Role of Champions in the Implementation of Patient Safety Practice Change

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Abstract

Practitioners of patient safety practice change agree that champions are central to the success of implementation. The clinical champion role is a concept that has been widely promoted yet empirically underdeveloped in health services literature. Questions remain as to who these champions are, what roles they play in patient safety practice change and what contexts serve to facilitate their efforts. This investigation used a multiple-case study design to critically examine the role of champions in the implementation of rapid response teams (RRTs), an innovative complex patient safety intervention, in two large urban acute care facilities. An analysis of interviews with key individuals involved in the RRT implementation process revealed a typology of the patient safety practice champion that extended beyond clinical personnel to include managerial and executive staff. Champions engaged to a varying extent in a number of core activities, including education, advocacy, relationship building and boundary spanning. Individuals became champions both through informal emergence and a combination of formal appointment and informal emergence. By identifying and elaborating upon specific features of the champion role, this study aims to expand the dialogue about champions for patient safety practice change.

Despite an intensified research focus and concerted efforts to achieve high reliability in healthcare, patient safety leaders have charged that progress has been "frustratingly slow" (Leape and Berwick 2005). This is not to say that healthcare organizations have not made concerted efforts; over 4,000 organizations voluntarily joined the Institute for Healthcare Improvement (IHI) 5 Million Lives patient safety campaign, and nearly 300 joined Canada's Safer Healthcare Now! campaign. The slow pace of improvement is more likely due to the fact that achieving successful change, which is difficult in any organization, can prove especially challenging in organizations as large and complex as those that provide healthcare.

Considering the investments in resources, energy and time that patient safety initiatives often require and the importance of these changes to quality of care, it is in the best interest of healthcare organizations to maximize their chances of successful implementation by having as many facilitating factors in place as possible. The presence of *clinical champions* has been promoted as one such success factor for patient safety practice change. These clinicians, dubbed "special people" by some authors, are thought by some to be a driving force behind the implementation of a wide range of change initiatives in healthcare settings (Ash et al. 2003). For example, a study of the adoption of safer alternatives to blood transfusion in hospitals found that "the presence of local clinicians who advocated or

'championed' a particular method [was] a significant influence on local practice" and that the absence of such a person was associated with poor adoption (Graham et al. 2002: 135). A similar conclusion was drawn from an investigation of success factors for the implementation of computerized physician order entry (CPOE): "one [chief executive officer], when asked how he would do it differently next time, replied, 'I would get the clinical champions in place earlier … the agents [who] are going to sell this change among their peers'" (Ash et al. 2003: 243). In its report *To Err Is Human*, the Institute of Medicine (1999) noted that champion presence was one of the factors that helped anesthesiology become one of the safest sectors of medicine; it hence recommended clinician leadership and advocacy as a way to establish a system-wide culture of safety in healthcare overall.

Despite the suggested importance of champions in the implementation of successful patient safety change, there is still a paucity of empirical literature that focuses on these individuals. Often, the presence of clinical champions is presented as but one of a number of other findings about successful practice change and discussed at a broad level. Questions remain as to the core features of the clinical champion role, what contexts serve to facilitate or impede the work of champions and how clinicians become champions.

In order to explore these questions about the role of clinical champions in patient safety practice change, we conducted a multi-case study in two urban acute care facilities that had recently implemented the same patient safety initiative. We aimed to select an initiative that was relatively complex and difficult to implement so that the role of the clinical champion would likely be prominent and, thus, more accessible to study. Our initiative of choice was the rapid response team (RRT), an on-call team of clinicians that operates outside of the intensive care unit (ICU) but within the hospital to provide critical care expertise to staff whose patients display signs of serious deterioration (Durkin 2006). RRTs are known by many different names, including medical emergency teams and critical care response teams. RRTs are similar to cardiac arrest teams in that they immediately respond to calls for assistance across the hospital; however, whereas calls to a code blue team are made after a critical event has occurred, calls to an RRT are initiated beforehand. RRTs are meant to prevent a phenomenon known as "failure to rescue," defined as the failure to prevent a clinically significant deterioration (e.g., death) after the development of a complication in a patient's condition (Agency for Healthcare Research and Quality n.d.). RRTs are not meant to take over the care of a patient or replace bedside staff but are instead intended as a resource to assist bedside staff in assessing and treating patients whose conditions may be worsening.

