wong, Lo, Muise, & Stafford, 2010a; Wong & Cummings, 2007).

Acting as a transformational leader to harness support for the innovation within the organization is a key role of the organizational champion (Greenhalgh et al., 2004).

Transformational leadership style supports nursing autonomy in practice and encourages positivity; increased job satisfaction has been reported in groups led by a transformational leader (Salanova et al., 2011). In a measure of extra-role performance (behaviors not considered formal job requirements that facilitate functioning of the organization) and engagement of staff nurse-manager dyads ($N=280$), a direct relationship was noted between transformational leadership in the manager and increased extra-role behaviors in nursing staff (Salanova et al., 2011). The scale developed, guided by the five dimensions of transformational leadership, was subjected to structural equation modeling in addition to preliminary factor analysis and descriptive statistics (Salanova et al., 2011).

A narrative synthesis of 26 papers on the influence of leadership on clinical learning and the spread of innovative practices revealed that a transformational formal leader was critical to learning in clinical practice (Walker, Cooke, Henderson, & Creedy, 2011). In several articles reported by the authors, transformational leadership is cited as the most effective leadership approach, encouraging a learning culture by supporting organizational learning and positively influencing the workforce, making staff more likely to engage in learning (Walker et al., 2011). In addition, positive leadership behaviors associated with transformational leadership were noted to promote collaboration and communication, supporting implementation of practices such as EBP and research (Walker et al., 2011).

Supporting this assertion is the finding that 30-day patient mortality is influenced by hospital nursing leadership styles, specifically emotionally intelligent leadership that supports participation, collaboration, and communication (Cummings et al., 2010b). In a secondary data

analysis of leaders from ninety acute care hospitals in Canada, Cummings et al., (2010b) found that patient mortality was significantly reduced (26% lower mortality odds) with an open and collaborative overarching nursing leadership style.

Transformational leadership has been shown to reduce absenteeism due to injury (Lee, Coustasse, Sikula, 2011; Wong & Cummings, 2007). In a nationwide survey of nursing assistants ($N=2882$) an association was found between transformational leadership style of the manager and injury-related absenteeism ($\beta=-3.65$, $p=.05$) (Lee et al., 2011). While the mean days lost due to injury was 6.89 in the overall group, the negative correlation ($-.21$, $p<.01$) suggests that it would be lower in the group of staff being led by a transformational leader (Lee et al., 2011).

Quality improvement and patient safety behaviors are increased in the presence of transformational leadership practices (Wong & Cummings, 2007). In a systematic review of 53 empiric articles, Cummings et al. (2010a) classified five themes of outcomes related to leadership style including: staff satisfaction, relationships with work, including turnover and intent to stay, staff health, the work environment of the nurse, and productivity and effectiveness. Transformational leadership among formal leaders was noted to improve all of these outcomes (Cummings et al., 2010a). In comparing the specific nursing workforce and environmental outcomes within each theme to the patient outcomes related to them, the importance of a transformational leadership style of the formal leader was demonstrated (Cummings et al., 2010a). Historically, job satisfaction has been used as a proxy for quality care issues, and reduced job satisfaction has been linked to poor patient outcomes and increased mortality (Cummings et al., 2010a). Another example, culture and climate were improved in a

transformational leadership setting where improvement work was supported, and use of research as an evidence base for practice was increased (Cummings et al., 2010a).

In a systematic review of 99 qualitative and quantitative research articles, Wong & Cummings (2007) found that patient outcomes were improved in the setting of transformational leadership. Leadership style was associated with mortality rates in all three studies measuring mortality, even though only one resulted in a statistically significant reduction attributed to transformational leadership by the formal leader (Wong & Cummings, 2007). In addition, improved outcomes were noted in the areas of patient satisfaction (Doran, McCutcheon, Evans, et al., 2004; McNeese-Smith, 1999), patient falls (Houser, 2003), medication errors (Houser, 2003), and incidences of both pneumonia and UTIs (Houser, 2003), though the result is indirect (Wong & Cummings, 2007).

In order to be successful at being transformational, a leader must have both a vision and the ability to implement the vision (Hendy & Barlow, 2012; Shanta & Kalanek, 2008). In a descriptive study using interview data from patient safety rounds ($N=406$), units with an organizational champion demonstrated that staff were empowered to report safety concerns and manage problems before they caused harm (Weingart et al., 2009). The staff nurse can use transformational leadership practices to act as an organizational champion by acting as a positive supporter of change and an advocate for patient safety, inspiring and empowering others to act.

Organizational Champions

Research has historically addressed diffusion, dissemination, and strategies to enhance the spread of an innovation mentioning “early adopters” (Becker, 1970), “opinion leaders” (Becker, 1970), and “champions” as important personnel in its lifecycle (Greer, 1977; Greenhalgh et al., 2004). Though the term “early adopter” is used colloquially in innovation

literature, it is not recognized as a well-defined concept and the significance of the early adopter is not well supported by evidence (Greenhalgh et al., 2004). For this reason, it is recommended to use the terms “opinion leader” and “champion” as more evidence suggests that these individuals can signal facilitation or obstruction of an innovation (Greenhalgh et al., 2004).

In a systematic review, Greenhalgh et al. (2004) raised the concern that there is a lack of empirical evidence around the characteristics and utilization of organizational champions. Without adequate evidence defining the characteristics, actions, and impact of opinion leaders and organizational champions, it is difficult to identify and utilize them effectively (Greenhalgh et al., 2004). By failing to identify true opinion leaders and assessing their opinions, one runs the risk of wasting resources on an individual who lacks peer influence or by utilizing an opinion leader with a negative opinion of the innovation (Greenhalgh et al., 2004). The opinion leader who is recognized by peers to be representative and credible will influence the actions of their colleagues (Greenhalgh et al., 2004).

The term opinion leader is used in innovation literature, but it does not address the type of impact the opinion leader has with regard to the innovation itself. In some cases, opinion leaders have been shown to have a negative impact on the spread of an innovation, particularly if they begin to become possessive of its success or failure and see a systems view as a threat (Hendy & Barlow, 2011). The most comprehensive and contemporary term is “organizational champion” and it is used to discuss an active supporter of innovation (Hendy & Barlow, 2011; Ploeg et al., 2010; Soo et al., 2009; Weingart et al., 2009).

This study will focus on organizational champions as individuals that contribute to the success of an innovation. The active role suggested by the term “champion” (as opposed to passive “adopter”) makes these individuals important to identify to support innovation

(Greenhalgh et. al, 2004). In addition, recent literature about innovations in healthcare utilizes the concept of a “champion”, particularly literature related to quality and patient safety (Hendy & Barlow, 2011; Kirchner et al., 2010; Ploeg et al., 2010; Soo et al., 2009; Weingart et al., 2008).

The process of innovation adoption or spread is a complex one. Each individual exposed to the innovation appraises the evidence regarding the decision to support or reject it differently, and adopts it at his/her own individual speed (Greenhalgh et al., 2004). Some individual adopters act both as organizational champions and early adopters, while others recognize the organizational champion to be an opinion leader and wait to see how the champion responds to the innovation before deciding to adopt it (Greenhalgh et al., 2004).

Through qualitative interviews of frontline staff and managers across five clinics (n=49), four affiliated medical centers (n=12), and three regional networks (n=7), Kirchner et al. (2010) found that organizational champions, particularly acting at the local level, such as a workgroup or department, can influence colleagues. Champions, particularly frontline staff, helped insure staff buy-in to quality improvement (QI) initiatives and improved their fit to local circumstances and culture. Local champions’ perspectives were noted to help “folks feel like their particular needs and concerns have been taken into account” (Kirchner et al., 2010; pg. 66). In addition, local informants noted that they would listen to a colleague reporting good outcomes with a newly implemented practice. In this case, the colleague acts as a local expert and resource.

Staff nurses use their frontline knowledge about care processes to inform an innovation, enhancing its spread (Hendy & Barlow, 2012; Patrick et al., 2012). In an ethnographic study of three organizations in the UK undergoing implementation of “telecare” organizational champions were identified to be critical to the success of the innovation (Hendy & Barlow,

2012). It was identified that the organizational champion, particularly in a smaller, more focused, group (such as a shift on an individual unit) persuaded organizational members to adopt the innovation (Hendy & Barlow, 2012).

Particularly in the first phases of adoption, when the organizational champion was viewed as part of the team, they were able to experiment with new practices within their workgroups and motivate others to participate (Hendy & Barlow, 2012). Organizations using established internal staff members found legitimacy of the work was enhanced among staff (Hendy & Barlow, 2012). Similarly, in testing the psychometric properties of a new measure of nursing leadership at the bedside (Cronbach α for total scale=0.86), Patrick et al. (2012), identified that empowered clinical staff nurses can “enable others to act” to implement change in a clinical area.

The most successful champions demonstrate a system view, and support the improvement for the betterment of the organization, without perceiving it as a threat when initiatives moved from a local to a system level (Hendy & Barlow, 2012). Organizational champions are recognized for their ability to leverage their experience and position to support an innovation, working together to facilitate championing at all levels (managerial and executive supporting front-line clinician) (Soo et al., 2009). Champions can work at a local level, with the support of organizational leaders, to build the structure for system-wide innovation spread (Soo et al., 2009).

In a study of peer-identified champions ($N=13$) from two sites, semi-structured interviews identified the various ways champions convince others to adopt the innovation (Soo et al., 2009). Using communication skills and knowledge of the organization, the champion brings groups of staff together, spanning barriers between units and departments (Soo et al., 2009). Relationship

building is important in this process such as when the champion cultivated personal relationships with staff nurses prior to implementation of rapid response teams and maintained them during and after the initiative rollout (Soo et al., 2009). Nurses perceived this as giving the team behind the implementation a human face, and other staff nurses felt supported by the champion. In addition, champions supported the implementation of the evidence-based rapid response team program by acting as peer educators and patient and peer advocates (Soo et al., 2009). This patient safety initiative gained local traction when a champion gathered evidence to share with staff, presenting several compelling and irrefutable arguments in support of the initiative and framing the project in a strategic manner that represented the local area's needs (Soo et al., 2009).

The champion often supports autonomy of the innovator, harnesses organizational support, buffers the innovation's effect on the organizations resources, and facilitates networking across the organization (Greenhalgh et al., 2004; Shane 1995). These characteristics inspire others to have a shared vision and feel involved in decision-making (Shanta & Kalanek, 2008). When all stakeholders' voices are heard and their needs are considered, spread of the innovation is further enhanced (Hendy & Barlow, 2011; Kirchner et al., 2010; Ploeg et al., 2010; Soo et al., 2009).

Conclusion

Healthcare in the United States is changing rapidly. Payment structures are changing and the expectation for clinical staff, including nurses, is to do more with less, which is unlikely to change (Berwick, 2010; CMS, 2012). Improving the efficiency, quality and safety, and value of patient care are strategies to address shrinking resources and work toward pay for performance thresholds. While staff nurses have not been expected to formally participate in designing and

initiating quality improvement strategies in the past, there is a call for nurses to fully realize the role that they play in the quality and safety of patient care (Berwick, 2010; IOM, 2010).

Activities once part of routine care are being subjected to new scrutiny in the era of modern healthcare reform where clinical providers, including nurses, must identify threats to quality and patient safety, implement strategies to improve efficiency and value of care, and work to improve the overall patient experience (Berwick, 2010; Tregunno et al., 2009). For some staff nurses, this may seem like an additional task to complete, but for organizational champions, even those without formal training in QI or patient safety, these activities are part of what it takes to help the spread of an innovation throughout a hospital (Kirchner et al., 2012; Salanova et al., 2005). Identification of staff nurses as organizational champions would allow formal leaders to identify them more readily and use their transformational behaviors to support change at both the unit level and the hospital level. An organizational champion who uses transformational leadership has a vision and demonstrates motivation to change, which supports linking local initiatives to a system-wide change. Staff nurses can act in this role.

Chapter 2

Research Framework

The purpose of this study is to describe how formal clinical leaders identify nurses as organizational champions as well as how they systematically harness the energy of nurses acting as organizational champions to support innovations. Kouzes and Posner's Five Practices of Exemplary Leadership (2007), a transformational leadership framework, was used to guide this study. This chapter will describe the Five Practices framework and its use in nursing research. This framework was used to guide interviews with leaders to elicit the characteristics of staff nurses who are organizational champions.

Framework Overview

James M. Kouzes and Barry Z. Posner (2007) developed the Five Practices of Exemplary Leadership as an extension of the Bass Transformational Leadership Model. This framework was developed to extend the work of Bass, establishing consensus about what leadership is, how it differs from management, and if it can be measured or taught (Posner & Kouzes, 1988). In this model, leadership is viewed as a relationship between the leader and the follower, and it is a skill that can be learned (Kouzes & Posner, 2007). The leader demonstrates practices that inspire the follower, patterns identified by reviewing managers' descriptions of personal-best leadership experiences (Kouzes & Posner, 2007). The Five Practices of Exemplary Leadership are: Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, and Encourage the Heart. These Five Practices are underpinned by The Ten Commitments of Leadership (outlined in Table 1). The Ten Commitments serve as a guide for a leader who is learning to demonstrate the leadership in practice (Kouzes & Posner, 2007). The Five Practices of

Exemplary Leadership support the idea that leadership ability is not limited to personality, but rather it's about behavior, and can be learned (Kouzes & Posner, 2007).

Table 1.

Major Tenets of the Five Practices of Exemplary Leadership Framework (adapted from (Kouzes & Posner, 2007)).

