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Walden University

College of Management and Technology

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Schola Mutumene Kabeya

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the review committee have been made.

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Walden University
2018

Abstract

Strategies to Implement Innovations in Hospitals

by

Schola Mutumene Kabeya

MS, National Graduate School of Management, 2001

BS, Northeastern University, 1996

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

October 2018

Abstract

The Patient Protection and Affordable Care Act, which promoted quality of care, started the transformation of healthcare systems in the United States. The purpose of this qualitative multiple case study was to explore clinical practice innovation strategies used by hospital middle managers to improve quality of care and profitability. Pettigrew's theory was the conceptual framework for this study. Participants were 8 middle managers from 2 high-performing hospitals in the southwestern region of the United States. Data were collected from semistructured interviews, personal notes, and review of the hospital's publicly reported documents and literature. Member checking and methodological triangulation increased the credibility, validity, reliability, and trustworthiness of the study findings. Content and thematic data analysis provided the basis for coding the findings. Data analysis resulted in the emergence of 4 themes: organizational culture, leadership, systematic approach to management by objectives, and staff engagement. The findings showed the interactions among internal context, content, and process constructs of Pettigrew's theory as relevant to clinical practice innovation strategies for improving the quality of care and organizational profitability. The implications for positive social change include the potential for hospital middle managers to implement innovative strategies to improve patients' quality of care and save lives and the overall health and wellness of individuals in the communities they serve.

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Dedication

I dedicate my doctoral study to my Lord and Savior Jesus Christ and my departed parents Gerald Sawala Mutumene and Suzanne Bayiprago Bwala. My parents were the inspiration and the driving force for me to be the first in my family to achieve the highest level of education. My parents always reminded me why they named me “Scholastique,” which means liking school. Dad and Mom, I have not disappointed you. I hope you are looking down and feeling very proud of my achievement. I continue your legacy by teaching my children the value of faith, hard work, and education. This accomplishment is also for the glory of God, my Savior and Lord.

Acknowledgments

My determination and the achievement of this milestone in my life would not happen without my faith and the trust I have in my Lord and Savior Jesus Christ. I felt the inspiration and determination to live my purpose and achieve my goal of reaching the highest level of education for God's glory. I would like to acknowledge my husband Dr. Charles Kabeya for his understanding, sacrifice, unconditional love, and constant readiness to support me throughout the journey. I also acknowledge my children; no words can express my love and gratitude for your encouragement, support, and love. I hope my achievement is an example for you to achieve your purpose and goal in your life, and a reminder not to allow anything to stand in your way. Always remember that HIM who is in you is stronger than him who is in the world.

I would like to acknowledge the support, encouragement, and guidance of my chair Dr. Janice Garfield, whose support and encouragement were instrumental to my success. To my second committee member Dr. David L. Moody, and my University Research Reviewer, Dr. Yvonne Doll, thank you for your valuable comments and feedback. I would like to acknowledge my father Gerald Sawala Mutumene and my mother Suzanne Bayiprago Bwala for instilling in me the desire to achieve the highest level of education I can afford, and by encouraging me throughout my life with such words as "education is the path to success." A special mention and acknowledgment to my colleagues for helping me become a better mentor, coach, facilitator, and an accountable scholar.

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Section 1: Foundation of the Study

The Patient Protection and Affordable Care Act (PPACA) has transformed the healthcare industry in the United States to a consumer driven market (Logan & Bacon, 2016; Rudnicki et al., 2016). To comply with PPACA regulations, hospitals need to implement innovative strategies that improve quality of care and profitability (Larkin, Swanson, Fuller, & Cortese, 2016; Lathrop & Hodnicki, 2014). PPACA has led hospitals to implement evidence-based, innovative approaches to patient care and to standardize their processes (Franz, Skinner, & Kelleher, 2017). Most healthcare organizational leaders consider innovation a critical managerial strategy to improve quality of care at bedside and remain competitive in the marketplace (Breton, Lamothe, & Jean-Louis, 2014).

Background of the Problem

The healthcare industry in the United States has evolved into a business that requires financial and operational management and well-designed specialties to remain competitive. The United States Congress changed care delivery and renewed a sense of urgency to improve the quality of care delivered to consumers (Logan & Bacon, 2016; Rudnicki et al., 2016). Consumers continue to demand safety and quality care at an affordable cost (Rudnicki et al., 2016). Hospital administrators may promote innovation as a strategy to remain competitive in the marketplace while ensuring compliance with a myriad of government regulations.

Many hospitals leaders promote innovation as a strategy to improve the quality of care and organization profitability (Birken et al., 2016; Omachonu & Einspruch, 2010).

Middle managers have an important role in the failure rate of innovation implementation (Birken et al., 2014; Jacobs et al., 2015; & Lavoie-Tremblay et al., 2015). Middle managers influence the effectiveness of improvement activities by disseminating and synthesizing data and information and mediating between upper management and frontline employees. Jacobs et al. (2015) identified middle managers lacking appropriate innovation implementation strategies as the leading cause of high failure rates of innovation in healthcare delivery.

Problem Statement

More than 98,000 avoidable deaths occur annually in U.S. hospitals (Keenan, Yakel, Lopez, Tschannen, & Ford, 2013). In October 2012, the Centers for Medicare and Medicaid Services (CMS) began and has continued to penalize hospitals 1 to 2% of total Medicare payments for poor quality of care in relation to the requirements of the PPACA (CMS, 2015). Cranfield et al. (2015) noted that innovation implementation is an important strategy to transform healthcare, save lives, and improve profitability. The general business problem is hospital administrators continue to experience financial penalties due to poor quality of care, which negatively affect their profitability. The specific business problem is some hospital middle managers lack clinical practice innovation strategies to improve quality of care and profitability.

Purpose Statement

The purpose of this qualitative multiple case study was to explore the clinical practice innovation strategies hospital middle managers use to improve quality of care and profitability. The targeted population was middle managers from two hospitals in the

southwestern region of the United States who successfully used clinical practice innovation strategies to improve the quality of care and profitability. The results from my study could add value to management practice by providing insights into middle managers' tactical strategies for successful innovation implementation. Stacey (2013) noted that healthcare leaders save lives by making commitment to employees and services that improve quality of care. The findings from this study may contribute to positive social change by providing strategies to improve quality of patient care and save lives.

Nature of the Study

I used the qualitative method to gain a deeper understanding of strategies used by middle managers in hospitals to successfully implement innovation in clinical practice. Qualitative method used to explore a phenomenon produce findings attributed to individuals' experiences and realities (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Kaczynski, Salmona, & Smith, 2013). Upjohn, Attwood, Lerotholi, Pfeiffer, and Verheyen (2013) described the quantitative method as the examination and analysis of data by using statistical tests to verify hypotheses and determine causal and correlational relationships among variables. The quantitative method was not appropriate for my study because of the focus on the logical experimental investigation of observable phenomena and the use of statistical analysis to verify hypotheses. Similarly, mixed methods, defined by Creswell (2016) as the integration of qualitative and quantitative methods in a single study, was not an appropriate research method for my study. I did not want to use the

additional complexity of the mixed-method approach, which may extend the time allocated for the study within the scope of the degree.

