8.3: Innovation, Leadership, and Clusters of Influence

Essential Learning Activity 8.2.1

Watch the following YouTube videos:

1. “What is Evidence-Based Practice?” with Ann Dabrow Woods (3:27)
2. “Evidence-Informed Practice” by the Ontario Centre of Excellence for Child and Youth Mental Health (4:14)

In the first video, Dabrow states that the Joanna Briggs Institute is a great source for health care evidence. Look at the Institute’s website. Resources like this are vital to evidence-informed nurse leaders. The speaker in the first video describes how McMaster University in Canada actually coined the term evidence-based practice.

The second video reinforces the importance of using best available evidence in service provision.

After watching both videos, answer the following questions: What should organizational leaders do to promote evidence-informed practice? What should individual nurses do to optimize use of evidence in their practice?

Regardless of whether you are a student nurse or are a leader in a formal role (e.g., unit manager, facility director, chief nursing officer), your decisions need to be informed by evidence. And yet, as emphasized in the first video, only a small proportion (20 per cent) of the decisions made in health care are based on evidence. Furthermore, Dabrow Woods states, “It takes 15 to 20 years to get evidence into practice.” What is going on?

Essential Learning Activity 8.2.2

Read Dr. Donald Berwick’s 2003 paper titled “Disseminating Innovations in Health Care.” This classic paper discusses

[Link to the paper]
why innovation, or positive change, is difficult to integrate within health care settings.

According to innovation experts such as Dr. Donald Berwick, “failure to use available science is costly and harmful; it leads to overuse of unhelpful care, underuse of effective care, and errors in execution” (2003, p. 1969). For nurses and doctors, our errors can cost injury and even loss of life. Dr. Berwick asks the following set of questions:

Why is the gap between knowledge and practice so large?

Why do clinical care systems not incorporate the findings of clinical science or copy “best known” practices reliably, quickly, and even gratefully into their daily work simply as a matter of course? (p. 1969)

For successful innovation uptake and use, there are three basic clusters of influence that need to be addressed by leaders at all levels of a health care organization: perceptions of the innovation, composition of staff, and contextual information.

Perceptions of the Innovation

The first cluster is perceptions of the innovation. Leaders need to thoughtfully consider how to introduce a new policy or protocol or a new piece of technology or medicine: first impressions count. Leaders need to consider five characteristics of an innovation by asking the following questions before introducing that innovation to their staff:

1. Will staff perceive the innovation as a benefit to them?
2. Does the innovation fit with staff’s current needs? (e.g., Will the innovation enhance care delivery?)
3. Is the innovation easy to understand? Is it simple to do? Complexity (e.g., multiple parts, steps) slows down innovation. Simplicity promotes “spread.”
4. Is it possible to do a small-scale pilot? Trialability improves the rate of innovation.
5. Is it possible for staff to observe the innovation in progress, to learn about it and answer any questions or concerns they may have? Observability and trialability often work well together.

Leaders, therefore, need to plan in advance for how they will influence staff’s first impressions of an innovation. Change is frightening to people; we typically resist proposed changes because change often involves extra effort, resources, and time. With the busyness in our lives, we need to know, from leaders, that they are making evidence-informed decisions about proposed changes. Why should we change the status quo?

Composition of Staff

The second cluster of influence that leaders need to think about is the composition of their staff. Leaders cannot impose innovation on their own; they need the right staff helping them out. Without the right complement of helpers, their attempts at innovation will fail. Take a look at Figure 2 in the Berwick paper (2003, p. 1972). For innovation to succeed, you need: innovators, early adopters, and an early majority.

Innovators are the source of proposed positive changes. They are those individuals within an organization that read scientific journals, attend conferences, and keep informed about best practices. They are well connected with sources of evidence outside the organization, and they bring ideas back to the organization.
Early adopters are well connected within the organization. They are the leaders who have influence and authority. They can make things happen, given their formal power within the organization. These leaders believe in the value of innovation, and they support their innovators. As one example, an early adopter leader provides release time and financial support for a nurse educator to attend a conference on medical-surgical practice innovations. The nurse educator brings back great ideas and presents them to the leadership and staff.

Once an early adopter leader recognizes the potential of an innovation, the leader gets to work, planning for how to present the innovation to staff (i.e., how to make the first impression). The leader proposes a pilot and asks for staff volunteers to help. Those staff who step forward to trial the innovation make up the early majority. In many instances, the early majority consists of new graduate nurses who are eager to try something new.

If the pilot has been successful, the rest of the staff—who have observed the positive outcomes from the pilot—will readily adopt the innovation. These staff comprise the late majority. And lastly, there are some staff, the laggards, who remain resistant to change. Leaders should listen to their concerns, but ultimately, if some staff members are uncomfortable with the change, it may be time for them to look for another unit or place of employment. The laggards typically represent only a small number of staff (16 per cent), and yet leaders often get sidetracked trying to convince them to change. The fact is that they may never change.

Leaders, therefore, should focus their energies on the initial 20 per cent of staff at the beginning of the innovation curve (i.e., innovators, early adopters, early majority) who need leadership support: they are the critical mass for positive change.