Major Tenets of the Five Practices Framework	The Ten Commitments underpinning the Five Practices Framework
<p>Model the Way Exemplary leaders are recognized for modeling the behaviors that they expect of others, which inspires the group being led to commit to the direction the leader is helping to shape. Inspiring others to commit supports the achievement of goals and meeting the highest standards as set forth by the leader</p>	<p><i>Find Your Voice by Clarifying Your Personal Values.</i></p> <ul style="list-style-type: none"> • Model expected behavior • Be clear with those being led about the guiding principles and values, expressing them in one's own voice <p><i>Set the Example by Aligning Actions with Shared Values.</i></p> <ul style="list-style-type: none"> • Act as an organizational champion • Work with the group to build agreement around common principles and ideals • Set the example by aligning word and deed. By demonstrating an action daily, show that they are deep commitment to beliefs
<p>Inspire a Shared Vision Exemplary leaders describe having a vision for the organization that is exciting and attractive; they dream and they believe in their ability to achieve the dreams. By clarifying that vision and sharing it with those being led, the group can work to reach the destination.</p>	<p><i>Envision the Future by Imagining Exciting and Ennobling Possibilities.</i></p> <ul style="list-style-type: none"> • Desire change and innovation • Have a vision of the future that, driven by passion pulls them forward. • Engage constituents to share in the vision, by listening deeply and determining what is meaningful and represents a cause that the group can work for. • When vision inspires change, particularly rapid change, be forward thinking and anticipate future needs. <p><i>Enlist Others in a Common Vision by Appealing to Shared Aspirations.</i></p> <ul style="list-style-type: none"> • To engage constituents, appeal to common ideals within the group, aligning their visions. • Animate the vision to inspire an image of the future.

<p>Challenge the Process Exemplary leaders envision change and innovation and venture out to achieve the change and improve the organization.</p> <p>Exemplary leaders challenge the status quo, taking risks and committing to the change they wish to see.</p>	<p><i>Search for Opportunities by Seeking Innovative Ways to Change, Grow, and Improve.</i></p> <ul style="list-style-type: none"> • Challenge the process, creating a climate of experimentation and recognize and supporting good ideas. • Kouzes & Posner (2007) found that “leadership is inextricably connected with the process of innovation (pg 165)” and that leaders “make something happen (pg. 168)”. • Encourage others to take initiative and consistently set the bar higher and higher, encouraging new ideas from within and outside of the group, and being open to challenges as they appear. <p><i>Experiment and Take Risks by Constantly Generating Small Wins and Learning From Mistakes.</i></p> <ul style="list-style-type: none"> • In challenging the process, take incremental steps and use small tests of change work best, as opposed to a complete process change at the outset. This allows for learning from the experience, supporting a climate of learning. • Be an active learner, analyzing problems and challenges and identifying opportunities.
<p>Enable Others to Act For a leader to be successful, constituents must believe in their ability to act. A team effort is essential and those being led must feel a sense of confidence. In case reviews, Kouzes & Posner (2007) began to track leaders’ use of the word “we” as opposed to “I” when describing personal-best cases and found that leaders with such cases used the word “we” nearly three times more. Leaders promote group collaboration and acknowledge the team effort</p>	<p><i>Foster Collaboration by Promoting Cooperative Goals and Building Trust.</i></p> <ul style="list-style-type: none"> • Promote collaboration by establishing a climate of trust and by facilitating the group relationships. Groups that trust are more likely to share feelings and work harder toward a goal. • Information and resource sharing among constituents is essential to building trust, as is a sense of reciprocity, which the leader can foster by cooperating freely with the group.

	<p><i>Strengthen Others by Sharing Power and Discretion.</i></p> <ul style="list-style-type: none"> • Exemplary leaders know that “you become more powerful when you give your own power away (pg. 251).” • Give control to others, allowing them to develop their talents, enhance their self-determination and feel control, and develop confidence and competence. • If the constituents feel in control of, and accountable for, their lives, they are more likely to take ownership of the group’s success.
<p>Encourage the Heart</p> <p>To inspire followers to continue the journey with their leader, which may be long and fraught with many challenges and setbacks, exemplary leaders demonstrate genuine acts of caring to uplift the group and encourage the heart.</p>	<p><i>Recognize Contributions by Showing Appreciation for Individual Excellence.</i></p> <ul style="list-style-type: none"> • Expect the best from constituents and follow with personalized recognition for accomplishments to stimulate an internal drive within each individual. • High expectations motivate and feedback keeps the group engaged. With personal recognition, from carefully considered creative incentives to a simple “Thank You”, constituents feel valued and perform at their highest ability. <p><i>Celebrate the Values and Victories by Creating a Spirit of Community.</i></p> <ul style="list-style-type: none"> • Celebrate team victories in a large, more public, venue and allow multiple teams to come together to share lessons and victories to encourage a spirit of community. • When leaders are personally involved and create this spirit, it reinforces the group’s vision and promotes future success.

Development of the Framework

The Five Practices of Exemplary Leadership framework is the result of the qualitative portion of development of the Leadership Practices Inventory (Kouzes & Posner, 1987; Posner & Kouzes, 1988). In developing the model, Kouzes & Posner (2007) asked managers attending

management development seminars to describe an experience when they had lead (not managed) a project to an extraordinary success. They were asked to describe when they were at their “personal best as a leader (pg. 484)”.

To fully describe these experiences, Posner & Kouzes (1988) administered a survey consisting of 37 open-ended questions. Sample questions include: “what made you believe you could achieve the results you sought? What special, if any, techniques or strategies did you use to get other people involved in the project? What key lessons would you share with another person about leadership from this experience (pg. 484)?” In the initial development of the instrument, 650 full-length surveys were collected, with an additional 450 managers completing a short-form (1-2 pages) survey (Posner & Kouzes, 1988).

From these surveys, Posner and Kouzes (1988) selected 38 middle- to senior-level managers to interview to develop case studies. Content analysis was first conducted by the authors, and then triangulated using two additional raters (Posner & Kouzes, 1988). The resultant Five Practices of Exemplary Leadership model represents a “fundamental pattern of leadership behavior which emerges when people are accomplishing extraordinary things in organizations (pg. 484).” The model has been validated over 25 years and its use has evolved from describing middle- and senior-level managers to describing a wide range of leadership roles, from formally-appointed leaders to more informal clinical leaders, including frontline staff and students (Kouzes & Posner, 2002; 2007).

A key component of this model, a transformational leadership model, is that leadership is a relationship between the leader and the constituents (Kouzes & Posner, 2007). Working together, the leader and the follower can raise the “human conduct and ethical aspiration” of both parties; doing so serves to enhance the work environment by improving the climate (Kouzes &

Posner, 2007). For the five practices to result in an improvement in morale, self-efficacy, and quality, the leader must be credible and those being led must be willing to lead (Kouzes & Posner, 2007). As a relationship-based model, the Five Practices of Exemplary Leadership remains a transformational leadership model (Kouzes & Posner, 2007).

Transformational Leadership

Leadership style plays an important role in quality and safety research. A transformational leadership style is associated with improvements in quality and safety of patient care (Cummings et al., 2009). A transformational leader is one who regularly inspires positive changes in those who follow, transcending personal needs for the benefit of the organization (Bass & Riggio, 2006).

Transformational leadership is a management model formally developed by researcher Bernard Bass (Bass, 1985). The Bass Transformational Leadership model encompasses four principles to inspire positivity and change among followers. In this model, the transformational leader provides:

- **Intellectual Stimulation** by challenging the status quo and encourage creativity among followers.
- **Individualized Consideration**, supporting and encouraging individual followers using open lines of communication and recognition of personal achievements.
- **Inspirational Motivation** and a clear vision that they are able to articulate to followers to inspire passion.
- **Idealized Influence**, serving as a role model for followers (Bass, 1985).

Transformational leadership is a long-term approach to team development. In opposition, transactional leadership focuses on short-term behavior compliance and using

rewards or punishments and is most effectively used to address immediate, crisis or emergency problems. The transactional leader is not looking to change or improve behavior (Bass & Riggio, 2006). Transformational leadership, however, is important in the long-term success of a team, inspiring those in the group being led to both achieve and grow as leaders themselves (Bass, 1985).

In developing the Five Practices of Exemplary Leadership, Kouzes & Posner (2007) expanded upon the transformational leadership model developed by Bass (1985) to measure the practices and ascertain whether or not it could be taught. Kouzes & Posner (2007) sought to make their research generalizeable to a wider range of leaders. The steps taken to develop the Leadership Practices Inventory (LPI) resulted in the Five Practices, expanding the Bass model.

Nursing and Use of the Five Practices of Exemplary Leadership

The Five Practices of Exemplary Leadership can be used to teach leadership skills. An important concept of this model is empowerment and the idea that those being led can be empowered to become leaders themselves (Kouzes and Posner, 2007). The majority of nursing research using the Five Practices and the Leadership Practices Inventory has focused on managers and the effect that leadership by a manager has on the workforce (Cummings et al., 2010a; Walker et al., 2011). In systematic reviews, Cummings et al. (2009) and Walker et al. (2011) showed that the LPI was used in several studies comparing leadership style to nursing workforce patterns such as decreased turnover (Cummings et al., 2010a), increased job satisfaction (Cummings et al. 2010a) and increased clinical learning by staff (Walker et al., 2011). None of the studies used the Five Practices as the overarching framework and the focus was formal nurse leaders in each case (Cummings et al., 2010a; Walker et al., 2011). However, the planned study will focus on staff nurses and will not utilize the LPI.

Some studies using the Five Practices as a framework or the LPI as a measure have focused on the effect that this transformational leadership model has on development of new nurse leaders. For example, in creating a permanent charge nurse role (a non-staff position), the framework outlined the dimensions of leadership on which the development program focused and the LPI was used to assess self and staff perceptions of leadership (Krugman & Smith, 2003). Because a disparity in the perceptions was noted (staff rated charge nurses' ability lower), the framework also guided further revision of the program (Krugman & Smith, 2003).

In some studies, the LPI is used as a measure to assess the presence of transformational leadership behaviors among nurse leaders in the UK, without using the overarching Five Practices (Bowles & Bowles, 2000). The LPI was also used in one study of staff nurses as a measure of the effectiveness of leadership and professionalism training, but the guiding framework for that study was Benner's Novice to Expert model (Abraham, 2011). Only one study could be found that used the Five Practices framework to identify and develop staff nurse leadership behaviors (Patrick et al., 2011).

Patrick et al. (2011) conducted a concept analysis and aligned clinical leadership attributes derived from the literature with Kouzes and Posner's Five Practice of Exemplary Leadership to develop the Clinical Leadership Survey (CLS). In doing so, they found that staff nurse clinical leadership attributes were consistent with core behaviors in the Five Practices (Patrick et al., 2011). A linkage between nurse manager leadership and staff nurse clinical leadership using structural empowerment was proposed and the CLS was developed using items to reflect staff nurses' clinical leadership behaviors based on the Five Practices framework (Patrick et al., 2011). Face validity and content validity (CVI=85%) were assessed, and psychometric testing was conducted (Patrick et al., 2011).

The survey was tested using survey design with a random sample of staff nurses ($N=1160$). The Dillman survey method was used and nurses were contacted four times; the final response rate was 46%, with 480 usable surveys (Patrick et al., 2011). In addition to the newly developed survey, Kouzes & Posner's Leadership Practices Inventory, a 30-item questionnaire based on the Five Practices of Exemplary Leadership was also administered to staff nurses to measure nurse manager leadership practices (Patrick et al., 2011). In this study, the overall Cronbach's alpha was 0.97 (subscales 0.93-0.95). Structural empowerment was measured using a separate measure, the Conditions for Work Effectiveness Questionnaire-II (CWEQ-II) (total Cronbach's alpha=0.89, subscales 0.64-0.85) (Patrick et al., 2011).

The CLS initially had 41 items rated on a five-point Likert scale. After a series of confirmatory factor analyses, the final instrument was reduced to a 15-item scale with three items per subscale (each of the Five Practices) (Patrick et al., 2011). While the reliabilities were relatively low for the subscales ($\alpha = 0.64-0.78$), the Cronbach α for the total scale was 0.86 (Patrick et al., 2011). The highest reliabilities were in the "encouraging the heart" ($\alpha=0.78$), "enabling others to act" ($\alpha = 0.72$), and "inspiring a shared vision" ($\alpha=0.70$) subscales. The authors report that this is consistent with their literature review (Patrick et al., 2011). It suggests that further research into the reasons why some of the Five Practices are more consistent with nursing practice than others would be beneficial. Knowing more about how nurses operationalize the Five Practices may help with future staff nurse leadership development, as the LPI and Kouzes and Posner's (2007) stance is that leadership is not an inherent ability, but a learned behavior among those willing to answer the leadership challenge.

This study suggested that nurse managers' transformational leadership practices had a significant direct positive effect on structural empowerment ($\beta=0.69$, $P<.05$), resulting in a

significant direct effect on the staff nurse clinical leader acting as a transformational leader ($\beta=0.29$, $P<.05$) (Patrick et al., 2011). While the relationship seems to be indirect (Sobel $z=4.0$, $P<.05$), it is valuable in that the clinical leadership demonstrated by staff nurses is consistent with the Five Practices (Patrick et al., 2011). Behaviors such as “engage in reflective practice”, “actively listen”, “use engaged communication”, “commit to patient centered care”, “acknowledge colleagues’ values”, and “provide positive feedback” were reported by staff nurses demonstrating clinical leadership to be regularly practiced (Patrick et al., 2011).

Linking the Five Practices of Exemplary Leadership and Organizational Champions

The Five Practices of Exemplary Leadership can be used to describe behaviors demonstrated by a wide variety of leaders, including frontline staff nurses acting as peer leaders. The model distinguishes between managing and leading and is focused on relationship building and goal setting with organizational goals in mind (Kouzes & Posner, 2007). One leadership role that staff nurses, acting in an informal capacity (e.g. not a hired role) may take is that of an organizational champion, acting as a peer clinical leader to support change initiatives and the spread of innovations throughout a workgroup (Patrick et al., 2011).