Reported barriers to the implementation of RRTs include workload and turf issues, interpersonal conflicts about roles and responsibilities, problematic cultural norms, resource constraints and the tendency for clinicians to work in professional silos (Daly et al. 2007; Devita et al. 2006; Gosman et al. 2008; Thomas et al. 2007). Unlike a novel software tool or a new clinical procedure, the RRT is a human-centric innovation whose success at integrating into the system-wide fabric of an organization may depend largely on interpersonal interactions and the presence of individuals who push for the innovation within their organization. This view is supported by the findings of the First Consensus Conference on Medical Emergency Teams, which identified the "lack of champions committed to a rapid response system" as a barrier to implementation (Devita et al. 2006). Thus, the RRT was an ideal patient safety innovation for studying the role of clinical champions.

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This paper presents the major features of the patient safety practice champion role that were found to be common across both sites during the RRT implementation process.

Methods and Setting

Study Design

An exploratory study was conducted on two cases of RRT implementation in two urban acute care facilities. The individual clinical champions working on the implementation formed embedded subunits of analysis within each case. This enabled our exploration of the champion's role in implementation within broader organizational contexts.

Site Selection

With the assistance of experts in patient safety research, the two organizations were purposively selected to achieve variation among important contextual variables; specifically variance was sought in teaching status, experience and level of investment in patient safety initiatives and method of RRT adoption. Organization A was a community hospital, while organization B was an academic tertiary hospital. Both were located in Ontario. This variation allowed for the identification of the features of patient safety champions that were likely to be constant even across in different settings.

Sampling

Initial contact was made with the patient safety officer or the senior staff member responsible for the RRT. Subsequent participants were determined using a snowball sampling approach whereby one participant was asked to identify other potential participants. Informed consent was obtained.

Data Collection

Data were obtained through one-on-one semi-structured interviews of 40–80 minutes. Participants were asked to describe and discuss their role in the implementation of the RRT and the role of others whom they considered critical to the implementation process. Interviews were digitally recorded and transcribed.

Data Analysis

Interview transcripts were analyzed using an inductive coding strategy derived from grounded theory methods (Strauss and Corbin 1990). Codes were generated from the data and grouped into broader categories and themes. Analytical reliability was ensured by recoding transcripts at different times and by having multiple investigators code transcripts and discuss and reconcile any differences.

Champion Identification

Peer nomination and self-nomination were used to identify champions. Since we were interested in learning about participants' conceptualizations of champions, no definition of the term *champion* was provided. Instead, participants were asked to qualify in detail why they thought of themselves, or others, as champions.

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Results

A total of 13 health professionals from the two participating sites were interviewed. The major themes and features of patient safety practice champions that emerged across both sites are presented here.

Types of Champions

Although clinical champions were the original focus of the study, interviews served to identify additional types of champions, each corresponding to different organizational positions:

- Executive champions who held senior leadership positions within the organization
- Managerial champions who were responsible for managing clinical departments, wards or units
- Clinical champions who were front-line clinicians

All champions leveraged their respective organizational position and networks to forward the implementation process. For example, one senior executive leveraged her authority to send a group of staff members to an international patient safety conference so that they, too, might become convinced of the merits of RRTs and act as champions.

Participants identified the coexistence of champion types as critical to the overall success of the patient safety change initiative. Relationships between champion types were mutually reinforcing; typically, managerial and executive champions used their positions to facilitate the work of clinical champions, recognizing the importance of providing clinical champions with vital resources such as protected time:

> "There is no way this is a corner-of-your-desk kind of operation because it will fall down. It really will. You've got to give them time."

Things That Champions Do

The overarching goal of each champion, whether during the adoption or implementation phase, was to convince others to accept the innovation. To achieve this goal, all champions at each organization, whether clinical, managerial or executive, engaged in a number of key activities: to educate, advocate, build relationships and navigate boundaries.