According to Yin (2014), using a case study design enables exploring and explaining phenomena within the original context. The researcher can use different sources of information to elucidate business practices through organizational processes such as policies, procedures, and protocols. Because I explored a phenomenon within the hospital context and used multiple sources of information, the case study approach was an appropriate design for my study. Phenomenology, ethnography, and narrative research were not appropriate designs for my study because my focus was not on middle managers' lived experiences, cultural interactions, or stories. Grounded theory design is an inductive approach to answer research questions when exploring relationships (Redman-MacLaren & Mills, 2015). The grounded theory was not an appropriate alternative for this study. The case study design is suitable for health science research when evaluating a program, developing theories, or developing interventions (Baxter & Jack, 2008).

Research Question

The overarching research question was: What clinical practice innovation strategies do hospital middle managers use to improve quality of care and profitability?

Interview Questions

The continuing process of open-ended questioning helped me understand the specific business problem.

1. What clinical practice innovation strategies do you use to improve quality of care and profitability?
2. What process do you use to translate these strategies into actionable steps?
3. How are strategic initiatives implemented in your organization?
4. What strategic realignment of your role, if any, accelerated an innovation implementation process?
5. What strategies have you successfully used to engage your frontline staff to increase the success rate of innovations to improve outcomes?
6. How do you ensure frontline staff commitment and keep them engaged during innovation implementation?
7. What key characteristics of the organization helped or hindered your strategies during the innovation implementation process and how did you overcome the challenges?
8. What are some of the challenges you faced during the innovation implementation process?
9. What additional comments and or information you would like to share regarding strategies to improve quality of care and profitability?

Conceptual Framework

Pettigrew and Whipp's framework based on context, content, and process constructs of the strategic management of change—known as Pettigrew's theory—is the conceptual framework guiding my study. Pettigrew's theory is appropriate when exploring and considering the implementation of innovation in healthcare (Boonstra,

Versluis, & Vos, 2014; Stetler, Ritchie, Rycroft-Malone, Schultz, & Charns, 2007). Pettigrew and Whipp (1991) noted that successful change resulted from the interaction among *what* of change, *how* of change, and *why* of change. Stetler et al. (2007) stated that Pettigrew's theory was suitable for studying phenomena from a practical perspective and presents different lens to guide an investigation.

The content dimension of Pettigrew’s theory provided a potential lens for me to perform an in-depth exploration of the processes that middle managers use to improve innovation implementation failure rates and profitability. The process dimension related to operational activities that included generating plans, measures, outcomes, and stakeholder interactions in the design and implementation of processes to implement innovation. The internal contexts dimension included the organizational culture, internal politics, resources, organizational capabilities and readiness to change.

Operational Definitions

Effective implementation: The achievement of performance goals and objectives as the result of an improvement process. Performance outcomes that meet or exceed stakeholders’ expectations are evidence of successful implementation (Varkey, Horne, & Bennet, 2008).

Implementation: A set of activities designed to put into practice a strategy or systematic process with projected outcomes (Kristensen et al., 2016).

Implementation strategy: A method or technique used to enhance the adoption, implementation, and sustainability of a change initiative or practice (Curran, Bauer, Mittman, Pyne, & Stetler, 2012).

Innovation: The introduction of a new concept, technology, idea, process, product, or procedure that creates value for customers and stakeholders (National Institute of Standards and Technology, 2015). Innovation in healthcare is usually in the form of new services, processes, and technologies that will improve patients' and healthcare providers' outcomes (Omachonu & Einspruch, 2010).

Magnet designation: Given to a hospital by the American Nursing Credentialing Center (ANCC) for commitment to improving quality of care, nursing practice excellence, and innovations in professional nursing practice (Drenkard, Wolf, & Morgan, 2011).

Middle managers: Employees who report to upper management, manage subordinates, and are responsible for innovation implementation (Birken, Lee, & Weiner, 2012). In my study, middle managers are nurse managers responsible for implementing effective strategies for delivering bedside care.

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are underlying perspectives assumed to be true that researchers may consider when planning a study (Paul & Elder, 2013). I assumed that all study participants answered all interview questions honestly and they had all experienced similar phenomena related to implementing innovations in hospitals. Additionally, I assumed that the middle managers who participated in my study provided accurate and well thought-out answers to the interview questions, willingly shared their tacit knowledge openly, and engaged in the research process.

Limitations

According to Kamati, Cassim, and Karodia (2014), limitations are characteristics of the study that are out of the control of the researcher. Dean (2014) suggested that limitations could be the basis of possible weaknesses of the study design. I further assumed that compliance with a hospital's confidentiality agreement policy may limit a study participant's willingness to participate in the study and result in refusal to share implementation strategies. Such limitations notwithstanding, my use of multiple procedures for collecting data and information (e.g., interviews, observations, document analysis) helped ensure the dependability and trustworthiness of the data and interpretation. Also, the small sample size, which did not include hospitals in other regions of the United States, could have limited the reliability of the study. The last limitation was that participants' work schedules, workloads, withdrawal from the study without notice, and uncontrollable circumstances conflicted with the timeframe allocated for the interview process, which prolonged the study timeline.

Delimitations

Yin (2014) said delimitations were controllable characteristics influenced by researchers, such as sample size, locations, and number of participants. According to Yin, delimitations might include research objectives, interview questions, conceptual framework adoption, and the selection of participants. I selected only those middle managers responsible for having increased productivity through innovations that met or exceeded objectives, goals, and stakeholders' expectations. Another delimitation was the fact that I only collected data and information from nurse managers responsible for

implementing effective strategies for delivering quality care at bedside.

Significance of the Study

Contribution to Business Practice

Congress approved a regulated competitive healthcare marketplace model of care delivery to improve clinical outcomes and reduce overall healthcare cost (Rudnicki et al., 2016). Since 2009, the CMS has reported hospitals' performance to the public, which enables consumers to compare services from different hospitals before deciding where to receive care. Most hospital leaders consider innovation as a critical managerial strategy to reduce financial losses and remain competitive within a highly regulated and competitive marketplace (Kristensen, Nymann, & Konradsen, 2016). Healthcare leaders face a dilemma to improve the quality of patient care while managing the adverse effects on profitability that are the result of reductions in reimbursements from insurance companies and penalties for poor quality care (Lathrop & Hodnicki, 2014; Oberlander & Perreira, 2013). For example, Omachonu and Einspruch (2010) findings showed that effective innovation implementation significantly increased the organization revenue by 78%, while patients' satisfaction improved by 76%, productivity increased by 71%, and profit margins rose 68%. The results from my study could provide leaders and managers with effective strategies to reduce failure rates and financial losses when implementing clinical practice innovations. Effective processes can lead to cost containment, efficiency, and productivity improvement.

Implications for Social Change

One of the PPACA objectives is to improve the quality of care patients receive from hospitals across the United States (Logan & Bacon, 2016). Clinical practice innovation increases the likelihood to improve the quality of care and patient outcomes and create opportunities to reduce the mortality rate (Kash, Spaulding, Johnson, & Gamm, 2014). For example, Cutler, Rosen, and Vijan (2006) stated that improvements in medical care contributed to a 7-year life expectancy improvement for newborns in the period from 1960 to 2000. Therefore, the potential of my study to bring about social change will lead to improved quality of care and saving lives.