Organizational champions support improvement initiatives by spreading a positive message about change (Greenhalgh et al., 2004). Acting in this role, the nurse demonstrates the behaviors outlined by the Five Practices of Exemplary Leadership to support change (Patrick et al., 2011). Challenging the status quo, inspiring others to share in the vision and enabling them to act toward change, with a goal of continuous improvement, are important clinical leadership behaviors a staff nurse leader can use to support quality improvement (Patrick et al., 2011).

Champions seek out information about an initiative and, once they adopt it, lead others in to a new way of doing things (Greenhalgh et al., 2004). By modeling the way, demonstrating the

desired behaviors and allowing for small tests of change to yield small victories, and by encouraging and rewarding those being lead, the clinical nurse leader uses the Five Practices of Exemplary Leadership to act as an organizational champion in support of change (Kouzes & Posner, 2007).

Conclusion

Transformational leadership is recognized to be a positive, supportive leadership style (Walker et al., 2010). The presence of transformational leadership behaviors among formal nurse leaders is well documented (Walker et al., 2010; Wong & Cummings, 2007). The positive impact that transformational leadership behaviors of formal nurse leaders has on outcomes such as job satisfaction (Salanova et al., 2011), clinical learning (Walker et al., 2010), and empowerment of staff (Walker et al., Salanova et al., 2011) has also been documented. The Five Practices and the supporting Ten Commitments of Exemplary Leaders are recognized to be transformational leadership behaviors (Kouzes & Posner, 2007).

Because these behaviors can be learned, and are recognized to apply in a wide variety of situations, a formal leadership position is not required for a nurse to demonstrate them (Kouzes & Posner, 2007). While research about nurses acting as transformational leaders has focused on formal nurse leaders, recent evidence has suggested that informal clinical leaders, staff nurses acting as leaders among their peers, also demonstrate these behaviors (Patrick et al., 2011). Use of the Five Practices by informal nurse leaders has been suggested in only one study, but the effect was positive and direct (Patrick et al., 2011). This model was used to inform the development of an interview guide for the purposes of describing how formal clinical leaders identify nurses as organizational champions and how they use these champions to support innovation in their clinical areas.

Operational Definitions

Clinical Leader - A clinical leader represents a leader with a formal title or authority position (may or may not be a nurse) who leads nurses in the clinical setting. The clinical leader may or may not have direct managerial responsibilities. This includes managers, directors, executives, and educators, as well as any other leadership position.

Exemplary Leadership- Exemplary leadership is an identifiable set of skills and abilities available to anyone who aspires to lead. These skills are demonstrated through the Five Practices of Exemplary Leadership (Kouzes & Posner, 2007).

Informal Clinical Leader- Informal clinical leaders in this study are nurses in the clinical setting without formal title or authority who intentionally influence others to accomplish a goal (Downey et al., 2011).

Innovation- Innovations in healthcare are “a novel set of behaviors, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users’ experience, and that are implemented by planned and coordinated actions (pg. 582) (Greenhalgh, 2004).”

Organizational Champions- Organizational champions are opinion leaders, respected by their peers as leaders and experts, who support organizational improvement initiatives by spreading a positive message about change (Greenhalgh et al., 2004). Champions seek out information about an initiative and, once they adopt it, lead others into a new way of doing things (Greenhalgh et al., 2004).

Patient Safety- Freedom from accidental or preventable injuries produced by medical care (AHRQ Patient Safety Network, 2012)

Peer Opinion Leader: Opinion leaders have influence on the beliefs and actions of their colleagues, exerted through their representativeness and credibility (Greenhalgh et al., 2004). The peer opinion leader may have a negative or a positive influence on the spread of an innovation.

Personal best Leadership Experiences- These are experiences that a leader recognizes as their personal best time leading, not managing, a project. Personal best leadership experiences are times when leaders felt that they achieved something extraordinary in an organization, leading projects to “plateaus beyond traditional experiences (pg. 484)”, and “everything came together (pg. 484)” (Posner & Kouzes, 1988).

Quality Improvement- “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Donaldson & Lohr, 1990 pg. 128).”

Ten Commitments of Leadership- Behaviors that are embedded in the Five Practices of Exemplary Leadership. These behaviors can serve as practical examples for how to demonstrate each of the Five Practices of Exemplary Leadership, providing a basis for those learning to lead (Kouzes & Posner, 2007).

Transactional Leadership- Transactional leadership focuses on short-term behavior compliance and using rewards or punishments and is most effectively used to address immediate, crisis or emergency problems. The transactional leader is not looking to change or improve (Bass & Riggio, 2006).

Transformational Leadership- Transformational leadership is a long-term approach to team development, inspiring the team to achieve and to grow as leaders themselves (Bass, 1985). The transformational leader provides:

- **Intellectual Stimulation** – Leaders challenge the status quo and encourage creativity among followers.
- **Individualized Consideration** – Leaders support and encourage individual followers using open lines of communication and recognition of personal achievements.
- **Inspirational Motivation** – Leaders have a clear vision that they are able to articulate to followers to inspire passion.
- **Idealized Influence** – Leaders serve as a role model for followers (Bass, 1985).

Chapter 3

Methods

This study used a qualitative descriptive design to explore how clinical leaders identify nurses as organizational champions and how they harness the energy of these champions to support innovations in the clinical setting. Formal clinical leaders, including executives, managers, clinical coordinators, and clinicians/educators shared their professional insight through individual interview sessions. Kouzes & Posner's Five Practices of Exemplary Leadership model (2007) guided this study. The Five Practices model outlines how leaders mobilize others to get extraordinary things done within an organization and can be used by anyone acting as a leader, formal or informal (Kouzes & Posner, 2007).

This chapter will describe the research methods used in this study. Logistics such setting, sampling strategy, data collection, management, and analysis, including steps taken to assure trustworthiness and reflexivity will be addressed. In addition, human subjects' considerations will be described.

Qualitative Descriptive Design

The qualitative descriptive design is meant to elicit the rich description of an experience, event, or process in easily understood language. As such, this low-inference descriptive methodology makes it more likely that most people would agree that the account was accurate (Sandelowski, 2000). Qualitative descriptive studies may be viewed as less theoretical than other qualitative approaches, drawing from the general tenets of naturalistic inquiry by not preselecting or manipulating variables and by lacking a preconceived notion about the target phenomenon (Sandelowski, 2000; 2010). These studies are not, however, atheoretical, and this study used the Five Practices to help inform several parts of the study (Sandelowski, 2010).

Setting

This study took place at UMass Memorial Medical Center (UMMMC), the clinical affiliate for the University of Massachusetts Medical School (UMMS). UMMMC is a 779-bed facility comprised of three main campuses located in Worcester, Massachusetts and several satellite clinics throughout the region. For this study, only inpatient and outpatient areas on the three main campuses (Memorial, University, and Hahnemann) employing nurses were invited to participate.

Sample

Only clinical leaders (not peers) currently employed by UMMMC were recruited for this study. This included directors, managers, and clinical coordinators as well as educators and senior leaders (e.g. Vice Presidents, Associate Chief Nursing Officers, Chief Nursing Officers, and leaders working in Quality and Patient Safety), provided they were directly involved with staff nurses.

In qualitative descriptive research, purposeful sampling techniques may be used (Sandelowski, 2000). In this study, while seeking information-rich cases to study, the goal is also to seek cases that represent maximum variation (Sandelowski, 2000; Sullivan-Bolyai, Bova, & Harper, 2005). The initial, purposive, sample was proposed to come from nomination papers for the UMMMC “Portraits of Excellence” nursing recognition program where peers and clinical leaders can nominate staff nurses who represent excellence in nursing practice. The nominees’ names are redacted, but the nominators’ names were available. This method yielded only one interested participant who ultimately declined to schedule an interview. Therefore, we recruited study participants via an email that was sent to all leaders meeting the inclusion criteria below. To achieve maximum variation sampling, every effort was made to include participants from

each of the following service lines: medical, surgical, women's health, children's medical center, emergency, and perioperative services. In addition, efforts were taken to adequately sample those with staff directly reporting vs. leaders with no management responsibility. There are 150 formal clinical leaders working in these settings, including all directors, managers, clinical coordinators, educators, and senior leaders and executives with direct knowledge or management of staff nurses. Redundancy (generalizations holding true for all data) was sought in this qualitative exploratory study and sampling continued until this was achieved (Lincoln & Guba, 1985; Sullivan-Bolyai et al., 2005). It was anticipated that a sample size of 20-25 interviews would be needed to achieve this redundancy (Sullivan-Bolyai et al., 2005). However, saturation for the major themes was reached after 9 interviews. An additional five interviews were conducted to ensure no new themes emerged.

Inclusion Criteria. The sample included:

- Clinical leaders at UMMMC with a formal management title or leadership position working with staff nurses in any area of the hospital
- Willing to have the interview audio taped
- Currently employment at UMMMC at the time of interview

Exclusion Criteria. Participants were excluded if:

- They were not in a formally-appointed leadership role
- They did not work directly with staff nurses
- They were a member of one of the hospital's several unions

Recruitment. The initial sample was to be obtained through review of the UMMMC "Portraits of Excellence" program nomination papers. While nominees' names are kept confidential, nominators' names are not redacted in these papers and were thought to be a source

of potential participants. The potential participants were contacted through email using contact information available from the nurse manager's list published on the UMMMC intranet. This list includes all clinical leaders, including educators, clinical coordinators, managers, and senior leadership. As these papers were primarily focused on staff, only one potential participant was identified, who was unable to schedule an interview due to increased clinical commitments at that time.

Additional potential participants contacted the researcher after being asked to participate via email sent on behalf of the investigator (Appendix A). This method yielded 13 participants. In reviewing demographics, emails were sent to purposively sample from the underrepresented group of potential male participants. This method yielded one additional participant. The final sample was 14 participants. Each potential participant was given a copy of the information form which was reviewed prior to the interview as part of the consent process (Appendix B).

Prior to any data collection, approval was secured from the UMMS Institutional Review Board (IRB). Verbal consent, including consent for audiotape, was obtained from each participant.

Data Collection

Demographics were collected on each interview participant prior to the interview (Appendix C). Semi-structured interviews were conducted in a private setting that was convenient to the participant. Interviews were anticipated to take between 60 and 90 minutes. The interview times ranged from 28 minutes to 75 minutes, averaging 46 minutes in length. To ensure quality of face-to-face interview recordings and protect against equipment failure, two digital recorders were used. A professional transcriptionist transcribed audio recordings verbatim. The interview consisted of both core open-ended questions and probes to encourage

dialogue (Price, 2001; Sandelowski, 2000). Through the interviews, it became clear that additional questions or probes were needed to promote understanding, and the interview guide was modified after discussion with the Chair of the dissertation committee.

After each interview, the investigator recorded field notes of any observations as part of the audit trail (Lincoln & Guba, 1985). Throughout the interview process, member checks were utilized with two participants to assure the researcher's understanding of the data and assure descriptive validity (Lincoln & Guba, 1985).

The interview guide was informed by Kouzes & Posner's (2007) "Five Practices of Exemplary Leadership" framework and the ten commitments underpinning these practices (Table 1). The questions and probes were derived from the specific aims as identified in Table 2.

Table 2.

Interview Questions and Probes

Specific Aim #1: To describe how clinical leaders identify nurses as organizational champions.		
Main Questions		
1. Tell me how you identify which nurses are organizational champions? 2. What are the characteristics of nurses that support innovation in your clinical area? 3. How do you know when a nurse is someone who will be supportive of change? 4. How do you know when a nurse is someone who will not be supportive of change?		
Practice	Commitments	Probes
Model the Way	a. Clarify Values b. Set the Example	1. Could you tell me how organizational champions serve as role models when a change is introduced? 2. How do these nurses work to help the group clarify what they value?
Inspire a Shared Vision	a. Envision exciting and ennobling possibilities b. Enlist others in a common vision	1. How do these nurses bring the group together around an exciting possibility of change? 2. What do they do to help the team develop a shared vision of the change?
Challenge the Process	a. Search for opportunities to innovate, grow, and improve b. Experiment and take risks	1. Can you give me an example of the type of processes these nurses challenge? 2. In what way are these nurses searching for opportunities to innovate, grow, or improve? 3. When a process is being challenged, what types of challenges do these nurses perform? Do they experiment?

Enable Others to Act	a. Foster collaboration and build trust b. Strengthen everyone's capacity	1. How do these nurses help others to act in support of a change? 2. Have you seen any ways that they bring the group together? What are they? 3. Can you describe for me a way that these nurses work to strengthen the ability of the team to act?
Encourage the Heart	a. Recognize contributions b. Celebrate values and victories	1. What do these nurses do to recognize contributions of their peers? 2. In what way do they help the team's victories get recognized on a bigger, more system-wide level?
Specific Aim #2: To Describe how clinical leaders systematically harness the energy of nurses acting as organizational champions to support innovations.		
Main Question		
1. How do you utilize nurses that act as organizational champions in your area? 2. Describe for me a specific innovation for which you've engaged staff nurses to help facilitate the spread? How did you utilize the talents of the champion to help facilitate it? 3. How does utilizing a staff nurse acting as an organizational champion support the spread of the innovation in your clinical area?		
Practice	Commitments	Probes
Model the Way	a. Clarify Values b. Set the Example	1. In what way do you encourage these nurses work as role models for change in your area? 2. Describe how you would encourage them to help clarify the group's values, establishing a culture about the change?
Inspire a Shared Vision	a. Envision exciting and ennobling possibilities b. Enlist others in a common vision	1. How do you utilize these champions to inspire the group to have a positive vision about change? 2. Tell me about how you would encourage them to help their peers consider the exciting possibilities of this change?
Challenge the Process	a. Search for opportunities to innovate, grow, and improve b. Experiment and take risks	1. Describe for me an example of how you utilize these champions to identify opportunities for improvement. 2. How do you utilize these nurses to help with small tests of change, pilot work, or trialing products or processes?
Enable Others to Act	a. Foster collaboration and build trust b. Strengthen everyone's capacity	1. Can you describe how you've engaged these nurses to build collaboration or trust around an innovation? 2. How do you utilize these champions to strengthen the capacity of the team to support change?
Encourage the Heart	a. Recognize contributions b. Celebrate values and victories	1. Can you tell me how these nurses can be utilized to recognize contributions of other staff? 2. How have you utilized these nurses to help celebrate the victories of your team at an organizational level?