Contextual Information

The third cluster of influence consists of contextual factors that facilitate or impede innovation within the organization. The leadership and the organizational culture both have major influence over innovation spread. You need evidence-informed leaders (i.e., early adopters) throughout the organization who: (1) promote staff interactions, discussions, and networking across the organization (remember observability?); (2) trust and enable their staff to adapt new ideas to their needs; (3) invest essential resources, supports, and time in innovation; and (4) “walk the talk” or champion the innovations themselves. As Dr. Berwick (2003) wrote about Captain James Cook, an early explorer and innovator and early adopter: “James Cook had to eat his own sauerkraut, and health care leaders who want to spread change must change themselves first” (p. 1974).

Essential Learning Activity 8.2.3

Answer the following questions:

1. What kind of leaders would you like to work with? Why?
2. What kind of organization would you like to work in? Why?
From the Field

Let’s take a look at what happens when you do not have evidence-informed leadership.

In England, there is a single payer system, the National Health Service (NHS), which is very similar to our health care system in Canada. The NHS is made up of health regions known as trusts. Over a period of several years, evidence around safe staffing was ignored by the leadership within one NHS trust, the Mid Staffordshire Trust. To balance their budget, the trust’s leadership began replacing nurses with unlicensed care aides. After a public outcry by the loved ones of patients who were harmed or died due to negligent care, an independent inquiry was conducted by the NHS to find out what was going on in the Mid Staffordshire Trust. The inquiry revealed appalling care conditions due to nurse understaffing. The NHS was “shamed” by this inquiry and vowed to enforce policies and procedures in place throughout all trusts to restore quality, safe public health care delivery.

The Mid Staffordshire Trust leadership chose to ignore over two decades of safe staffing research evidence. For example, the numbers (patient to nurse ratios) and the types of nurses (skill mix) are directly linked to rates of patient morbidity (e.g., hospital acquired infections, preventable falls, and pressure ulcers), patient mortality, and failure to rescue. Heavy nurse workloads, characterized by high patient to nurse ratios (e.g., 10 patients per nurse) results in adverse patient events and nurses’ inability to detect changes or deterioration in patients’ status (Berry & Curry, 2012). Richer skill mix, with proportionally more RNs among direct care staff, is associated with better patient outcomes (Needleman, 2016).

The NHS was puzzled: what went wrong? Why didn’t the Mid Staffordshire leadership use the evidence to inform their staffing decisions? Dr. Berwick, who wrote a 2003 paper on innovation, is considered an internationally renowned expert on quality and safety. Dr. Berwick was asked by the NHS to review the inquiry report and to recommend quality and safety policy changes. Dr. Berwick’s recommendations are set out in a document titled “A Promise to Learn—A Commitment to Act.” What he recognized, right away, was that the Mid Staffordshire Trust had a culture of secrecy and oppression, as well as a significant lack of leadership throughout the organization. In fact, doctors and nurses were afraid to speak up. There was evidence of leaders bullying and threatening doctors and nurses who complained about unsafe work conditions.

Based on information from “Valuing Patient Safety: Responsible Workforce Design” (MacPhee, 2014).

One of Dr. Berwick’s key recommendations to the NHS (discussed in the From the Field textbox) was about leadership. Leaders are essential for creating an open, transparent culture of learning, where everyone is expected to use the evidence to ensure best practice and best possible delivery of care to patients. Leaders are essential for modelling the way for others and providing the necessary information, resources, and supports so that all nurses and other staff have the means to provide quality, safe care to patients. Leaders are essential for promoting a culture of continuous learning, openness, and transparency toward sharing and using evidence to make a difference—what is known as a learning organization.

Take a look at the following table, from Dr. Berwick’s “Promise to Learn.” Under his recommendations on leadership, he identifies the overarching responsibility of all staff and leaders.
Table 8.2.1 Who and What for Staff and Leaders (Data Source: Table based on material from Berwick, 2013, p. 16.)

<table>
<thead>
<tr>
<th>Who</th>
<th>What</th>
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<tr>
<td>All staff and leaders of NHS-funded organisations</td>
<td>Every person working in NHS-funded care has a duty to identify and help to reduce risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job, team, and adjacent teams. Leaders of health care provider organisations, managers, clinical leaders . . . have a duty to provide the environment, resources, and time to enable staff to acquire these skills.</td>
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All members of an organization, staff and leaders alike, are expected to contribute to a learning organization culture.

**Essential Learning Activity 8.2.4**

Watch the following three videos on learning organizations, then answer the questions that follow:

“**What is a Learning Organization?**” (4:56) by the Ontario Centre of Excellence for Child and Youth Mental Health

“**Introduction to Organizational Learning**” (3:13) by Peter Senge

“**Learning Organisation**” (2:01)

1. Imagine you are a nurse within a learning organization, such as the Ontario Centre of Excellence for Child and Youth Mental Health. Describe how you will contribute to the culture of continuous learning.

2. The Ontario Centre of Excellence for Child and Youth Mental Health adopted core values associated with learning organizations and continuous learning. Why do you think they chose these core values?