Review of the Professional and Academic Literature

In this qualitative multiple case study, I explored the clinical practice innovation strategies hospital middle managers use to improve quality of care and profitability. I expanded my search to explore literature across multiple industries before converging evidence from scholarly sources into a focus on middle managers within the hospital context. My integration of scholarly literature from various sectors helped me to delineate the strategies used by middle managers from different industries. Birken, Lee, Weiner, Chin, and Schaefer (2013) suggested middle managers with effective strategies have the potential to bring about social change when implementing innovation as an opportunity to save lives and improve the quality of care.

I used Pettigrew's theory as the conceptual framework to underpin my study. My systematic analysis and synthesis of the relevant peer-reviewed literature allowed me to gain the necessary knowledge regarding middle managers’ strategies for implementing

innovation in clinical practices. I found a limited number of studies on middle managers' effective strategies to implement innovation in clinical practices. Nonetheless, the literature review served as a significant reference during the data analysis phase of my study.

Literature Review Strategy

I performed a search of the literature using the following databases: EBSCOhost, ProQuest, SAGE Publications, Emerald Management, PubMed, and ScienceDirect through the Walden University Library. Additionally, I used Google Scholar and the Google search engine. I systematically identified literature related to innovation implementation by using the following keywords: *PPACA, middle managers' roles*, *barriers and enablers of innovation implementation*, *middle managers' successful change strategies*, *and healthcare innovation policies and regulations.* I also searched for *change management, potential challenges and benefits of innovation implementation, and Pettigrew's theory.*

I completed a critical review of empirical literature related to my study topic, analyzed the assumptions and conclusions presented by the researchers, and detected emerging key themes across the literature. I collected 160 peer-reviewed scholarly resources, and 96 met my established selection criterion. I used a classification matrix to organize the literature. My selection process complies with the requirement of Walden's DBA program that 85% of sources were published within 5 years of my graduation date, with no more than 15% published more than 5 years ago (See Table 1).

I performed a review of the relevant literature followed by analysis and synthesis of the information. The key themes that emerged from the literature are the effect of the regulatory environment on hospital middle managers' strategies for implementing innovation, the foundation of innovation in healthcare, and the usefulness of Pettigrew's theory as a lens for understanding hospital middle managers' strategies for implementing innovation in healthcare. Additionally, I included success strategies, potential challenges and benefits, and middle managers' roles and responsibilities in innovation implementation.

Table 1

Classification Matrix: Alignment to the Walden DBA Rubric

Sections	> 5 years	≤ 5 years	Total
Regulatory Environments for Innovation	2	20	22
Foundation for Innovation in Healthcare	1	22	23
Conceptual Frameworks	6	17	23
Innovation implementation success strategies	2	10	12
Potential Challenges and benefits of innovation implementation	1	3	4
Middle Manager's Roles and Responsibilities	0	12	12
% Totals	12.5% (12)	87.5% (84)	96

Regulatory Environment for Innovation in Healthcare Settings

Different U.S. government agencies regulate the process of innovation in the healthcare industry to ensure consumers' safety. For example, CMS promotes innovations such as Medicare payments under the value-based purchasing program, quality measures, and support for biomedical research (CMS, 2015). Integration of public policies into innovation processes occurs at the development, implementation, and maintenance phases of innovation (Chambers et al., 2013; Ciani et al., 2016). Multiple government agencies adjudicate for healthcare improvement through innovation to achieve quality care. PPACA and CMS requirements present a challenge for healthcare professionals in a highly regulated healthcare environment.

Healthcare providers are required to comply with federal and state regulations and different insurance company requirements. Hospital leaders must comply with regulatory requirements; therefore, leaders allocate resources to performing audits instead of providing patient care or investing money in innovative projects (Weske, Boselie, van Rensen, & Schneider, 2018). Consumers and policymakers continue to demand safety and an improvement in the delivery of care services at an affordable cost (Rudnicki et al., 2016). Healthcare leaders need to understand successful strategies, politics, and policies to remain competitive in the marketplace, and also to ensure compliance with the myriad of regulations (Breton et al., 2014). Healthcare providers can enhance their knowledge of regulations through training. Thus, well-informed healthcare providers can facilitate the translation of regulations into practices and comply with federal and state regulations and insurance company requirements.

Innovation in highly regulated industries is challenging, and the threat of litigation does not enhance healthcare professionals' motivation to innovate. Patient-centered innovation is at the center of many healthcare organization leaders' strategy in the United States, but the multitude of government regulations affect the rate of the innovation implementation (Hernandez, Conrad, Marcus-Smith, Reed, & Watts, 2013). According to Wisdom, Chor, Hoagwood, and Horwitz (2014), sociopolitical, internal, and external environments, government policy and regulations, and innovation characteristics associated positively with the adoption of innovations. The overregulated healthcare environment creates an atmosphere of fear, which affects providers' creativity. Overregulated environments impact leaders' ability to promote intelligent risk-taking and innovation to improve quality of care and profitability.

The Congress use cost-benefit analysis to establish societal goals and the processes to achieve the goals. In most businesses, cost-benefit analysis drives decisions without the threat of lawsuits (Renkema, Broekhuis, & Ahaus, 2014). Congress has overregulated the healthcare industry with adverse effects on practitioner behaviors. These effects have disrupted the relationship between health professionals and patients while creating a hostile environment in which patients become prospective litigants (Renkema et al., 2014). According to Buff (2014), the enactment of Medicare and Medicaid increased the demand for services, while restricting the supply of doctors and hospitals. As a result, healthcare prices rose at twice the rate of inflation. Policy decisionmakers could use cost-effectiveness analysis to compare alternative methods of achieving public health goals.

Healthcare costs may be reduced without an adverse effect on patients' quality of care if the policymakers simplify and reduce the number of regulations. Weinstein and Skinner (2010) noted Congress repeated the same mistake with the introduction of PPACA by adding more regulations without removing unusable regulations. Overregulation can compromise patient care and hinder innovation (Sao, Gupta, & Gantz, 2013). Also, most of the new regulations are technology driven and therefore, few regulations focus on consumers' concerns (Weinstein & Skinner, 2010). Policies to reduce the number of regulations and maintain the quality of care for consumers is essential to foster innovation. Coordination of the relevant regulatory entities to facilitate the adoption of innovations can reduce healthcare costs and improve quality of care.

Impact of polyintervention environment on innovation implementation. Healthcare regulations are standards for improving clinical practice, organizational performance, and patient safety culture. The National Institute of Healthcare (NIH), Food and Drug Administration (FDA), and CMS provide funding to organizations in the form of a grant to promote innovation. The approval system for new medical devices provides pathways to market that ensure consumers' protections (Kramer, Xu, & Kesselheim, 2012). The FDA is the pre-market and post-market regulatory authority over the medical devices industry since 1976 and monitors the introduction of innovation (Kramer et al., 2012). Kash et al. (2014) noted most healthcare leaders agreed that overregulation impedes innovation in two main areas: public policy and the lengthy FDA approval process. Health professionals follow ethics first to do no harm and second to heal the patient and found overregulated environment complex and a barrier to the promotion of

innovation implementation (Bernstein, 2013). Therefore, creating a complex overregulated environment with conflicting regulations and goals frustrates care providers who want to spend time with their patients rather than complying with the multitude of regulations.