Data Management

Demographic data were entered into an Excel file for analysis. Each audio recording was reviewed in its entirety for sound quality and content. A brief summary of the interview was written and stored for later reference and analysis. Interviews were downloaded onto a password-protected computer. All transcribed interviews were cross-referenced with the audio recordings for accuracy.

Data was managed using the process outlined by Knafl and Webster (1988), including identifying major coding categories, double coding all interview transcripts, transferring data to color-coded highlighted word document, identifying any subcategories and coding those, and constructing descriptive diagrams.

Kouzes and Posner's Five Practices of Exemplary Leadership informed initial coding categories. Patterns and themes were identified, with the goal of remain true to the participants' own words, seeking an accurate account of the phenomenon and its meaning (Sandelowski, 2000). A logbook was kept of all coding decisions and these were discussed with the peer debriefer (described on page 42-43) as well.

Data Security

All written data sources were maintained in a locked cabinet within a locked office until they could be transferred to an electronic spreadsheet/database. Electronic data, including tape recordings, field notes, and the reflexive journal were maintained on an encrypted, password-protected drive on a password protected computer. All data will be destroyed in five years.

Data Analysis

Descriptive statistics were used to describe the sample by age, race, gender, leadership role, education, clinical area, and years of experience. Some data were kept in aggregate form in

order to protect the anonymity of the participants. The analysis process for this study was the qualitative analysis framework outlined by Miles and Huberman (1994). The three-pronged approach to qualitative analysis included: (a) Data reduction by selecting, abstracting, and transforming the raw data, including initial coding and searching for themes, (b) creating data displays such as matrices, graphs, and charts which aided with more complex analyses and permitted across-case analysis, and (c) conclusion drawing and verification including making generalizations and examining the data in relation to what is already known about the phenomenon (Miles & Huberman, 1994).

Trustworthiness

Trustworthiness is the means for demonstrating the credibility, transferability, dependability, and confirmability of the qualitative study (Lincoln & Guba, 1985). Steps taken to assure these characteristics are important in qualitative descriptive studies, where the researcher is the instrument, close to the data, in this minimally-interpretive design where the participants' own words are the findings (Sandelowski, 2000).

Credibility. Credibility is a measure of the “truth value” (pg. 290) of the study, demonstrating confidence that the findings reflect the participants' intent (Lincoln & Guba, 1985). To enhance the credibility of this study, a peer debriefer, doctorally prepared and trained in qualitative research methods, was utilized. The peer debriefer worked with the investigator, probing any biases and asking for clarification and exploration of meanings and interpretations as needed. This occurred in parallel with analytic sessions, at least once every 5 interviews.

A second action to help establish credibility was the use of member checks. Participants were asked to help provide clarification or comment during interviews. This informal member checking was utilized as needed. A more formal check was done with 2 participants who

participated in the interviews. They were asked to review the preliminary version of the findings to determine if they accurately reflect their experiences (Lincoln & Guba, 1985). Finally, a member of the investigator's dissertation committee conducted an independent review and coding of some transcripts.

Dependability. Demonstration of credibility is required to establish dependability, the assurance that the study can be replicated by another researcher (Lincoln & Guba, 1985). To supplement the steps taken to assure credibility, an auditor assessed the process for managing data as well as the products of the data for the fairness and accuracy of the account. Carol Bova, PhD, RN, ANP served as the auditor for this study.

Confirmability. Confirmability, the assurance that the data, findings, interpretations, and recommendations are representative of the accounts, is supported by the confirmability audit used as part of establishing dependability (Lincoln & Guba, 1985). As such, in qualitative description, a separate process was not needed. The audit trail and process suffices to fulfill the establishment of confirmability.

Transferability. Transferability represents the applicability of the study results to another situation or group (Lincoln & Guba, 1985). To establish transferability, one is seeking thick description, interpreted by the researcher, which does not fit with the basic tenets of qualitative description. This study focused instead on rich description of the experience and may not be directly transferred to other groups or experiences.

Human Subjects Considerations

IRB application process. This study was approved by the UMMS IRB.

Protection of human subjects. Verbal consent was obtained prior to interviews. An information sheet was provided to participants (Appendix B). Potential participants received

assurance that participation is entirely voluntary and that deciding to participate (or not) will be kept anonymous and have no impact on their employment at UMMMC. Data was de-identified and reported in aggregate. Participation was confidential, voluntary, and participants were instructed that they may end the interview at any time. The investigator was also an employee at UMMMC functioning in a regulatory role including authoring the hospital's policy on reporting occurrences, adverse events, and patient safety concerns. Participants were informed that if anything discussed presents a risk to patients or staff, the investigator would stop the interview to address the risk protecting the anonymity of the participant. The UMMMC procedure and resources for reporting these concerns will be discussed and the conversation will be disclosed to the investigator's dissertation Chair. This did not occur in any of the interviews.

There were no anticipated physical or emotional risks to the participants. If participants had experienced any distress as a result of participation, referrals would have been made to the Employee Assistance Program (EAP) as needed. There were no participants that reported any distress during interviews.

A token of appreciation was provided to each participant by the investigator at the completion of the interview session. The token was a \$10.00 gift card to a local coffee chain within walking distance of each campus.

Reflexivity. In order to reduce bias, disclosure of the values or experiences of the researcher must occur. This investigator has 11 years of experience working at UMMMC including 4 years as a staff nurse, 2 years as a member of clinical leadership, and is currently in a regulatory role. The investigator was open to any potential biases that might occur during data collection and analysis and utilized personal reflexive journaling to record these biases throughout the study. The journal includes details about the data collection process (Lincoln &

Guba, 1985) as well as the investigator's thoughts, feelings, and experiences that could have potentially influenced findings. As an additional measure, the content of the reflexive journal was discussed regularly with the dissertation committee Chairperson.

Summary

This study utilized the qualitative descriptive method to explore how clinical leaders identify nurses as organizational champions and how they harness the energy of nurses acting as organizational champions to support innovation in the clinical setting. The sample included 14 clinical leaders invited from a cohort of formal clinical leaders at UMMC. Data collection was accomplished through face-to-face individual interviews. Qualitative content analysis was conducted using the process outlined by Miles and Huberman (1994). Efforts were taken to assure trustworthiness and human subjects' protection as outlined previously.

Chapter 4

Results

A qualitative descriptive approach was used to describe how clinical leaders identify nurses as organizational champions and how they systematically harness the energy of these nurses acting as organizational champions. The purpose of this chapter is to report the results of the study. Three main themes, each with two subthemes, emerged from the data to describe how clinical leaders identify nurses as organizational champions (Figure 1). “Go-To Person,” “See the Bigger Picture,” and “Own Their Practice” were themes that emerged to define the characteristics of the staff nurse acting as an organizational champion in support of innovation within a clinical area. Supporting the “Go-to Person” are the subthemes of “Great Nurses” and “Walk the Talk”. The theme of the champion as one known to “See the Bigger Picture” evolved to include the subthemes of the champion acting as a “Leader” and as one who acts as a “Voice for the Unit.” The staff nurse acting as an organization champion was reported to “Own Their Practice” by being a “Lifelong Learner” and by acting to “Actively Support Innovations.”

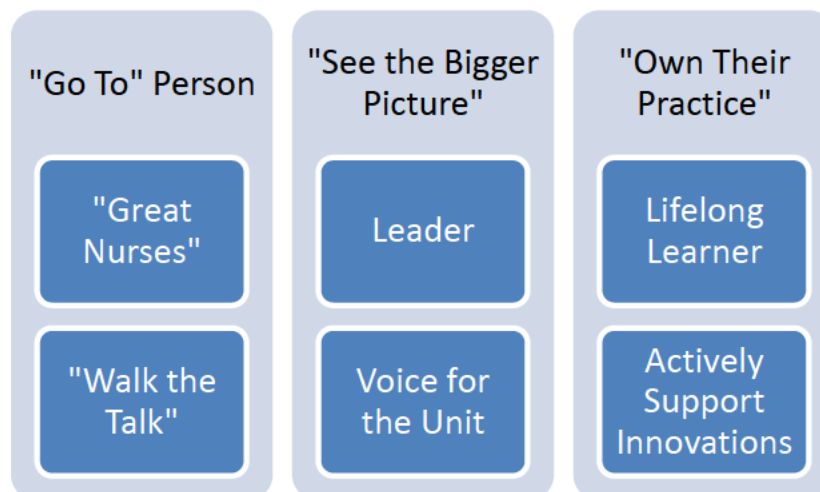


Figure 1. Identifying Staff Nurses as Organizational Champions

A cyclical and iterative model of identifying, engaging, and supporting champions emerged from the data to describe how clinical leaders harness the energy of nurses acting as organizational champions (Figure 2). This model is represented as a cycle of the themes “Be Present” “Match Talent to Innovation,” “Secure Buy In,” and “Get it Into the Drinking Water.”

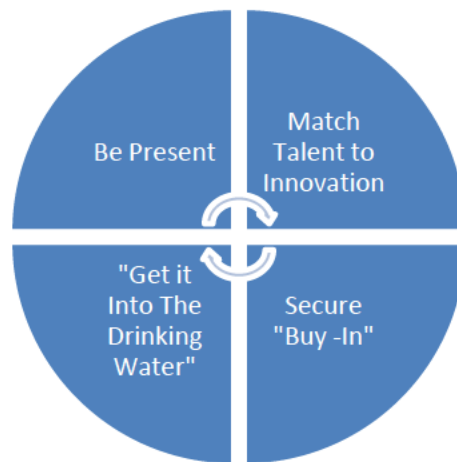


Figure 2. Harnessing the Energy of Nurses Acting as Organizational Champions

Sample

A total of 14 subjects participated in the face-to-face interviews (Table 3). Saturation for the major themes was reached after the 9th interview. An additional five interviews were conducted to ensure no new themes emerged. Member checks were done with two leaders to verify the findings. Both leaders agreed that the models represented their interpretations of the characteristics of nurses acting as organizational champions as well the systematic harnessing of the organizational champions' talents. They were able to provide clarification on three points:

- In reviewing characteristics of the champion, it was noted that leaders can be leaders without being a role model; this suggests that the role model belongs as a supporting behavior under the subtheme “walk the talk” and that it should be kept separate from the subtheme “leader.”

- Being present allows the manager to harness the energy of the champion and further support the model by seeing when a champion is becoming “burnt out” and working to stop that process. This permits the cycle to continue.
- As part of getting “buy in”, participants indicated that they make clear which changes/innovations are “required” by senior leadership to meet an organizational or immediate safety/practice need (e.g. policy change or implementation of a new computerized documentation system) and which changes are “optional” to improve practice but may still have flexibility or be modifiable to meet unit characteristics (e.g. procedure implementation). Participation is always optional, but knowing the background of a proposed change helps the potential champion appraise their anticipated role.
- The cycle of harnessing champions’ talents benefits the clinical leader’s practice; because it makes the leaders more energized and further promotes future iterations within the cycle. Further review of the data supports this as evidence of “getting it into the drinking water” by exposing staff to positive change, which was believed to be a factor in staff willingness to participate in future changes. Once the culture changes, the manager finds that his/her job becomes easier and “growing champions” is easier.

Table 3.

Participant Characteristics

Variables	n
<u>Age</u>	
30-39	3
40-49	5
50-59	5

Years Experience as a Leader

1-10 years	9
11-20 years	2
21-30 years	1
31-40 years	2

Highest Level of Education

Bachelors Degree	1
Masters Degree	12
Doctorate	1

Job Title/Role*

Educator/Clinician	5
Clinical Coordinator/Assistant Manager	2
Manager	6
Administration/Senior Management	2

Clinical Area*

Acute Care	9
Critical Care	4
Ambulatory Clinic	3
Other	5

*some leaders indicated having two roles and/or covering more than one clinical area concurrently

The sample included 13 female participants (93%). Participants' ages ranged from 32-58 years, with a mean age of 47 ($SD=9.7$). Most were at least master's prepared (93%) with from 2 to 33 years (mean 11.7 years, $SD=10.9$) experience as a leader. While all 14 participants were Registered Nurses, some participants indicated having educational preparation in other fields, including Business and Healthcare Administration.

Clinical leaders participating in interviews were asked to identify their clinical area and role. Some indicated working within more than one clinical area. Clinical areas identified were acute care ($n=9$), critical care ($n=4$), and ambulatory clinics ($n=3$). Specialty areas represented included: perioperative, emergency, and a variety of specialty clinics. Some participants indicated that they held more than one role within the organization, concurrently. The

roles/titles included: clinician/educator ($n=5$), clinical coordinator/assistant manager ($n=2$), manager ($n=6$) and administration/senior management ($n=2$).