Educate

Education was a major element of the champion role. Champions spent considerable time educating their peers about the innovation by giving detailed presentations about the concept of the RRT, its structure, its purpose and how to use it. Champions also participated in the development of additional educational materials such as pamphlets, stickers and posters. However, participants noted that these basic education efforts alone were not enough. To convince others of the merits of the RRT, the educational message had to be meaningful. Champions achieved this by specifically tailoring each RRT presentation to the receiving audience:

> "It was hard to convince people without the appropriate education. So that was a challenge … We had to make sure that we knew our audience. Presenting it to the floors – these are novice nurses and allied professionals – we had to make sure we turned it in such a way that was meaningful for them … We tailored every message for all the groups."

Meaningful education was also achieved by careful consideration of peer relationships. Champions capitalized on intra-professional collegiality by educating their own professional group: physician champions educated other physicians, just as managerial champions educated other managers. Champions understood the importance delivering a meaningful, customized message, and they put time and effort into peer education as a means of convincing others to accept the innovation.

Advocate

Advocacy was another way that champions worked to convince others to accept the innovation. Champions used a variety of tactics to spread positive messages about the RRT throughout the organization and to defend the innovation from critics. Some champions took an evidence-based approach to their advocacy efforts and spent time gathering research evidence from literature to incorporate into their arguments for adoption. Others advocated for the RRT by using irrefutable arguments and strategic framing. One managerial champion appealed to others' sense of "what's right" and compellingly promoted the RRT as a way to save patients' lives:

> "It was in the best interests of the patients … that's a hard argument, right? You can't say, 'No it's not.' An ICU nurse and an RT are going to go see a patient at two in the morning. Help me with why that wouldn't be a good idea. And everybody recognized there's no argument there."

Champions engaged in advocacy work both within and beyond their formal roles in the organization. For instance, the same managerial champion described how she would talk about innovation to anybody who would listen:

> "I truly believed in what I was hearing and reading and became a huge advocate and champion. And to anybody who would listen, I was blowing the RRT horn, I was blowing the Safer Healthcare Now! horn, the IHI horn … Any time I had an interaction with somebody, this is what we talked about … We shone the spotlight on it in any venue we could."

Build Relationships

Champions facilitated successful implementation of the RRT by cultivating positive relationships with end users. A clinical champion at one organization took special care to establish personal rapport with nurses on the floor. Before the RRT was officially rolled out, he took the initiative to visit other units of the hospital and introduced himself to the ward nurses. He would ask if there were any patients about whom they were particularly concerned; if so, he would assess the patient together with the bedside nurse, using the situation as an illustrative case for when to call the RRT. After the RRT was operational across the organization, he continued to visit other units between RRT calls in order to familiarize himself with floor staff. Deemed "walking about" by other participants, this process served to put a human face on the innovation:

> "I think the relationship piece is the top lesson … Having a person going out there to influence the change, to build the relationships, was probably our single biggest win. Simply because they knew who he was. They knew who the team was through him. It wasn't just some stranger who was going to show up."

Champions were skilled at building positive relationships and made special efforts to do so, helping to ensure the success of the RRT implementation.

Navigate Boundaries

A fourth champion activity was boundary spanning. Champions demonstrated agility in navigating the boundaries of the hospital, the divides – real or perceived – between professions and between hospital units and departments. Champions spanned boundaries by effectively communicating with and reaching out to members of other units and professional groups. As noted by one clinical champion, this was often a difficult task:

> "I think it's always a hard sell for a nurse to come to a group of physicians and tell them the best way to treat patients. Regardless of what you bring to them, they're just going to right away have a certain attitude toward that … There is that sort of resistance to hear it from somebody outside your group."

Navigating the boundaries of the hospital required champions to have not only excellent communication skills but also familiar knowledge of the organization and the people in it. One executive champion who was tasked with convincing the senior leadership team of the innovation was noted for being particularly skilled at delicately placating certain groups and individuals whom she knew from experience were likely to be wary or cynical of the innovation. To be able to successfully convince others to adopt the RRT, champions had to navigate the boundaries inside their organizations, an activity that requires both strong communication skills and well-developed institutional knowledge.

Becoming a Champion

Participant interviews revealed that champions came into their roles through both informal emergence and a combination of informal emergence and formal appointment.