Impact of PPCA. President Obama signed the PPACA into law on March 23, 2010; the U.S. Supreme Court upheld the law on June 28, 2012. The PPACA created an integrated competitive and highly regulated healthcare marketplace (Logan & Bacon, 2016; Rudnicki et al., 2016). Beginning in October 2012, the CMS began penalizing hospitals 1 to 5% of the total Medicare payments for quality of care that did not meet regulatory standards (CMS, 2015). The PPACA changed care delivery services and renewed healthcare practitioners' sense of urgency for changes to improve quality of care (Rudnicki et al., 2016). For example, health information is easily accessible through patient portals and smartphones, allowing the provider to provide care through telemedicine. Congress had a goal to improve the quality of patient care and control Medicare reimbursements (CMS, 2015). Some of the improvement areas required by PPACA policymakers included inpatient and outpatient services, coverage of prescription drugs, and mental health services. For example, Telehealth, Mobile Health Unit, and Minuteman Clinics introduced into care delivery have improved accessibility and portability of care.

PPACA has a significant impact on the business model used by healthcare organizations leaders. The transformational change in care delivery has created new business models that focus on partnership and shared risk within the continuum of care.

The competition created in the healthcare industry by policymakers has enabled the promotion of innovation, new business models, and a new payment structure (Logan & Bacon, 2016). The healthcare business model may have shifted from the hospital's administrators' and doctors' needs and expectations to consumers' and stakeholders' needs and expectations (Larkin et al., 2016). Cranfield et al. (2015) noted that innovation implementation is an important strategy to transform healthcare, save lives, and improve profitability. The consumer-driven business model continues to benefit the patient and allows access to health information in real time. Healthcare leaders in the United States shifted their business model to a consumer driven model and pay a penalty to the government for poor quality of care.

I explored the impact of healthcare delivery restructuring related to the introduction of the PPACA on hospitals' profitability. Pratt and Belloit (2014) reviewed 212 California hospitals' quality data, patient outcomes, operating costs, and financial statements and showed a reduction in reimbursement had negatively affected the quality of patient care. Additionally, the authors reported 89.2% of the hospitals experienced negative cash flow. For example, for every $1 reduction in Medicare payment, the hospital loses $1.55 (White & Wu, 2013). The leaders of underperforming hospitals lay off 1.69 full-time equivalent (FTE) employees for every $100,000 reduction in Medicare reimbursement (White & Wu, 2013). According to Abuhejleh, Dulaimi, and Ellahham (2016), organizations need effective and efficient innovation implementation processes to achieve competitive advantage in their respective marketplaces. White and Wu (2013) said that hospitals have not profited from Medicare reimbursable reduction because of

leaders shifting operating costs through the adjustment of operating expenses, but rather through successfully implementing innovation into their clinical practices. The PPACA has negatively affected the profitability curve of most hospitals, which has significantly reduced total revenue. Hospitals' survival depends on adopting an innovative approach to adjust to new cost structures, technology, regulations, and processes.

Impact of Innovations on Healthcare

I explored the impact of innovation on healthcare to understand the different aspects of the implementation process, which depend on the scope of the innovation. Some organizational leaders consider innovation a critical managerial strategy needed to achieve competitive advantage (Breton et al., 2014). According to Berwick, Bauchner, and Fontanarosa (2015), innovation is a measure to assess the capability of economies and individual businesses. Glor (2014) suggested four type of research to determine the impact of innovations (a) case studies, (b) research innovation impact on people, (c) investigate the relationship between the change and organizational factors, and (d) studies the effect of innovation to the population survival and mortality. Innovation in healthcare includes new drug development, sophisticated diagnostic testing, information technology, evidence-based clinical practices, and therapeutic medical devices.

I also explored the different types of innovation that healthcare organizations use to gain a competitive advantage in the marketplace. Some hospitals leaders perceive innovation as a critical managerial strategy to gain competitive advantage (Kristensen et al., 2016). The development of new therapies, pharmaceutical drugs, and medical devices helped to improve patient outcomes and increase accessibility and the quality of care

(Berwick et al., 2015). Lee (2015) findings showed positive outcomes of operational innovation on quality management and safety practices and organizational performance. Innovative organizational leaders promote research and development, innovation training, strategic partnerships, and internal competency development (Ratnapalan & Uleryk, 2014). The CMS supports innovations such as Medicare payments under the value-based purchasing program and quality measures, and also promotes biomedical research (CMS, 2015). McManus (2013) stated that new technology innovations could improve care by streamlining processes and maximizing profit. Healthcare industry leaders benefit from three types of innovation: innovations that can change the way consumers use and buy health care services, technology and new products and treatments that improve care, and new business models that involve mergers and acquisitions to deliver options and choices to consumers.

Types of Healthcare Innovations

Clinical practice innovations: care delivery processes. I explored evidence-based clinical practice innovations that enhance the quality of care. Innovations in care delivery can result in improving accessibility, operational costs, and consumer empowerment (Berwick et al., 2015). The Institute of Medicine (IOM) and the Institute for Healthcare Improvement (IHI) provide evidence-based processes of innovation transferable into clinical practice and address areas of improvement for implementation of innovation to establish efficient clinical processes. A wellness program that involves customers managing their lifestyle to receive a reduction in their health insurance costs promotes healthy behaviors and give consumers greater control over their healthcare

spending. Innovations in clinical practices are at the core of health systems and hospital operations. A proliferation of innovations in the healthcare industry enhances the quality of life, efficiency, and costs.

Innovative technology: medical device and software applications. The effects of innovative technology and the implications for treatment have transformed care delivery. Innovators have introduced new applications, drug delivery systems, medical devices, and advanced diagnostic imaging. Some innovations are disruptive, while others are nondisruptive (Cranfield et al., 2015). The introductions of technological innovation in healthcare have transformed the structure and the practice of medicine and have the potential to expand unbiased care delivery globally (Chao & Mody, 2015). Any patient can now monitor his/her disease more effectively with implanted sensors. Also, information technologies innovations have connected healthcare information, and have improved the quality of information that providers need to make informed decisions to reduce sentinel events and errors. Commercial markets cover a wide-range selection of products—from hospitals to physicians' offices, laboratories, and durable medical equipment (DME). Kash et al. (2014) argued that innovation in medical devices technology saves lives and improves organizations profitability, but it is also a critical factor in increasing medical costs. Technological innovation is an opportunity to balance cost containment and quality of care. The interaction between services and technology result in high quality of care for the patients.

Business model: healthcare industry. Innovative business models have emerged from the introduction of PPACA and the need for healthcare organizations to remain

competitive. I explored the content of the models, which ensure standardization, separation, and patient-centeredness. Innovations in healthcare business models have created a marketplace environment, which promotes competition among providers and create value for the consumers (Pourabdollahian & Copani, 2014). Castano (2014) noted the significance of business model innovation as an important step to secure healthcare systems survival. Thus, business models that integrate healthcare services can improve efficiency and enhance the quality of care. For example, horizontal integration can create economies of scale, while vertical integration can create a one-stop shop with efficient and convenient treatment within the continuum of care. Appropriate business model is essential for sustainability and patient-centeredness.