Identification of Staff Nurses as Organizational Champions

Participants readily identified that they knew what a staff nurse acting as an organizational champion was, but many had a hard time listing the characteristics of the champion. They identified that champions represented a small percentage of their staff. Study participants ($N=14$) estimated that they oversaw, on average, 75 staff nurses in their roles as clinical leaders. Of these staff nurses, the average number of staff nurses that were identified as organizational champions (when looking at the operational definition) was 9, representing an average of 12% of the staff. The percentage of organizational champions on a unit generally ranged from 2-32%; however there was one outlier who indicated that in her small unit 90% ($n=28$) of staff nurses fit the description of “organizational champion.” This leader was able to support this high percentage with examples that demonstrated the various characteristics and behaviors unique to these champions.

Participants struggled to identify the tangible characteristics of champions, instead, they often described intangible characteristics such as “just great nurses,” “you just know,” or “it’s just the nature of who they are” and there is something “innate” about them. Most ($n=11$) participants stated that they were able to immediately or very quickly identify the organizational champion because the true organizational champion made him/herself apparent, generally by approaching the leader with ideas and plans for execution. This is in contrast to the “great nurses...[who] do their job like they are supposed to do...but, don’t pull other people in.” Most ($n=13$) participants specifically identified the ability to “pull in” coworkers (subtheme: leader) as a valuable characteristic of the organizational champion. While nurses that are good at their

jobs were recognized by participants to be an important asset, the organizational champion was described as having something else “above and beyond” clinical expertise that enabled them to act as opinion leaders and build trust around an innovation. The way the champion is viewed by peers and clinical leaders makes them uniquely skilled in fostering the success of an innovation.

The Go To Person

Study participants identified that the staff nurses acting as organizational champions in support of innovation were the “go-to” people in their clinical area and were generally the first person that was approached by staff and leadership alike to “bounce off ideas.” The “go-to” person was readily apparent when the clinical leader took the time to observe the unit. The “Go To” Person was described as:

Never working by herself, [not] isolated in her own bubble, [or] in her own corner just doing her work and what needs to be done. She is always...talking to this nurse over here, over the shoulder of another nurse on the computer helping her figure things out. She is always with another nurse and she is always asking other people on the unit questions.

Many participants ($n=11$) described how, upon hire, they were able to quickly identify the “Go To” person. One clinical leader stated: “you know day one” who to go to. Participants reported that the “go to” person became readily apparent to them within a short period of time, simply from watching for the nurse that fellow staff approach for support or ideas. The “go to” person was generally a well-respected nurse on the unit to whom other nurses would go for questions related to clinical practice and whose clinical opinion about innovations was highly regarded (subtheme: “great nurse”). One participant stated: “staff seem to know what the talents of these champions are, too.” Another participant indicated: “they become apparent not only in

my interactions with the staff through just informally being on the unit...it has also come about through staff meetings and...participation in the various activities and things going on on the unit that I have really been able to identify pretty quickly which nurses that I would consider [champions].”

As the “go to” person, the nurse acting as an organizational champion also acts as a preceptor for new nurses or when a new practice is rolled out and is seen as a resource and mentor for all nurses (subtheme: “walk the talk”). The word “respect” was used by some participants ($n=3$) to describe the impetus for peers’ willingness to readily approach the “go to” nurse. Many described the champion as visible on the unit ($n=11$) and reported that they were outgoing or approachable ($n=9$). Part of being a “Go To” Person for peers was attributed to the nurse’s ability to demonstrate excellence in nursing practice. Participants described excellence in nursing as being both a “Great Nurse” and one who was willing to “Walk the Talk.” Demonstrating these characteristics was part of what made the “Go To” Person so successful in that role.

Great Nurses. Organizational champions were recognized as strong nurses. Information seeking was a champion characteristic valued by study participants (subtheme: lifelong learner), yet formal education was not required. Additionally, years of clinical experience required for a nurse to be recognized as a champion was inconsistent among study participants. While some ($n=7$) indicated that newer nurses wouldn’t be described as strong clinicians, many ($n=9$) indicated very clearly that they might still be effective organizational champions. Statements such as “not necessarily the most expert as far as knowledge” and “newer, younger, nurses that don’t have as much of a cynical view of nursing” were used to outline how clinical skills went above and beyond years of experience. Further, while technical skills were not discounted, study

participants reported that organizational champions were recognized to be strong all-around nurses, with an emphasis on interpersonal interactions and decision-making skills in addition to being excellent practitioners. Additionally, some participants ($n=9$) cautioned that experience could be a detriment to champion behavior when the nurse finds that it “makes them feel entitled” or “they just don’t want to change,” particularly when they feel that they are “experts in this field” but are not or “they’ve not really developed...or they’ve plateaued (sic).”

Participants described the practice of the nurse acting as a champion holistically and focused on being “great with patients” and being a “critical thinker” and “reflective practitioner.” The champion was described as “treating patients like family” ($n=4$) or “going above and beyond” ($n=4$). Additionally, these nurses were ($n=7$) described as having an understanding of when they needed more resources and knowing how to utilize their resources. As one participant described, the champion “didn’t have to be the absolute smartest nurse who knew every drug inside and out and all that stuff; it was really about your total package of patient care.”

As one participant stated, this strong clinical practice helped support the organizational champion being the “Go To” Person by lending credibility to their opinions and by gaining them acceptance as an informal clinical leader. For example one participant stated:

How they demonstrate their leadership skills with their peers is how they approach challenging situations; they are truly a resource, not only when they are in a resource role but they are that “go to” nurse because they have sound judgment, their interactions with patients are exemplary, their documentation, the way they interact with physicians, PCA’s...so, it’s behaviors that are that they are truly role models and staff do look up to them frequently asking them...not only

look up to them in terms of clinical knowledge but they are very well respected for all of those reasons because of their practice.

Participants also described another component of the “Go To” Person, “Walk the Talk”, which contributed to the perception that the nurse acting as an organizational champion goes “Above and Beyond”.

Walk the Talk. The person who “walks the talk” was recognized to be someone who “will become an authority on it, master of it, and then they will teach.” Participants reported that it was more than simply knowing what to do: it was showing what to do and being able to support their peers in their practice. For example, one participant explained that to identify a champion who “walks the talk”:

It’s just how they approach every situation, every interaction. They are truly role models and you can see that. It’s quite obvious to their peers, to leadership, when you see them in action that they are not just talking and talking out of both sides of their mouths. They actually stand behind what they say and do.

Experience in bedside nursing practice was valued as an element of being a “go to” person, but as there was no consensus among participants on the years of experience required to be a champion. An important contributing factor was the willingness of the nurse to “walk the talk.” In addition to being strong practitioners, the champion was recognized by study participants as someone who could act as a role model for their peers. Knowing what to do and practicing consistently (subtheme: “Great Nurse”) was reported by participants to be a separate skill set from being able to support others in their development. Some participants ($n=7$) identified that the individual that was recognized as the “go-to” person was often the same

individual who precepted new nurses in their area because of their ability to take information and share it while modeling expected behaviors.

While many participants reported that their units' organizational champions were known to be excellent at teaching/precepting, most ($n=8$) recognized that even if the champion's strength was not teaching/precepting, they were still recognized as role models by their peers and were able to act as mentors by modeling their practices and acting as part of the team when new practices were introduced. Survey participants reported that part of being a "go-to" person is the expectation that the nurse is "credible" ($n=5$) to peers and that they set the expectation that practice should be at the highest level ($n=9$). As one participant described, organizational champions that "walk the talk", "have a really strong standard, self-discipline so they like to always do what's right; they expect this of themselves and get frustrated when others don't meet their standard." The drive to do "what's right" was viewed as part of the champion's ability to see how the staff nurse role fits within the larger organization and the impact that the nurse has in the staff nurse role. This forward-thinking process about practicing at the highest level within the scope of their role makes the organizational champion a "Go To Person" supporting the two other themes ("See the Bigger Picture" and "Own Their Practice").

See the Bigger Picture

Most participants ($n=12$) also reported that they believed the organizational champion to be aware of how their practice and support of innovation buttressed the overall organizational mission and impacted patient care on the unit as a whole. The nurse acting as an organizational champion understands how "the small stuff they are doing every day influences the bigger picture." This ability of the organizational champion to see the impact that their ground level efforts have on both the program-specific level and the organization-wide level was highly

regarded by study participants as supporting the work that they do. One participant described how the organizational champion is “always seeking to improve their own practice and they know what is going on {on} the unit” as well as “paying attention” to “where healthcare is going.” Staff nurses acting as organizational champions are believed to understand the impact change has on both present and future patients and how to integrate change into the work of nursing. Through this understanding, he/she is able to use their leadership abilities to bring issues forward to management and to share management feedback with their peers.

Leader. Study participants identified that staff nurses acting as champions were recognized as leaders among their peers and were viewed similarly by other colleagues and clinical leaders. Many participants ($n=9$) used the word “leader” to describe the nurse acting as an organizational champion within the clinical area. The most common leadership traits that were described were the ability to communicate effectively ($n=13$), the ability to “pull in” coworkers by engaging them around an innovation ($n=7$) and being recognized as approachable and non-threatening ($n=5$). One participant described this ability as indicative of “emotional intelligence.”

Formal leadership roles demonstrated by staff nurses are those with formal, defined, responsibilities such as resource/charge nurse ($n=8$) or unit council/committee member ($n=10$). However, not all champions demonstrate formal leadership. Some nurses take on informal leadership roles, still “see the bigger picture” and demonstrate day-to-day leadership among their peers by getting them to “rally” in difficult times or in support of change.

Participants ($n=6$) identified that there was a role for the “informal leader” on the unit, and that these informal leaders were able to take on championing work and use conversations to bring the group together and act in support of innovation. The importance of informal leadership

was reported by study participants to be indicative of their overall perception of the strength of the organizational champion as a leader, regardless of role because it was the champion who helped frame an innovation for his/her peers.

The ability to be a leader, formally or informally, is something that participants recognized would be a strength to clinical leaders in harnessing their energy because:

There is something there right off the bat that develops because, from a leadership perspective, there are inherent leadership skills that people have that they can develop and, particularly when they get into a specialty like nursing, as they become more clinically competent and comfortable and become more of a clinical leader, then that natural leadership takes over for them to be more innovative...to champion certain projects or certain ideas and bring it forward...

In bringing “it forward”, the nurse acting as an organizational leader acts as a “voice for the unit”, bringing ideas to management as well as to staff. In “seeing the bigger picture” the champion is willing to be the voice for the unit, too.

Voice for the Unit. Many study participants reported that nurses acting as organizational champions also acted as a voice for the unit. In doing so, champions were reported to act as the intermediary between staff and their formal clinical leaders. This individual may be very engaged and speak up in staff meetings ($n=6$), or may be the peer-elected representative ($n=8$) to present an idea to the formal Clinical Leader. Some participants identified that their champions were the ones that “asked the most questions” ($n=4$).

Champions were identified by most participants ($n=11$) as the first person to approach their clinical leaders to ask a question or bring up a suggestion. As one participant explained “every time I’m on the floor they always come and talk to me and ask me a question” and

another stated “I am not approaching them first; they are approaching me.” These nurses acting as champions were also reported by many participants ($n=10$) as not afraid to share their opinions with or approach other clinical leaders within the organization to raise ideas or to support their team’s efforts. They are identified as the individuals that “bring things forward” and in doing so, they are demonstrate forward thinking as well as an ability to recognize the immediate benefits of improving practice in the moment.

Own Their Practice

All study participants ($N=14$) identified that organizational champions were actively engaged in improving their practice. They were described by participants ($n=6$) as “very professional” and they “own their professional practice” which was demonstrated as “taking practice seriously” and not needing “a lot of hand holding in terms of knowing and identifying their weaknesses and their strengths.” This was seen as something different from simply utilizing their experience and being viewed as an expert clinician because it was mentioned by nearly all participants ($n=13$) that growing and improving as a practitioner was a critical component of being an organizational champion. Those who failed to do so were mentioned by participants to be likely to be “burnt out,” despite their experience. Those that became “burnt out” were at risk of becoming “negative thought leaders” and “old crusties,” locked into a way of doing things. Most participants ($n=9$) identified that they thought these nurses were “quality-oriented...safety based.” They were reported by most to “take initiative and follow through.” As some participants stated “they love nursing” ($n=3$) and “they’re not ones that just come in to do their job and then go home” ($n=7$). Champions demonstrate “owning their practice” by seeking to improve continually. This is bolstered by their actions as lifelong learners, improving themselves, and by their actions when actively supporting innovation.

Lifelong Learner. Study participants felt strongly that nurses acting as organizational champions demonstrated several lifelong learning behaviors, some formal and some informal. All participants reported that the nurses they viewed to be organizational champions were actively seeking information to improve their knowledge about particular topics of interest. Most participants ($n=10$) indicated that the nurses were undertaking formal education such as RN to BSN programs, advanced degrees, or certification programs. Of these participants, most ($n=9$) noted that the nurses undertaking such formal educational endeavors would bring their experiences back to inspire their peers in support of lifelong learning.

All participants indicated that nurses acting as organizational champions took steps to gain knowledge, many on a regular basis, and mostly in an informal setting. Most participants ($n=11$) described these champions to be “self-motivated” to seek information through scholarly journals, conferences, interdisciplinary rounds, and through researching best practices for the purposes of working with leaders to develop policy or procedure. They were described as wanting to “learn outside of the workplace” and as those that would always “look for an answer.” This desire to be a lifelong learner extended into their willingness to actively support innovation to support their being recognized as “owning their practice.”