Informal Emergence

In the informal emergence process, individuals learned about RRTs from an outside source and decided, under their own initiative and outside their formal organizational roles, to work toward adopting and implementing the RRT within their own organization. For example, one champion learned about RRTs from a conference and consequently attempted to bring the innovation back to the organization. Her efforts to do so went beyond her day-to-day role and were motivated by a personal

incentive to improve quality and patient safety within the organization.

Informal Emergence and Formal Appointment

In the combined process, individuals first demonstrated champion-like qualities and a passion for patient safety and were then appointed to a formal position on the RRT implementation team. For example, one physician openly demonstrated a keen interest in patient safety within critical care. Upon being hired into the organization, he immediately took it upon himself to advocate the importance of patient safety:

> "I started selling the idea of patient safety in critical care, and I'd have rounds and I'd meet with these people and I'd talk with this group, and really started saying, 'Look, it's time to open our eyes. There's a problem; but if we all get involved, we can fix it.'"

Because of his visibility in the organization as a patient safety advocate, he was an obvious candidate when the hospital sought someone to lead the RRT initiative and other quality patient safety initiatives, and he was subsequently appointed to the position.

There were no champions who were merely appointed without previously having demonstrated champion-like qualities. Indeed, this approach of titular champion appointment was purportedly attempted in one organization without much success:

> "We did use that champion language, although usually it was the poor individual at the bedside who'd been given a course on pain, or whatever. You can't make the assumption that just because you give somebody a workshop on skin, that this person is automatically going to feel comfortable teaching, is going to know how to make a poster, is going to know how to get a crowd together to tell them to what to do. That stuff all takes a huge amount of energy and a huge amount of time and connection with other forces that be. And that bedside nurse often doesn't have that."

Discussion and Implications

Previous research has stressed the importance of clinical leaders for successful patient safety practice change (e.g., Roberts and Perryman 2007; Stanley et al. 2008). This study builds on this research by exploring the role of a particular type of clinical leader for which research is sparse: the clinical champion. That said, we found that clinical champions did not achieve success in isolation. The coexistence of managerial and executive champions emerged as an important key success factor to RRT initiatives. These three roles were complementary, supportive of one another and together contributed to the success of the RRT implementation.

> **"I think the** relationship piece is the top lesson … Having a person going out there to influence the change, to build the relationships, was probably our single biggest win. Simply because they knew who he was."

All champions possessed a passion not just for quality and patient safety, in general, but also for the RRT innovation itself. They so ardently believed in the merits of the initiative that they took every opportunity to endorse the innovation as a way to improve patient care. Their interests and belief in the value of the RRT intensified through attendance at patient safety forums such as the annual Institute of Health conference.

RRT champions exhibited distinct traits and capabilities that enabled them to carry out the four key activities previously described. Champions (1) were skilled communicators who were able to educate and advocate effectively to their colleagues; (2) tended to be personable, well-respected and capable of building important intra-organizational relationships; and (3) possessed excellent institutional knowledge, familiarity with their organizational culture and a certain degree of political acumen, allowing them to span the boundaries of their organization and reach out to different units and professional groups. Individuals who are weaker in these traits and capabilities may find it difficult to engage in champion activities to the same degree of success as the champions in this study.

Practical Implications

Bradley et al. (2004: 1878) recommend that senior leaders who are hoping to effect organization change should identify clinical leaders with "credibility within hospital, high personal commitment to program, linkages to organization's administrative structure, and knowledge about the organizational culture." In addition to these traits, our study suggests that senior leaders should also look for individuals who are effective communicators, receptive to change and innovation, able to establish strong positive relationships throughout the organization and demonstrate genuine deep-rooted enthusiasm for the initiative at hand. Organizational leaders may be able to develop excitement for patient safety initiatives by encouraging potential champions to attend patient safety workshops, symposiums and conferences. By providing training opportunities that focus on education, communication and negotiation, organizational leaders can also help individuals obtain or reinforce the skills necessary to carry out the four core champion activities.

The importance of having all three types of champions represents an important finding that brings with it practical considerations. Senior leaders need to identify not only clinical champions but executive and managerial champions as well.

Further, all champions, irrespective of type, require protected time to focus on the initiative they are implementing.