I explored dimensions of innovation in healthcare organizations that can improve quality of care and cost containment. Healthcare leaders' adaptations of an innovative concept benefit both the consumers and healthcare organizations and reduce the probability of errors (Radley et al., 2013). A focused factory business model is the segmentation of services according to homogeneous groups of customers that can increase the efficiency, utilization, and productivity of healthcare organizations (Cook et al., 2014). Lathrop and Hodnicki (2014), and Larkin et al. (2016) suggested organizational leaders implement innovative strategies to improve performance and enhance delivery of care to remain competitive. Davis, Dent, and Wharff (2015) argued transformation and sustainability of innovation happen when the organization adopts a systems-thinking leadership business model.

The Effects of Disruptive and Nondisruptive Innovation in Healthcare

I explored the effects of disruptive innovation in the healthcare setting. Disruptive innovations are radical, revolutionary, and transformational (Garrety, McLoughlin, & Zelle, 2014). Disruptive innovations disturb existing systems and create competition in the marketplace and deliver value to stakeholders and customers (Oberlander & Perreira, 2013). The da Vinci surgical system, video scopes, computerized physician order entry (CPOE), and electronic health records (EHR) are examples of disruptive innovations that have transformed care delivery (Mozaffar, Cresswell, Lee, Williams, & Sheikh, 2016). Innovation can increase the likelihood to improve patient outcomes, productivity, and the value of services rendered and creates opportunities for social change (Kash et al., 2014). Effective implementation depends on a leader’s ability to explain operational definitions of terms, build commitment to change, and ensure standardization of work practices (McAlearney, Robbins, Garman, Song, & McVey, 2013). Most of the healthcare disruptive technology has brought accessibility, affordability, and convenience to consumers.

In this paragraph, I discussed the effects of nondisruptive innovation in the healthcare setting. Nondisruptive innovations are the incremental improvement of existing products, processes, or services that introduce opportunities to solve an existing problem (Stary, 2014). Minuteman Clinic is an example of a nondisruptive innovation offering limited diagnostic services. Lean Six Sigma methodology is another example of nondisruptive innovation adopted from manufacturing into clinical practices continuous quality improvement (CQI) framework. Toussaint and Berry (2013) noted process

innovation such as Lean Six Sigma—a combination of Lean (waste reduction) and Six Sigma (variation reduction)— delivered breakthrough results in hospital environments. According to Al-Balushi et al. (2014) and O'Neill et al. (2011), Lean Six Sigma practitioners focus on eliminating non-value-added activities while reducing variation in care delivery and promotes a culture of innovation within the organization. The innovation impacted social change by increasing accessibility, efficiency, and by providing a cost-effective approach to preventative care services without the delay and high cost of obtaining such services from primary care providers.

Conceptual Frameworks

I drew the categorization of the findings from the selected articles on Pettigrew's theoretical constructs of content, process, and context for me to understand middle managers' strategies for effective innovation implementation. Boonstra et al. (2014) noted Pettigrew's framework as applicable for case study research design regardless of the organizational context. Also, Pettigrew's theory is a framework to understand the interaction between the three constructs of management of strategic change. I selected the theory because of its comprehensive approach to the analysis of case study, the inclusion of various conclusions, and the management of organizational change focus. The external context of Pettigrew's theory served to identify the economic, government policies, and social variables that can influence the implementation of innovation. Nonetheless, the external context will be excluded from this study because the variables are outside of the scope of the study, and also because middle managers have no control of the variables. The internal context such as the organizational culture, structure, and management of

processes are within middle managers' control. The process construct of Pettigrew's theory will allow me to explore the effects of the strategies on the success of the implementation.

Pettigrew's theory and applications. I selected Pettigrew's theory (1991) as my conceptual framework, and as an appropriate lens to explore my central research question. Drawing on the work of Pettigrew and Whipp (1991), my analysis of empirical literature focused on organizational transformation under Pettigrew's theory lens of content, context, and the process of change and their interaction to better understand middle managers' strategies when implementing innovative change. Based on Pettigrew's theory of management of change, I will focus on the *content* (what of change), internal *context* (why and when of change), and *process* (how of change), and not the external context of change. Internal organizational context factors contribute significantly to the development of the strategies, and external factors do not affect strategy development (Ovretveit et al., 2012).

The developmental evolution of the innovation implementation strategy explains the change process through a systematic approach to the adaptation of the innovation. Pettigrew and Whipp (1991) described the change in term of processes, cultural, political and historical aspects of the organization, and depict human and social aspects that complement the theory of management of change in organizations or society. Additionally, Pettigrew and Whip suggested change implementation depends on the environmental pressure through the assessment of both the internal and external environment, leading change, and understanding the importance of linking strategy to

operational factors.

I described the conceptual framework guiding the study from an organizational transformation perspective. Pettigrew and Whipp (1991) presented context, process, and content of change as three essential dimensions of management of change, and showed a continuous interaction between the three dimensions of change as seen in Figure1 Pettigrew's Theory. Sminia and de Rond (2012) agreed with Pettigrew and Whipp (1991) about strategy as a shared process that some individual uses to direct activities toward outcomes. According to Ovretveit et al. (2012), strategies and process of change implementation were different depending on the innovation context.

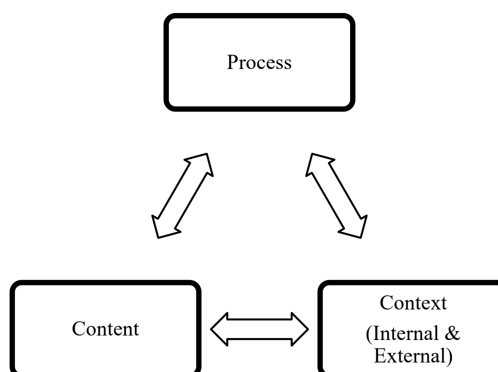

Figure 1. Pettigrew's conceptual framework. Adapted from "*Managing Change for Competitive Success*" by A. M. Pettigrew and R. Whipp, Oxford, England: Blackwell Publishers.

Pettigrew's theory offers insights into the innovation implementation process and shows the interactive dimensions of strategic change purposes, objectives, and goals. The theorist emphasized the constant interactions between the three change dimensions to achieve successful change. According to Moullin, Sabater-Hernandez, Fernandez-Limos, & Benrimoj (2015), innovation implementation frameworks vary based on the context of the innovation, and the inclusion of appropriate components while considering the end-

users. This observation is in alignment with Pettigrew's theory by emphasizing the interaction of the components of change.