Actively Support Innovation. Another key characteristic of the organizational champion acting to “own their practice” is that they actively seek opportunities to improve and support innovation. While they are seeking to improve themselves and their practice, another key component of the nurse acting as an organizational champion is that they are bringing in “ideas to share with people” and searching for ways to improve the unit. Additionally, when innovations emerge, champions actively “rally” the team or take steps to secure group “buy in”

to the innovation. Participants reported that champions actively support innovation in a variety of ways including:

- socializing the positive or needed aspects of change ($n=11$)
- taking initiative to promote the change or educate staff ($n=13$)
- conducting their own tests of change ($n=11$)
- performing their own literature search to suggested changes ($n=7$)
- taking ownership of a change ($n=10$)

Socializing the positive aspects of change was seen by participants through the behaviors such as “talking amongst themselves to figure out a plan and then go to staff and start talking about it” as well as “sharing positive impact on patients because ultimately that’s what everybody is here for.” Those participants that described champions “taking initiative” reported such behaviors as “photocopying information for staff” or “sharing messages from meetings with staff.” Additionally, these champions were known to bring their lifelong learning strategies to work with them to support others. As one participant noted “you can tell that when they’re home they’re reading articles; they come in and say ‘hey, I’ve heard about this. Why don’t we try this idea?’”

As champions bring in ideas for innovation or are presented with innovations, they were noted by most participants ($n=11$) to conduct some sort of test of the change. Behaviors included questioning the innovation from several angles (“poking holes in it”) or trying something new and then altering it if it didn’t work and reporting any improvement to their quality councils or clinical leaders. These behaviors were indicative of an awareness of the need for quality improvement for the sake of improving patient care or workflow and not just changing practice. However, when practice changes were required by leadership and not

suggested by frontline staff (due to new documentation, processes, or computer systems, for example) champions still would conduct tests of change but would also perform their own literature searches to support or to refute the need for such a change or to make the change “work for their unit.”

Ultimately, champions have ownership over the change as it supported his/her own practice. Most participants viewed the champions as “willing to try new things” ($n=13$) and able to “carry it forward to staff” ($n=13$), supporting a team approach when embracing change. These champions were felt to demonstrate passion by many participants ($n=7$).

Harnessing the Energy of Nurses Acting as Organizational Champions

Study participants described an iterative process harnessing the energy of nurses acting as organizational champions (Figure 2). The cycle begins with the identification of champions by observing and interacting with staff and the need to “be present” followed by “matching talents to the innovation” and then utilizing the champion to help “pull in” peers and to actively support the innovation by “Securing Buy In” from peers. While “buy in” was important for the initial success of an innovation, participants identified that they actively strive to “Get it Into the Drinking Water” and support a culture of championing and innovation, allowing continued success.

For many participants, it was hard to formally explain how they harnessed the energy of organizational champion. Initial participants paused or took the opportunity to clarify the question when asked how they systematically harness the energy of nurses acting as organizational champions; commonly, they identified that they had never really thought about how they do this, they just do.

Regardless, all participants ($N=14$) were able to identify that there was a benefit to knowing which staff are champions in an area. From the educator/clinician perspective ($n=5$), all agreed that one important benefit of the champion was their willingness and ability to act as an extension of the educator/clinician role and to help support education initiatives. From the perspective of the larger group, including those in manager and educator roles, the most commonly mentioned benefits were the champion's ability to encourage their peers to at least consider an innovation ($n=13$) and their willingness to suggest opportunities for improvement ($n=11$) that the participant him/herself may not have otherwise seen.

Be Present

When describing the process of harnessing the energy of organizational champions, most ($n=10$) identified that they were very involved in the day-to-day details of their units in an effort to observe and interact with staff. Some examples of being present that supported their observations and encouraged interaction included having an "open door policy" ($n=7$) and keeping the door open, "working [in a] staff [role]" ($n=3$) and taking steps to "role model" expected behaviors and attitudes ($n=6$). Additionally, participants ($n=9$), validated the importance of the culture of championing change starting with the formal clinical leaders representing the desired behaviors and guiding champions to support innovation (theme: getting it into the drinking water). As one participant, noted: "There is a lot in this system to overcome but, you know, I think that when I was a staff nurse I always looked up to my leader who was always out there and just seemed to be doing the right thing and always invested. So, I kind of try and be like that."

Participants also described that they tried to be as visible and approachable to the staff as possible. This included being present on all shifts as much as possible ($n=5$). Being present on

all shifts and supporting staff in day to day work allows the clinical leader to see how innovations are working and “where [staff] are coming from” when they implement something new. Additionally, it allows them to watch behavior and see how nurses interact with their patients and coworkers in providing patient care. Some participants ($n=7$) indicated that only by being present in the halls of their clinical area and knowing the work of the staff firsthand could they achieve seeing an accurate and complete picture of a nurse.

Participants ($n=7$) also indicated that they focused on observing interactions with staff on the unit and during meetings because they found that helped them to interact with staff, observe those becoming “burnt out” ($n=4$) to intervene before losing a champion, and also see who may present a barrier for champions. The “burnt out” nurse was described by clinical leaders as a staff observed to “practice with blinders on...on autopilot...pay very little attention to what is going on around them and...are really, really difficult to get them to engage” or one who “stops asking questions.” Participants described using their staff interactions to identify threats to their desired way of doing things as well as those that were likely to support a given innovation. They explained that they felt being present was their greatest strength in being able to identify who the staff nurses acting as organizational champions on their unit were, which made “Matching Talent to Innovation” possible.

Matching Talent to Innovation

Participants described matching talent (identified while “being present”) to an innovation as the next step in the cycle of harnessing the energy of the champion. This process included utilizing both informal discussions such as “tapping them on the shoulder” and formal meetings including performance reviews to ascertain the particular talents and interests of their staff and match them to the proposed change. One participant described the following process:

First thing...look at the overall job performance, also too their willingness to want to participate in things...I look at their involvement at staff meetings. Often times, though, the nurses will come to you and offer...they're champions on maybe one topic but maybe not another topic so you kind of try to figure out what they are passionate about...Usually they will volunteer [but] I've gone and asked them.

Nearly all study participants ($n=13$) reported placing emphasis on considering the strength and interest of the identified organizational champion before considering how to engage them around an innovation. The rationale for this included considering "skill sets" and realizing that they "may not be a champion in one area but successful in another" and accepting that champions may have different levels of interest getting involved in formal projects. Some participants ($n=3$) identified that part of their leadership strategy was to discuss nurses' growth and willingness to participate in their formal staff evaluations. This process enabled them to direct their focus to those already interested in championing work. As one participant stated:

If I know there is a particular interest when I do staff evaluations, my last question I always ask is 'What can I do for you? What are you interested in? Are you interested in certification? Are you interested in going back to school?'...I ask them what their challenges are. Sometimes, they're personal, sometimes they're professional, sometimes they are both... 'So, what can I do for you and so how does that look to you?' That's the next question.

While some participants were more detailed in their description of how they match a champion to an innovation, many ($n=10$) simply acknowledged that knowing the interests and strengths of the champion made them more likely to engage in support of an innovation. Knowing the strengths of the unit staff, achieved by first observing and interacting with them,

made the study participants' harnessing of a champion more successful. Matching the talents of the champion to the innovation being introduced supported ongoing success. If champions felt strongly about a project, he/she was felt to be more likely to "buy in" to the innovation and work to support the clinical leader's efforts to "get it in the drinking water."

Secure Buy In

Study participants were vocal that "buy in" around an innovation was critical. This term was used by most participants ($n=9$) to describe when staff become engaged around an innovation and work to promote it (as a champion) or are willing to participate in its' spread because the project appears credible and they trust the source (the champion). Participants used this term both to describe both initially harnessing the identified champion around an innovation ($n=12$) and how a network of staff nurses acting as organizational champions work to secure peer "buy in" to the innovation and encourage spread ($n=13$).

While champions are a positive influence on the success of the innovation, the inherent characteristic of the champion as the voice of the unit makes them predisposed to asking questions that help them see the need for and benefit of the innovation, so they may initially appear to have a negative impression of an innovation. However, as the champion is able to see the bigger picture, buy in can be obtained with leader transparency and support of the champion. The benefit of organizational champion "buy in" was identified as "you need to get buy in from nurses and then they need to help engage their peers".

Most participants ($n=11$) echoed the sentiment that once they did some work up front explaining the innovation and providing the background and intended benefit to the champion, "buy in" followed and success was more likely. As one participant stated "once you drink the Kool-aid you are hooked...you can hook them and then they tend to fly." If the champion buys

into the innovation and perceives that it is beneficial to the unit or the patient, they are more likely to act in support of it and engage their peers, securing peer buy in. Successful staff/peer “buy in” was described by one participant as “your colleagues understand what is going on and want to jump on board with you and champion along with you and make things better.” Another participant explained:

...just because I tell you to do something you are not going to do it. It really takes a wave to come out...you have your initial buy ins then it goes to the next group, then it goes to the next group, and so that you get people actually buying into something that they think is worthwhile but you have to show them why it is worthwhile.

As champions were described to be engaged members of the unit, participants reported that they tend to volunteer or show interest in a project being rolled out. All participants ($N=14$) reported that most champions simply “step up” or express an interest in an innovation, and many also acknowledged that others may not initially volunteer ($n=12$). Many study participants ($n=10$) identified that these champions would often “buy in” to an innovation as a result of staff meetings or information disseminated via committees or on-unit. Other champions may not step up initially, but are still willing to support an initiative. One participant described these individuals as “being always willing to help, but rarely willing to volunteer.” Participants reported that in this case, when they had determined the individual might be a good fit for an innovation, they would simply “ask” or “tap them on the shoulder” and would provide any additional needed information or support to secure buy in.

Champions that are asked instead of volunteering may require some additional support to accomplish successful champion buy in and trigger their support to gain peer buy in. Many

participants ($n=11$) mentioned that they felt there is a level of distrust in management and their organization which may require additional efforts on the part of the clinical leader to overcome the barrier and secure “buy in”, or engagement. One technique used to engage champions is to engage the identified champion as a thought leader on the topic. Most participants ($n=12$) reported that the way they would ask the champion to participate is to ask their opinion about a topic or planned innovation and once there was interest, outright ask for participation.

Participants ($n=11$) stressed that leadership transparency was critical. Clinical leaders need to be clear about initiatives being “must do” vs. “can do” and should indicate why they are required, if so, and if they are optional, give latitude to the champion and take their feedback seriously into consideration. Champion efforts to secure peer buy in are enhanced when ideas go from the “bottom up” as opposed to “top down” ($n=13$). Looking at innovation efforts from this standpoint has the added benefit of securing feedback from frontline staff to help make the planned innovation a success.

As one participant states:

The first thing is maybe to float these issues to those people and see what their response is and then maybe modify the program or the project based on that input and then, when the project or the change is launched, those individuals, usually because they’ve bought into it already, will implement the changes themselves.

Importantly, some participants also used the strategy of focusing on securing buy in from the strongest critics, including those that tend to reject change ($n=12$) or those that felt that change went against the beliefs of the union ($n=6$). Converting the naysayers was reported by some ($n=9$) to be a tactic to engage those that may otherwise have been negative opinion leaders. While these nurses may present a challenge, participants felt that approaching them for their

feedback and inviting the negative leader to participate enabled them to direct their energy into supporting change. Once they felt invested, the “negative leader” was able to act as a “positive leader” in many cases.

Many participants ($n=10$) identified another group which may not require active recruitment or efforts to secure buy in. Champions who actively seek improvement opportunities will approach their clinical leaders with their own ideas for innovative ways to solve clinical problems. These individuals have already bought into the idea they are proposing and are engaged around fixing the problem. They demonstrate one of the biggest benefits of the clinical leader “getting it into the drinking water” to support future innovation.

Getting it Into the Drinking Water

Study participants identified that a final step in their process of harnessing the energy of staff nurses acting as organizational champions was to create a culture of championing and positive change and to actively work to eliminate what one participant described as “a culture of mediocrity.” By supporting the development of a professional work environment, participants ($n=12$) reported that in their clinical leadership roles they found they had greater success “getting it into the drinking water” and engaging other staff to support practice changes and improvement. Participants described how staff input was critical to the success of any initiative and the more champions they had, the more likely they were to get input that was beneficial. As one participant stated in describing a successful project: “I knew what the goals were, but I didn’t know the processes, so their knowledge of the daily operations was crucial and so we were credible. They were credible to their peers...It’s harder to not listen when you have that.”

Once it’s “in the drinking water” participants identified that the culture that supported champion behavior allowed the leader to “grow champions.” Participants recognized the benefit

of having more staff nurses that would support innovation than those that rejected change. One participant offered:

Whatever change, big, little, you need to start talking about it in order to get it into the drinking water. That could take years but it does need to bubble up so you need to start talking about the ideas, get the staff's input...you know you are going to get a lot more buy in when they feel, and truly feel, that they have contributed to it...it's coming from their ideas. That's where you develop the trust and that's ongoing...and is going to get those champions to surface and have a voice.

Specific measures taken to “get it into the drinking water” varied from participant to participant. However, participants described common ways that they tried to promote champion growth; these included:

- supporting unit-based committees and councils ($N=14$)
- provide education resources (e.g., formal education, conference attendance, in-services) ($n=13$)
- provide opportunities for staff to participate in change ($n=12$)
- Empowering nurses to take the lead ($n=12$)
- Provide consistent and constant feedback ($n=12$)
- Rewarding team efforts ($n=10$)

While different strategies were used to “get it into the drinking water” each strategy is a way for the clinical leader to support professionalism by providing opportunity or demonstrating trust. As one participant stated, “I have said to them...if you make a decision and I'm not here and we might have thought it could have been done differently, we'll talk about it but make the

decision, take the risk.” A key element to feeling empowered and safe to act, participants acknowledged, is trust that is built from open communication and feedback. Additionally, support for ideas and recognition and recognition and rewarding of successes, should come from the “top down” according to participants ($n = 10$). Participants expressed that when they celebrated victories with their teams, champion efforts were enhanced.