Future Research

This exploratory study uncovered preliminary findings about patient safety practice champions. Future research directions could include studies of the intersection between the role of patient safety champion and formal leadership and of the relationships between champions and other accepted change management roles such as knowledge brokers, opinion leaders and change agents.

Conclusion

Many practitioners of patient safety practice change already realize from experience the importance of champions in achieving successful change. This study furthers understanding of this crucial role by elucidating champion types, activities and emergence. By taking a more systematic and evidence-based approach to identifying, understanding and supporting champions, healthcare professionals will have one more tool in their arsenal as they work toward improving quality and patient safety in their organizations. HQ

References

Agency for Healthcare Research and Quality. n.d. *Patient Safety Network Glossary.* Rockville, MD: Author. Retrieved December 15, 2008. <http://psnet.ahrq.gov/glossary.aspx>.

Ash, J.S, P.Z. Stavri, R. Dykstra and L. Fournier. 2003. "Implementing Computerized Physician Order Entry: The Importance of Special People." *International Journal of Medical Informatics* 69(2–3): 235–50.

Bradley, E.H., M. Schlesinger, T.R. Webster, D. Baker and S.K. Inouye. 2004. "Translating Research into Clinical Practice: Making Change Happen." *Journal of the American Geriatrics Society* 52(11): 1875–82.

Daly, M.L., J. Powers, V. Orto, M. Rogers, T. Dickenson, M. Fabris and M. Honan. 2007. "An Innovative Approach to Support Nurses on General Care Units." *Dimensions of Critical Care Nursing* 26(1): 15–20.

Devita, M.A., R. Bellomo, K. Hillman, J. Kellum, A. Rotondi, D. Teres, A. Auerbach, W.J. Chen, K. Duncan, G. Kenward, M. Bell, M. Buist, J. Chen, J. Bion, A. Kirby, G. Lighthall, J. Ovreveit, R.S. Braithwaite, J. Gosbee, E. Milbrandt, M. Peberdy, L. Savitz, L. Young, M. Harvey and S. Galhotra. 2006. "Findings of the First Consensus Conference on Medical Emergency Teams." *Critical Care Medicine* 34(9): 2463–78.

Durkin, S.E. 2006. "Implementing a Rapid Response Team." *American Journal of Nursing* 106(10): 50–53.

Gosman, G.G., M.R. Baldisseri, K.L. Stein, T.A. Nelson, S.H. Pedaline, J.H. Waters and H.N. Simhan. 2008. "Introduction of an Obstetric-Specific Medical Emergency Team for Obstetric Crises: Implementation and Experience." *American Journal of Obstetrics and Gynecology* 198: 367.e1–e7.

Graham, I.D., G. Alvarez, J. Tetroe, L. McAuley and A. Laupacis. 2002. "Factors Influencing the Adoption of Blood Alternatives to Minimize Allogeneic Transfusion: The Perspective of Eight Ontario Hospitals." *Canadian Journal of Surgery* 45(2): 132–40.

Institute of Medicine. 1999. *To Err Is Human: Building a Safer Health System.* Washington, DC: Author. Retrieved December 15, 2008. <http://www.ion.edu/Object.File/Master/4/117/ToErr-8pager.pdf>.

Leape, L.L. and D.M. Berwick. 2005. "Five Years after To Err Is Human: What Have We Learned?" *Journal of the American Medical Association* 293(19): 2384–90.

Roberts, V. and M.M Perryman. 2007. "Creating a Culture for Health Care Quality and Safety." *Health Care Manager* 26(2): 155–58.

Stanley, J.M., J. Gannon, J. Gabuat, S. Hartranft, N. Adams, C. Mayes, G.M. Shouse, B.A. Edwards and D. Burch. 2008. "The Clinical Nurse Leader: A Catalyst for Improving Quality and Patient Safety." *Journal of Nursing Management* 16(5): 614–22.

Strauss, A. and J. Corbin. 1990. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* Newbury Park, CA: Sage Publications.

Thomas, K, M. VanOyen Force, D. Rasmussen, D. Dodd and S. Whildin. 2007. "Rapid Response Team Challenges, Solutions, Benefits." *Critical Care Nurse* 27(1): 20–27.

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