I explored the application of Pettigrew's theory by several researchers. Husser (2014) used Pettigrew's content dimension and the convention theory to explain hospital middle managers' strategies while interacting with frontline staff during implementation. Husser observed a stressful nonreceptive environment when senior leaders did not involve middle managers in innovation selection or the decision-making process. Permana, Halim, and Ismail (2013) focused on the internal context of change when implementing innovation in banking to show the importance of middle managers' strategic commitments and effectiveness of their strategy to mediate the relationship between different roles and efficient implementation. Gilbert et al. (2015) combined the integration of context and process dimensions of organizational innovation implementation to elucidate the influence of different group on the dynamics of change and noted the complexity of the process of change, and the different context and content of change. Moullin et al. (2015) and Gilbert et al. (2015) agreed with Pettigrew and Whipp (1991) that the innovation implementation framework varies based on the content, process, and context of change. Gilbert et al. (2015) demonstrated the complexity of change implementation, and the interaction of content, process, and context of change difference. Moullin et al. (2015) and Gilbert et al. (2015) attested to the appropriateness of Pettigrew's theory to assess and better understand implementation strategies. The conceptual framework reveals a continuous interaction between context, content, and process of change. The results of these studies indicate the significance of using the three

dimensions of Pettigrew’s theory to explore innovation implementation. Pettigrew’s theory provides an in-depth understanding of the interaction and variation that exist between the three constructs, which can affect the effectiveness of innovation implementation.

Senior leaders and managers’ role are crucial to the success of innovation implementation. Ovretveit et al.’s (2012) longitudinal cross-case study on innovation implementation in Swedish hospitals showed senior leaders having a significant role in the success of the innovation implementation than managers. Ovretveit et al.'s results are in opposition to Birken et al. (2012) findings, which showed that middle managers had a significant role in the effectiveness and success of innovation implementation. A shared responsibilities relationship could exist between the senior leaders and middle managers regarding innovation implementation.

I depicted the impact of innovation on performance and middle managers strategies. According to Friis, Holmgren, and Eskildsen (2016), the strategy has a significant effect on performance, and middle managers ability to execute and achieve the most significant impact, depend on the organizational capacity to be (a) flexible, (b) innovative, and (c) productive. When developing strategy, and considering content and process within the strategic context, the creation of a balance between productivity, flexibility, and ability to better manage change is necessary. According to Boonstra et al. (2014), Pettigrew’s theory has been widely applied in research when exploring and considering the implementation of innovation in healthcare. A parallel relationship exists between Pettigrew's theory and the diffusion theory of innovation.

Diffusion of innovation theory. Diffusion of innovation theory developed by Gabriel Tarde, a French sociologist in 1903, showed an S-shaped innovation diffusion curve. In 1983, Rogers popularized the adoption of the diffusion of innovation theory and presented a possible explanation for the rapid adoption or lack of adoption of selected clinical practices regardless of significant evidence of their potential benefits (Rogers, 2003). The tenets of the diffusion theory are the degree in which innovation shows (a) better value, (b) complexity, or the degree of usability, (c) observability, or degree of visibility to encourage discussions, (d) compatibility, or degree of alignment to the existing problem, and (e) the ability to run a trial, or test of change (Rogers, 2003). An innovation discussion should focus on the diffusion of innovation theory to depict the elements that produce a successful innovation implementation from middle managers' receptivity and the ability of end users to adapt (McManus, 2013). According to Rogers (2003), it is important to understand the diffusion of innovation, which can help explore and explain the rate of adoption of certain innovation over another. Diffusion of innovation theory is a change model to use when developing strategies to implement innovation effectively across all levels of the organization (Rogers, 2003). Rogers argued innovation diffusion as a communication process to spread innovation across the organization. The diffusion theory explains the *how*, *why*, and *what* rate at which innovation dissemination occurs at all levels of an organization. While Pettigrew's theory is the lens to assess the content, process, and context of change, the diffusion-of-innovation theory evaluates the effectiveness of the strategies for effective implementation. My objective is to understand the internal context, content, and process

of innovation implementation based on middle managers applying successful strategies to achieve effective implementation.

Organizational readiness for change theory. I explored the organizational readiness for change theory about innovation implementation within the hospital setting. Healthcare is a complex environment with many different functions and leadership structures that require collective behaviors change, systems redesign, and new business models to improve patient outcomes (Martinez-Garcia & Hernandez-Lemus, 2013). Organizational readiness for change is a multi-level theory developed by Weiner (2009) as a conceptualize framework, which focuses on organizational members shared a commitment to implement change effectively. Weiner's theory has three main factors (a) task demands, (b) resource availability, and (c) situational factors that affect change. Weiner (2009) suggested that organizational readiness for change increase the probability for members to initiate change, commit to change, show perseverance, and exhibit cooperative behaviors, which increase the effectiveness of the implementation. Organizational readiness is a significant precursor of an efficient and effective implementation (Sharma, Upadhyaya, Schober, & Byrd-Williams, 2014; Weiner, Lewis, & Linnan, 2009). Weiner (2009) suggested that organizational changes in a healthcare environment require a shared and harmonized behavior change at every level of the organization. Klein and Sorra (1996) described organizational readiness as the pre-implementation phase. According to Madsen, Miller, and John (2005), consistent leadership behaviors, open communication, transparency of information, and shared knowledge about past change initiatives promote shared aims in organizational members'

readiness to change. Change valence, change efficacy, and contextual factors are determinants of organizational readiness for change in support of an effective implementation (Shea, Jacobs, Esserman, Bruce, & Weiner, 2014). Madsen et al. and Shea et al. provided arguments depicting the importance of an appropriate leadership style to influence followers to accept and support change initiative, Weiner noted that a sympathetic context should not be confused with readiness in the context of change or innovation. The theorist suggested that organizational changes in a healthcare environment such as hospitals require a shared and harmonized behavior change at every level of the organization. Weiner (2009) agreed with Rogers (2003), and Pettigrew and Whipp (1991) about the content of change and the interactive relationship with context and process of change. Therefore, an individual's commitment to change can determine the level of shared beliefs and capabilities the individual can contribute to the implementation of change.

Innovative Implementation Success Strategies

I explored the factors that contribute to innovation implementation success strategies. Organizations promoting innovation implementation have a culture of creativity and a flat organizational structure with leaders devoted to change (Büschgens, Bausch, & Balkin, 2013). Rogers (2003) suggested an organizational focus on cost-benefit strategy is needed to encourage middle manager participation and promotion of innovation. The execution of strategy implementation requires planning, communication, and allocation of resources to bring about change effectively (Friis et al., 2016). Some aspects of diffusion theory are useful during the strategies decision-making process to

help develop appropriate strategies for effective implementation of innovation (Rogers, 2003). According to Urquhart, Porter, Sargeant, Jackson, and Grundfeld (2014), stakeholder involvement, management of the change process, having appropriate administrative and managerial support, and innovation context are factors that may influence the implementation process. Safdari, Ghazisaeidi, and Jebraeily (2015) suggested (a) creation of a roadmap, (b) establishment of teamwork, (c) leaders' readiness, and (d) providing appropriate training to end-user, which will support, maintain, and promote the change as success factors. The systemic adoption of evidence-based best practice depends on the success of the implementation process, yet a limited knowledge level exists about the successful strategies used by middle managers in healthcare in support of innovation implementation (McAlearney et al., 2013). The variability highlighted by the complexity of the innovation content, process, and context in many organizations clarifies the factors contributing to the effectiveness of the implementation process. Nonetheless, the active pattern of influence may depend on the individual manager's competency and management of the organization's need for control and flexibility.