Some participants ($n=4$), managers or administrators, indicated that they specifically sought to hire nurses that demonstrated the characteristics of nurses who act as organizational champions in support of change. They felt that this established a good baseline from which to work while engaging in the cyclical model of “harnessing the energy of nurses acting as organizational champions.”

Some participants acknowledged that “getting it into the water” made their roles more challenging ($n=6$) as they were faced with constant debate and questions, but simultaneously made their job more rewarding and inspiring ($n=6$). As one participant, a manager, stated:

...my staff makes me look good every single day...They do a really good job for our patients and many times it is unsung, unrecognized, and it is just what they do because that is their standard. So, that makes being a manager a whole lot easier but it also presents challenges because I don't want them to stagnate. I want them to keep raising the bar. So, that is what I see as my yearly challenge. How are you going to raise the bar for people who are already really, really good? How are you going to make them better?

Summary

There are clear ways that clinical leaders identify nurses acting at organizational champions. These ways include identifying the go to person, recognizing nurses who see the bigger picture and selecting nurses who are able to own their own practice. Once these nurses

are identified, nurse leaders harness the energy of these champions by being present on the units, matching the talents of the champions with the innovation planned, securing buy in from the champions and working over time to get this into the drinking water (or the culture) of the unit.

Staff nurses can use this information to appraise their own characteristics and behaviors to see how they can act in support of innovation in their clinical area. Also, this knowledge provides staff nurses suggestions for behaviors that are desired by clinical leaders when planning innovation and seeking champions. This knowledge is also important because it gives new leaders a framework to work from when developing the culture of their clinical area. Additionally, it provides existing clinical leaders with suggestions about how to look at their staff and identify the champions who may not immediately present themselves. This evidence provides clinical leaders with four steps to harness the talents of nurses that can act as organizational champions in support of innovation in their clinical areas. Finally, the evidence provides clinical leaders with suggestions for characteristics and behaviors to use as probes during a behavioral-based interview, which supports the clinical leader in developing a culture of innovation.

Chapter 5

Discussion

The purpose of this study was to explore how those in formal clinical leadership positions (e.g. managers, directors, executives, and educators) identify and utilize staff nurse organizational champions. The main findings were that participants were able to clearly identify key characteristics of the nurse acting as an organizational champion. All participants saw how nurses acting as organizational champions support innovation in their clinical areas and nearly all participants saw the benefit in actively engaging these champion nurses around innovation. While participants had a harder time explaining exactly how they systematically harnessed their energy, they were nearly unanimous in describing the iterative process used to support innovation in their areas.

The study findings will be discussed in relation to the study's guiding framework, Kouzes and Posner's (2007) Five Practices of Exemplary Leadership. Additionally, this chapter will discuss the relationship of the findings to prior empirical evidence as well as implications for practice, research and health policy.

Kouzes and Posner's "Five Practices of Exemplary Leadership"

Kouzes and Posner's (2007) Five Practices of Exemplary Leadership" framework extends the Bass Transformational Leadership Model and provides guidance about what leadership is, how it differs from management, and that it can be measured and taught (Posner & Kouzes, 1988).

The major findings of this study are encompassed within two proposed models. The first, "Characteristics of Nurses Acting as Organizational Champions" (Figure 3) describes what clinical leaders are looking for as they identify nurses acting as organizational champions. These

are the behaviors and characteristics of the nurse champions themselves. The second model, “Clinical Leaders’ Harnessing the Energy of Nurses Acting as Organizational Champions” (Figure 4), focuses on the behaviors of the clinical leader in harnessing the talents of the champion, which involves supporting and engaging the champion to further an innovation and establish a culture of innovation.

In both cases, participants described transformational leadership consistent with the “Five Practices” whether it is the nurse acting as an organizational champion among peers or the clinical leader acting to harness the champions’ talents and support innovation in a clinical area. The proposed models each describe characteristics and related behaviors that fit within the five practices for both the staff nurse acting as an organizational champion and the clinical leader harnessing the energy of the organizational champion (see Table 4).

Table 4.

Relationship of Proposed Models to Kouzes and Posner’s (2007) “Five Practices of Exemplary Leadership”

Major Tenets of the Five Practices Framework and the Underpinning Ten Commitments	Relationship to Study Findings	Themes and Subthemes Represented
Model the Way Exemplary leaders are recognized for modeling the behaviors that they expect of others, which inspires the group being led to commit to the direction the leader is helping to shape. Inspiring others to commit supports the achievement of goals and meeting the highest standards as set forth by the leader	<i>Characteristics and behaviors of the staff nurse acting as an organizational champion</i>	
	<ul style="list-style-type: none"> • Treat patients like family • Go above and beyond 	Theme: “Go To” person Subtheme: “Great Nurse”
	<ul style="list-style-type: none"> • Recognized as role models and mentors by their peers • Set the expectation that practice should be at the highest level 	Theme: “Go To” person Subtheme: “Walk the Talk”
	<ul style="list-style-type: none"> • Ability to take information and share it while modeling expected behaviors; carry forward to peers 	Theme: “Own Their Practice” Subtheme: <i>Actively support innovations</i>

Major Tenets of the Five Practices Framework and the Underpinning Ten Commitments	Relationship to Study Findings	Themes and Subthemes Represented
<ul style="list-style-type: none"> • <i>Find your voice by clarifying your personal values</i> • <i>Set the example by aligning actions with shared values</i> 	<i>Clinical Leader's Harnessing of Organizational Champions</i>	
	<ul style="list-style-type: none"> • Take steps to role model expected behaviors and attitudes; aware that staff model leader behaviors • Try to be as visible and approachable as possible. 	Theme: "Be Present"
	<ul style="list-style-type: none"> • Be clear about unit needs/required changes when presenting innovations 	Theme: Secure "Buy-In"
<p>Inspire a Shared Vision Exemplary leaders describe having a vision for the organization that is exciting and attractive; they dream and they believe in their ability to achieve the dreams. By clarifying that vision and sharing it with those being led, the group can work to reach the destination.</p> <ul style="list-style-type: none"> • <i>Envision the future by imagining exciting and ennobling possibilities</i> • <i>Enlist others in a common vision by appealing to shared aspirations</i> 	<i>Characteristics and behaviors of the staff nurse acting as an organizational champion</i>	
	<ul style="list-style-type: none"> • See how their practice supports the overall organizational mission and impacts patient care on the unit • Know where healthcare is going 	Theme: See the Bigger Picture
	<ul style="list-style-type: none"> • "Bring things forward"...forward thinking 	Theme: See the Bigger Picture <i>Subtheme: Voice for the Unit</i>
	<ul style="list-style-type: none"> • Take a message and "carry it forward with their coworkers" and support a team approach when embracing change • Day to day, get peers to "rally" 	Theme: "Own Their Practice" <i>Subtheme: Actively support innovations</i>
	<i>Clinical Leader's Harnessing of Organizational Champions</i>	
	<ul style="list-style-type: none"> • Consider the strength and interest of an identified champion before considering how to engage them • Discuss nurses growth and willingness to participate with them 	Theme: Matching talent to innovation

Major Tenets of the Five Practices Framework and the Underpinning Ten Commitments	Relationship to Study Findings	Themes and Subthemes Represented
	<ul style="list-style-type: none"> Be a “cheerleader” about a change to overcome any distrust 	Theme: Getting it into the drinking water
<p>Challenge the Process Exemplary leaders envision change and innovation and venture out to achieve the change and improve the organization.</p> <p>Exemplary leaders challenge the status quo, taking risks and committing to the change they wish to see.</p> <ul style="list-style-type: none"> <i>Search for opportunities by seeking innovative ways to change, grow, and improve</i> <i>Experiment and take risks by constantly generating small wins and learning from mistakes</i> 	<i>Characteristics and behaviors of the staff nurse acting as an organizational champion</i>	
	<ul style="list-style-type: none"> They’re not the ones that just come in to do their job and then go home Growing and improving is critical component which helps them avoid becoming burnt out Always seeking to improve their practice 	Theme: “Own Their Practice”
	<ul style="list-style-type: none"> Undertaking formal education Bring their educational experiences back to inspire their peers Engaged and speak up in staff meetings Self motivated to seek information 	Theme: “Own Their Practice” <i>Subtheme: Lifelong Learner</i>
	<ul style="list-style-type: none"> Conduct their own tests of change Willing to try new things Actively engaged in improving their practice 	Theme: “Own Their Practice” <i>Subtheme: Actively Support Innovation</i>
	<ul style="list-style-type: none"> Peer elected representative “ask the most questions” First to approach the leader 	Theme: See the Bigger Picture <i>Subtheme: Voice for the Unit</i>
	<i>Clinical Leader’s Harnessing of Organizational Champions</i>	
	<ul style="list-style-type: none"> Observe for signs of staff becoming “burnt out” to prevent it 	Theme: Be Present

Major Tenets of the Five Practices Framework and the Underpinning Ten Commitments	Relationship to Study Findings	Themes and Subthemes Represented
	<ul style="list-style-type: none"> Find that staff nurse organizational champions make their leadership role more challenging but also more rewarding and inspiring and encourages them to grow Seek to hire staff that fit within the desired culture of innovation. 	Theme: Getting it Into the Drinking Water
<p>Enable Others to Act For a leader to be successful, constituents must believe in their ability to act. A team effort is essential and those being led must feel a sense of confidence. In case reviews, Kouzes & Posner (2007) began to track leaders' use of the word "we" as opposed to "I" when describing personal-best cases and found that leaders with such cases used the word "we" nearly three times more. Leaders promote group collaboration and acknowledge the team effort</p> <ul style="list-style-type: none"> <i>Foster collaboration by promoting cooperative goals and building trust</i> <i>Strengthen others by sharing power and discretion</i> 	<i>Characteristics and behaviors of the staff nurse acting as an organizational champion</i>	
	<ul style="list-style-type: none"> Approachable and non threatening 	Theme: "Go To" Person
	<ul style="list-style-type: none"> Socialize the positive or needed aspects of change Take initiative to promote the change or educate staff 	Theme: Own Their Practice <i>Subtheme: Actively Support Innovation</i>
	<ul style="list-style-type: none"> Have the ability to "pull in" coworkers by engaging them around an innovation 	Theme: See the Bigger Picture <i>Subtheme: Leader</i>
	<i>Clinical Leader's Harnessing of Organizational Champions</i>	
	<ul style="list-style-type: none"> Having an open door policy (and keeping the door open) 	Theme: Be Present
	<ul style="list-style-type: none"> Work to engage staff nurse champions to promote the change and secure "buy in" from peers Work to secure champion buy in from critics (convert naysayers) Provide information to identified champions who have not yet committed to a change to help build trust Engage the champion as 	Theme: Secure Buy In

Major Tenets of the Five Practices Framework and the Underpinning Ten Commitments	Relationship to Study Findings	Themes and Subthemes Represented
	an opinion leader and then ask for support to facilitate changes <ul style="list-style-type: none"> • Remain transparent about goals and needs. • Permit flexible solutions when possible 	
	<ul style="list-style-type: none"> • Provide consistent and constant feedback • Empower nurses to take the lead • Support changes coming from the “bottom up” 	Theme: Get it into the Drinking Water
Encourage the Heart To inspire followers to continue the journey with their leader, which may be long and fraught with many challenges and setbacks, exemplary leaders demonstrate genuine acts of caring to uplift the group and encourage the heart. <ul style="list-style-type: none"> • <i>Recognize contributions by showing appreciation for individual excellence</i> • <i>Celebrate the values and victories by creating a spirit of community</i> 	<i>Characteristics and behaviors of the staff nurse acting as an organizational champion</i>	
	<ul style="list-style-type: none"> • Celebrate team victories • Treat their peers like family 	Theme: See the Bigger Picture <i>Subtheme: Leader</i>
	<ul style="list-style-type: none"> • Not afraid to share opinions or approach other clinical leaders in the organization 	Theme: See the Bigger Picture <i>Subtheme: Voice for the Unit</i>
	<i>Clinical Leader’s Harnessing of Organizational Champions</i>	
	<ul style="list-style-type: none"> • Reward individual and team efforts • Celebrate victories from the “top down” 	Theme: Get it into the Drinking Water

These findings add to prior work using the “Five Practices” by describing more clearly how these principles, which were originally developed for industry, can be applied to nursing practice. In addition, these results identify the importance of “presence” as a key concept for nurse leaders. By adding nursing-focused characteristics and behaviors, it describes how those in nursing practice operationalize the “Five Practices of Exemplary Leadership” and, by adding the concept of presence, ties the art of nursing to the art of leadership.

Relationship to Prior Empirical Evidence

Most prior empirical evidence about innovations and utilization of champions was established in industries other than healthcare and those that have been conducted in a healthcare setting have primarily focused on fields other than nursing (Greenhalgh et al., 2004). Some findings in this study are supported by prior empirical evidence. For example, the proposed model of “Identifying Staff Nurses Acting as Organizational Champions” (Figure 3) expands upon the work of Tregunno and colleagues (2009). This study showed that both nurse leaders and staff nurses can act as patient safety leaders and that they are “go to” individuals who are “on the ball” and can “keep the ball rolling.” The current study adds a link to transformational leadership behaviors by further defining the characteristics and behaviors of these nurses and linking them to the “Five Practices of Exemplary Leadership (Table 4). Additionally, this study offers some new insights into innovation, organizational champion, and leadership research.

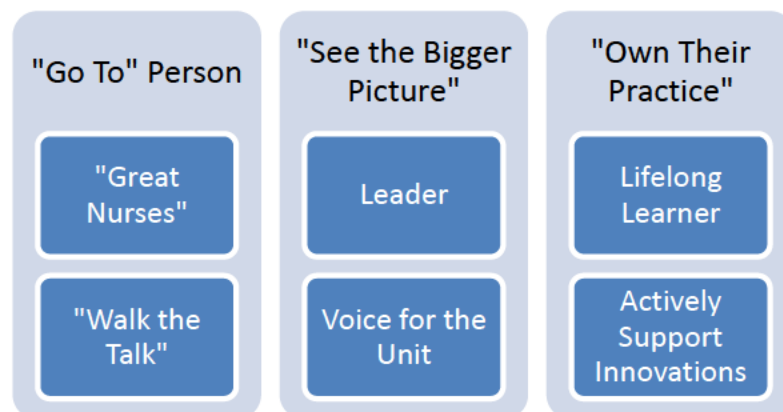


Figure 3. *Identifying Staff Nurses Acting as Organizational Champions*

Presence. In “being present”, clinical leaders engage in the work of the unit and experience the work environment and staff firsthand and demonstrate the concept of “presence” by sharing the human experience (Hessel, 2009). This study adds to prior empirical evidence by showing that engaging those that are willing to act as champions requires clinical leaders to be

present and engage with staff in order to see where their strengths and weaknesses lie. In describing the way that they harness the talents of staff nurses acting as organizational champions, clinical leaders explained that one key component was to be present in the clinical area and engage their constituents (Figure 4).

Presence is about connections. It is greater than just being on the unit; it reflects openness and values dignity and freedom to choose (Hessel, 2009). The concept of “presence” is essential the art of nursing and, despite the development of nursing as a profession, has always remained a central concept to the patient-centered care that nurses strive for and are taught to give, but presence is believed to be the interplay of inherent characteristics (Hessel, 2009) and the competencies developed by the professional nurse that permit meaningful interactions (Benner, 1984). Presence in nursing is a well-established concept and linking presence to leadership behaviors demonstrated by staff nurses and clinical leaders suggests that there are characteristics that nurses have developed as part of their nursing training and experience, that they carry with them into formal clinical leadership roles.



Figure 4. Harnessing the Energy of Nurses Acting as Organizational Champions

Prior evidence describing the role of the nurse leader in the implementation of innovation in a clinical area has supported that leadership type has a strong influence on the success of a proposed change (Becker, 1970; Cummings et al., 2010a; Greenhalgh et al., 2004; Kirchner et al., 2010; Stapleton et al., 2007). A transformational leadership style, which is linked to creating an environment supportive of change, is inspiring and motivating to constituents (Bass, 1985; Bass & Riggio, 2006). While models explaining transformational leadership, most notably the Bass Transformational Leadership Model and the Five Practices of Exemplary Leadership, encourage leadership practices to and support constituents, none discuss the concept of presence (Kouzes & Posner, 2007).

Cycle of Leadership. Kouzes & Posner (2007) suggest that the “Five Practices” can be taught. In contrast, participants in this study felt that the nurse acting as an organizational champion had something “innate” that “couldn’t be taught.” None of the models previously discussed, nor the literature reviewed addressed this phenomenon. This disconnect may be explained by new evidence in the fields of business and leadership highlighting the importance of the concept of “executive presence,” to explain the “you just know” concept of the intangible qualities an excellent leader has that you can’t put your finger on but you know upon meeting them. This concept, which represents “the confidence to express ideas with conviction and the ability and desire to engage and influence others in the process” is a “balance of personal power and persuasion with compassion and connection (Williamson, 2011, p).” Consistent with nursing presence, the focus is on meaningful connections to achieve mutually desired outcomes.

Executive presence links closely to the behaviors that were described in the present study as they harness the talents of staff nurses in their clinical area (Shirey, 2013). Additionally, they link to the behaviors and characteristics described by clinical leaders as those of the staff nurse

acting as an organizational champion (Shirey, 2013; Williamson, 2011). Executive presence can be taught and nurtured, which may lead to early detection of candidates to step into formal clinical leader roles (Carriere, Cummings, Muise, & Newburn-Cook, 2009; Shirey, 2013). Staff nurses may have something “innate” that is sparked, or turned on, by a supportive leader.

This study shows that some clinical leaders seek to and successfully engage the “naysayers” to act as champions, suggesting that there is a link between the personal characteristics of the individual nurse and the learned behaviors that are then supported by their clinical leadership. Additionally, as prior evidence shows, innovation spread is influenced by the “innovation-system fit” (pg. 590) (Greenhalgh et al., 2004). A telling finding of this study was that the champion was reported as someone who “rises above” system challenges. This signals that even in a less supportive structure there is something that keeps the champion moving forward. Supporting that can help drive even “unpopular” innovations (such as practice changes required to meet regulatory requirements) forward.

As Kouzes and Posner (2007) found, those that are “led” must also take on the willingness to “lead.” This study shows that the staff nurses that clinical leaders seek to harness are those who have a shared vision. Just as there is a recognized difference between leadership and management, there is also a difference between following and being led. Those being led take an active role in working to support a shared vision as opposed to blindly following a directive. In this way, staff nurses acting as organizational champions partner with their clinical leaders in support of a common goal; a shared vision. Consistent with prior empirical evidence, a leader must have both a vision and the ability to implement the vision in order to be a successful transformational leader (Hendy & Barlow, 2012). When formal clinical leaders work

to support the staff nurse acting as a champion, they empower the champion to be transformational and continue the cycle of leadership.

Implications for Practice

The study findings have implications for practice for both the staff nurse acting as an organizational champion and the clinical leader. For the staff nurse, it validates that even “little” efforts are beneficial to the success of an innovation. It permits the staff nurse to consider the innovation/talent match for himself/herself and encourages him/her to “step up” to offer to help in a way that is both meaningful and manageable. For example, the staff nurse who completes required training and models expected behaviors but is also able to spread a positive message about the change in day-to-day work is recognized to be a powerful organizational champion by clinical leaders.

Several ways that clinical leaders can use data from this study to harness the energy of champions are: (a) being present in their clinical area and engaging clinical staff regularly (b) supporting nurses’ professional development efforts, (c) providing consistent, transparent, feedback about both challenges and successes and recognizing their team’s effort and (d) using these data as a guide for recruiting new staff nurses who have the most potential to be organizational champions. By increasing champion behavior in a clinical area, the likelihood that a leader may be able to support their unit in successfully overcoming systemic barriers and survive organizational change increases.

Implications for Research

The first research implication is the need to develop a measure of nurse champion characteristics that will help identify these nurses. This scale could then be used to recruit new nurses and examine change in behaviors when champion-encouraging interventions are put in

place. Additionally, future research is needed to evaluate the both the staff nurses' view of champion characteristics as well as concordance between clinical leader characteristics and the organizational champion characteristics and the level of executive presence required by bedside clinical leaders is needed to support efforts to progress transformational leaders from the bedside to the boardroom as a means of succession planning.

Implications for Health Policy

Nursing must continuously evolve to meet the ever-changing demands of healthcare including the need to practice to the full extent of their education, be willing to lead on the cutting edge of healthcare practice, play an important role in the health and safety of patients and in the development and support of innovative ways to practice and be full partners with their physician colleagues in meeting improvement needs (National Research Council, 2011). Currently, efforts are underway to include quality and patient safety education in undergraduate curriculum, but there is no national standard for healthcare providers' minimum training in improvement work, which they are expected to undertake (Berwick, 2010). Steps to support this evolution include:

- Consistent with Josiah H. Macy, Jr. Foundation priorities and the suggestions of the Institute of Medicine (IOM) Future of Nursing Report, providing funding and regulatory support for lifelong learning activities in nursing as a means of improving the quality of healthcare (Josiah Macy, Jr. Foundation, 2008; IOM, 2010).
- Specifically, supporting nursing education and development programs that encourage the growth of nurses and help guide them into leadership roles by extending Title VIII Nursing Workforce Development Funding which

supports nursing education at all levels and develops a stronger workforce in underserved and rural areas (NLN, 2014).

- Establishing consistent and regulatory minimum standards for undergraduate nursing education
- Considering more steps to support process improvements in addition to measuring process and outcomes for any future regulations related to healthcare quality (NDNQI, 2012).

Nurses are practicing in a time where their practice is under scrutiny and affects reimbursement for care and yet measures are primarily outcomes-oriented and not focused on supporting improvements in nursing practice that might help with patient safety improvements (CMS, 2012, Van Den Bos et al., 2011, NDNQI, 2012). Given that recent research has shown that the cost of nurse turnover averages \$62,100-\$67,100, and 72-78% of the cost directly attributed to vacancy costs (i.e. hiring temporary RN staff, closing beds) including practices that have been shown to impact patient care and directly reach the patient, it is clear that the issue has implications to overall cost in addition to healthcare quality (Bland-Jones, 2005).

Limitations

The study limitations include that data were collected in one large academic teaching institution with a union environment. In addition, there may be a historical effect present since a job action (strike threat) and significant staff downsizing was taking place concurrently with data collection for this study. It is possible that the results of this study might differ in a magnet institution or one without a unionized workforce.

Conclusion

This qualitative descriptive study explored the characteristics of nurses acting as organizational champions as well as the way that clinical leaders systematically harness the energy of these champions in support of innovation. The specific aims of the study were guided by prior empirical evidence and identified research needs. The current study, including the interview guide, was informed by Kouzes and Posner's (2007) Five Practices of Exemplary Leadership. Overall, participants believed that there is a need for organizational champions to support innovation in their clinical area. Participants explained how nurses acting as organizational champions seem to have an "innate" characteristic that makes them a champion and the importance of being truly present on the unit in order to harness the energy of these champions. The clinical leaders find themselves actively working to support champions and promote a culture of innovation. This activity enhances the clinical leader's own experience and makes him/her feel inspired and engaged. Finally, two models were developed based on the participants' description of their experience working with staff nurses acting as organizational champions. These models provide a framework for clinical leaders to identify and engage organizational champions in their clinical areas in support of innovation.

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APPENDIX A

A Study for Clinical Leaders Working With Staff Nurses That Are Organizational Champions

Summary: Melissa Tuomi, a UMass Worcester, Graduate School of Nursing PhD student is conducting a research study to learn more about how to identify and utilize nurses that act as organizational champions and support innovation.

What is involved? If you decide to participate in the study you will be asked to meet with the researcher to discuss your experiences in identifying nurses that act as organizational champions. There will be one audio-taped interview, which will last 60-90 minutes. You will receive a \$10 gift card after you complete the interview.

Am I eligible? If you are a clinical leader on the Memorial, University, or Hahnemann campuses with direct involvement with staff nurses, in any setting, you may be eligible.

If you are interested and would like to learn more about the study please call¹ or email:

• *Melissa O'Malley Tuomi, BS, RN at 774-641-9559 or Melissa.tuomi@umassmed.edu*

Thank you

¹ Leave your name and telephone number on the voice mail – only the person you are calling can hear the message because it is protected by a password.

APPENDIX B

A Study for Clinical Leaders Working With Staff Nurses That Are Organizational Champions

- The purpose of this dissertation study is to describe the characteristics of staff nurses who are considered by clinical leaders to be organizational champions. If you choose to participate, you will be involved in a one-time interview that will take 60-90 minutes. You may be asked to review information after your interview to make sure that the interpretation of the interview data accurately reflects your intent.
- This interview will be audio-taped. All information will be de-identified (no name or identifying information- we will use a study ID number on all data and recordings) and kept anonymous for reporting. Information you provide, and all data sources, including the taped interview will be converted and kept electronically on a password-protected drive.
- There are no physical risks anticipated with this study. The benefits of this study include the opportunity to enhance the identification of staff nurses acting as organizational champions within a clinical area.
- Because the dissertation student conducting this study (Melissa Tuomi) is employed in a regulatory role at UMMC, if there is concern for patient or staff safety, Ms. Tuomi will stop the interview to address the risk and will share with the participant the UMMC procedure and resources for reporting these concerns.
- If you have any questions regarding this research, you may contact Melissa O'Malley Tuomi, BS, RN at 774-641-9559 or Melissa.tuomi@umassmed.edu or Carol Bova, PhD, RN, at 508 856-1848 or carol.bova@umassmed.edu. To contact someone independent of the research team, you may contact the Office of Human Subjects protection at 508-856-4261 or email: IRB@umassmed.edu.
- You will receive a \$10 gift card for your participation in this interview at the conclusion of the interview.

Your participation in this study is entirely voluntary. Choosing to participate or to not participate will have no impact on you or on your employment at UMMC or UMMMS. You may discontinue your participation at any time.

APPENDIX C

Participant Demographic Form

Study ID: _____

Age: _____

Gender: Male Female

Are you a registered nurse? (circle one): Yes No

For RN clinical leaders – please complete the following:

Highest Level of education obtained (circle one):

Diploma Associates Bachelors Masters Doctorate

For non-RN clinical leaders – please complete the following:

Highest level of education completed (circle one):

Associates Bachelors Masters Doctorate

In what discipline did you receive your training/education?

_____ (please indicate)

For all clinical leaders – please complete the following:

Years as a clinical leader (in a formal role): _____ insert # of years

Clinical area where you act as a leader of nurses (circle all that apply):

Acute Care Critical Care Emergency Obstetrics

Operating Room Pediatric Float Pool Department of Nursing Administration

Other: _____ (Please indicate)

Ambulatory Clinic (Please indicate type of clinic) _____

Job Title/Role:

Educator/Clinician Clinical Coordinator/Assistant Manager Manager

Shift Supervisor Director Administration/Senior Management

Other (please indicate): _____

Is your role unit-based (including multiple units) or organization-wide (oversight of nurses in multiple service lines)?

Unit-Based Organization-wide

How many staff nurses do you supervise? _____ insert # of staff nurses

Of these, how many nurses do you consider “organizational champions”?

_____ (insert number)