I explored the effects of organizational culture and the drivers of successful innovation implementation. Hartnell, Ou, and Kinicki (2011) suggested organizational culture as the glue that held the team together and a precondition for teamwork and a successful innovation implementation process. Korner, Wirtz, Bengel, and Goritz (2015) agreed with Urquhart et al. (2014) and Safdari et al. (2015) that interdisciplinary collaboration in healthcare organizations had promoted teamwork and team effectiveness,

which have a direct effect on the overall organizational performance. Korner et al. (2015) noted poorly performing teams affected performance negatively due to a lack of commitment to the innovation implementation process. Alamsjah (2011) reiterated the importance of a performance-based rewards system as a tool to engage the staff. Kash et al. (2014) generated 10 success factors, and the top three were culture and values, business processes, and people and engagement, which were common regardless of industries. Kash et al. added three additional factors that were specific to healthcare (service quality, customer satisfaction, and access to information) which were strategic for change initiatives. Abuhejleh et al. (2016), Alamsjah (2011), Al-Kandi, Asutay, and Dixon (2013), Knapp (2015), and Ruiz and Ortiz (2016) noted leadership commitment, organizational culture, management models, integration of the care, and administration of functions as success factors. Management role, organization learning, continuous improvement, communication, teamwork, and feedback contributed to a culture of patient safety (Alahmadi, 2010). Regardless of industries, the informal networks contributed to the success of the implementation process (Lunts, 2012). Organizational culture and clear directives from top managers contributed to the middle managers' flawless execution of the implementation process (Gellert et al., 2015). Al-Kandi et al. (2013) explored the interactions among and between the factors that influence the outcomes of the implementation of the strategic decision process in Saudi Arabian banks. The results showed the process, and personal factors significantly influenced the effectiveness of the application process. The authors also illustrated social capital relationship, change agent approach, a bi-directional vertical flow of information, and management models as

contributors to a successful innovation implementation. Additionally, reward and recognition had a significant impact on the employees' commitment and performance.

Middle managers’ involvement in the planning process was a critical factor for a successful innovation implementation. Middle managers’ behaviors and strategies were essential factors in achieving effective innovation implementation (Kissi, Dainty, & Liu, 2012). The challenge of sustaining successful innovation implementation throughout the organization remains poorly understood (Birken et al., 2016; Pannick, Sevdalis, & Athanasiou, 2015). Klas, Johan, and Håkan (2015) reported significant areas of inconsistencies in the implementation of innovations at all levels of the organization and described quality and innovation interconnectivity as complementary strategies to increase customer value. According to Anderson, Potocnik, and Zhou (2014), research and development, innovation training, strategic partnerships, and internal competency development are essential factors for a successful innovation implementation and the development of an innovative culture. Gellert et al. (2015) noted accountability and ownership as important success factors during the implementation process. Transparency and an explanation of the *why* of change combined with a reward and recognition program increased the probability of achieving success in implementing organizational change. Managers in the human resource department are the critical partner in assisting leaders to create change by providing effective communication and access to information. These strategies showed the importance of aligning culture and values, commitment, communication, and developing a social-capital relationship to create an efficient innovation implementation process.

Potential Challenges and Benefits of Innovation Implementation

The challenges can originate from the technology itself, the regulatory environment, the end-users, and the healthcare environment. Some doctors' slow adoption of electronic medical records (EMR), and some healthcare organizational leaders' failure to implement EMR, can affect the rate of innovation implementation (Boonstra et al., 2014). In spite of the innovation implementations success in the healthcare industry, many challenges are noticeable and impending (Candido & Santos, 2015). The challenges or benefits of innovation implementation originate from the interface between the human, technical, and managerial strategies use to adopt the innovation into the existing healthcare systems.

Potential challenges of innovation implementation. Healthcare organizations may develop a risk mitigation plan to manage potential challenges during innovation implementation. The healthcare industry has an increase of innovations designed to improve life expectancy, the efficiency of clinical practices, and increase value to the customers (Omachonu & Einspruch, 2010). According to McAlearney, Walker, Livaudais-Toman, Parides and Bickell (2016), lack of support from upper management, competing priorities, lack of funding, ambiguous value, lack of innovation champion, lack of awareness about the innovation, and unclear or complex policies and procedures are internal environment challenges. Also, external environmental factors such as (a) market pressure, (b) regulations, and (c) the community as a whole could also affect the implementation of innovation (McAlearney et al., 2016). According to Lunts (2012), culture, time, capacity, senior leadership turnover, and ambiguity of middle managers'

role and responsibilities are potential innovation implementation challenges. Lunts' study results were consistent with Birken et al. (2012), who attributed the gap between corroboration of adequate care to poor healthcare innovation implementation. However, Pannick et al. (2015) cited clinical staff disengagement, and lack of alignment of departmental vision, mission, and goals led to the ineffective implementation of innovations. During the implementation process, unexpected internal and external challenges can lead to unanticipated changes, which can threaten the innovation implementation. Organizations can avoid potential problems during innovation implementation by developing a risk mitigation plan upfront, monitoring the implementation process and managing the changes to enhance the success of the innovation implementation.

Benefits of innovation implementation. I explored critical factors that can significantly affect the benefits of innovation implementation. According to Omachonu and Einspruch (2010), environmental and operational factors motivate leaders to introduce innovation in healthcare organizations. According to Abuhejleh et al. (2016), successful implementation of Lean methodology improved safety, patient satisfaction, and supported the empowerment of frontline caregivers' culture. Stacey (2013) noted innovation implementation in healthcare improves the quality of care and saves lives. According to Fleming et al. (2014), expenses increased, and productivity decreased following an innovation implementation in the short-term due to the staff learning curve, but in the long-term, the return on investment is substantial. Implementation success depends on the type and value of the innovation from the consumers and stakeholders'

perspective (Brewster et al., 2015). Innovative solutions are beneficial during implementation to solve technical problems. Moreover, technical capabilities, training, management pre, and post-innovation implementation are significant factors in realizing innovation benefits.

Middle Managers' Roles and Responsibilities in Innovation Implementation

I explored the implications of middle managers' roles and responsibilities in successful innovation implementation. Middle managers have an essential role to create a supportive environment for the frontline staff and champion the change initiative (Kissi et al., 2012). Middle managers considered diffusion and synthesizing of the information and advertising of innovation as the most important role for a successful implementation process (Birken et al., 2016; Birken et al., 2013; Hawk, Ricci, Huber, & Myers, 2015; Larsen, 2015). Birken's theory of middle managers' role in healthcare innovation implementation consists of four essential roles (a) improving awareness through diffusion of information, (b) interpreting and communicating upper management directive, (c) arbitrating between application of strategy and daily operations, and (d) motivating staff to support innovation implementation. Birken et al. (2014) and Engle et al. (2016) noted a similar role for middle managers as influencers, information diffusers, translators, and mediators between strategy and daily tasks, and advertisers of innovation implementation. Middle managers have significant roles as mediators between the administration and frontline employees and are important contributors to the success of the innovation implementation process (Urquhart et al., 2014; Birken et al., 2014). According to Birken et al. (2012), and Kash et al. (2014), non-healthcare industries

middle managers have influenced innovation implementation with positive effects on overall organizational performance. Middle managers' responsibilities evolved as healthcare experienced a paradigm shift in care delivery at the bedside (Birken et al., 2012). As middle managers' responsibilities increased, their influence on innovation implementation also increased (Birken et al., 2016). Birken et al. (2016); Engle et al. (2016); Pannick et al. (2015) noted some middle managers in hospitals had limited success in innovation implementation because of their dual role of managing staff and providing bedside patient care simultaneously. The organizational leader should establish a balanced approach to management and leadership to deliver specific outcomes (Kwamie, 2015). Healthcare organizational leaders will increase innovation implementation effectiveness by understanding the content of middle managers' roles, responsibilities, and strategies.

I explored the importance of middle management strategic commitment to innovation implementation. Pannick et al. (2015) argued that regardless of middle managers' influence, a limited number of researchers have focused on middle managers' roles and commitment to healthcare improvement. Middle managers pursue their interests in the process of organizational politics when curtailed by contextual situations (Sminia and de Rond, 2012). According to Permana et al. (2013), the strategic commitment of middle managers could mediate the relationship between their different roles and efficient implementation of the strategy to achieve a successful outcome. Larsen (2015) emphasized middle managers' commitment to change, control, and autonomy as important factors to achieve a successful outcome. Birken et al. (2012) noted that a gap

exists between theory and the care-delivery practice. Burgess (2013) argued a centralized structure to ensure standardization of systems and processes result in a top-down approach to leadership decision making that can make middle managers ineffective. Also, senior executives who were unable to encourage the antecedents that facilitated middle managers' creativity and innovation to develop successful strategies were ineffective leaders (Permana et al., 2013). The inclusion of all staff members to support the change, and peers' recognition of the change process, created an organizational culture supportive of innovation implementation (Larsen, 2015). Successful integration of innovation into daily practices promoted business sustainability when the change made the end-users' job manageable and more gratifying (Brewster et al., 2015). Thus, understanding the process of integration of innovation characteristics can help hospital leaders foster innovation in their organizations.

The content of middle managers' competency and leadership are essential to lead innovation implementation successfully. Birken et al. (2014) noted that middle managers' competencies and leadership skills are essential factors in achieving a successful implementation. However, Engle et al. (2016) suggested middle managers lack commitment and a strategy to lead a change initiative negatively affected the outcome. Most managers considered the intervention by both senior and middle managers beneficial to the effectiveness of the implementation process (Tistad et al., 2016). Additionally, Tistad et al. noted that leaders should focus on developing organizational capability in implementation science on leadership and behaviors to enhance the probability of success. The relationship between clinical department middle managers

and the senior leaders was a factor controlling the sustainability of the change (Ruiz & Ortiz, 2016). According to Kissi et al.'s (2012) study in the construction industry, middle manager empowerment promoted ownership, autonomy, and freedom to control the change process. The authors noted (a) middle managers using intellectual stimulation, (b) benchmarking other industries, (c) capturing evidence-based practice, (d) securing the team and stakeholder buy-in, (e) performing the test of change, and (f) standardizing the practice. Middle managers support of innovation influence innovation outcomes by fostering a climate receptive to change and promoting teamwork to enhance organizational performance. Middle managers are integral to the successful implementation of change. Therefore, leaders should consider the importance of assessing managers' knowledge level and skills before assigning them the responsibility to lead the innovation implementation process.

Transition

In Section 1 the foundation of the study, I identified a general business problem as hospital administrators continue to experience financial penalties for the poor quality of care, which negatively affect their profitability. The specific business problem was some hospital middle managers lack clinical practice innovation strategies to improve the quality of care and profitability. The purpose of this qualitative, multiple case study was to explore the clinical practice innovation strategies hospital middle managers use to improve the quality of care and profitability.

The fundamental research question for my study was: What clinical practice innovation strategies do hospital middle managers use to improve quality of care and

profitability? The results from my study might provide middle managers with effective tactical strategies that reduce financial losses and failure rates when implementing innovation. Effective processes may lead to cost containment, efficiency, and productivity improvement. Therefore, the potential of my study to bring about social change is the opportunity to provide middle managers' tactical strategies that can improve the quality of care and save lives.

Pettigrew and Whipp's (1991) framework is based on context, content, and process constructs of the strategic management of change—known as Pettigrew's theory – was the conceptual framework that will guide my study. Pettigrew and Whipp's framework is a comprehensive structure that I used to explore middle managers' strategies for successful implementation of innovation in clinical practices. The following themes emerged from the literature review: the effect of the regulatory environment on hospital middle managers' strategies for implementing innovation in bedside care, the impact of innovation in healthcare, and the usefulness of Pettigrew's theory as a lens for understanding hospital middle managers' strategies for implementing innovation in bedside care.

I also identified innovation implementation success strategies, potential challenges and benefits of innovation implementation, and middle managers' roles and responsibilities in innovation implementation. The literature review provided the opportunity to discover barriers middle managers can anticipate and avoid, and successful strategies they could use for effective innovation implementation. I established the background of my study through the literature review of existing research through the

lens of Pettigrew's theory. Understanding the middle manager's success strategies can reduce the failure rate of innovation implementation.

I described the study's methodology in Section 2, which includes information on the purpose of the study, the role of researcher, study participants, and an explanation of the research method and design. Additionally, Section 2 includes a description of the research population and sampling method, ethical research, data-collection instrument, data collection and organization techniques, and the reliability and validity of the study. In Section 3, I presented the results of my study, the relevance of these findings to business practice, and the implications for social change. Furthermore, I made a recommendation for future study, and provided a conclusion and appendices.

Section 2: The Project

This section of the study includes the purpose of the study, an explanation of the role of the researcher and study participants' selection protocol, a detailed description of the research method and design, population, sampling method, and ethical research, data collection instruments and techniques, data organization techniques and data analysis, and a description of how I ensured the study's reliability and validity. The section ends with a transition and summary. Section 2 shows the integrity of the study and contain discussions addressing the fundamental research question: What clinical innovation strategies do hospital middle managers use to improve quality of care and profitability?

Purpose Statement

The purpose of this qualitative multiple case study was to explore the clinical practice innovation strategies hospital middle managers use to improve quality of care and profitability. The targeted population was middle managers from two hospitals in the southwestern region of the United States who successfully used clinical practice innovation strategies to improve quality of care and profitability. The results from my study could add value to management practices by providing insights into middle managers' tactical strategies for successful innovation implementation. Stacey (2013) noted that healthcare leaders save lives by making commitment to employees and services that improve quality of care. The findings from this study may contribute to positive social change by providing strategies to improve quality of patient care and save lives.

Role of the Researcher

As the sole researcher for this qualitative multiple case study, I had the responsibility to select of the appropriate research method and design. I selected the study participants and developed the research project. The qualitative researcher is the data collection instrument during the data collection phase of the study (Pezalla, Pettigrew, & Miller-Day, 2012; Yin, 2014). As the primary data collection instrument, I was responsible for data collection, analysis, and reporting. Adams and Miles (2013) noted that The Belmont Report, released in 1978 and created for the protection of human subjects participating in research, provides detailed requirements for ethical principles and guidelines for a researcher to ensure ethical practices. I followed the ethical principles and guidelines of The Belmont Report.

In my role as the researcher, I ensured that I conducted data collection processes in an ethical and respectful manner in alignment with the requirements of the Belmont Report. I completed the National Institute of Health (NIH) Web-based training which helped to ensure my understanding of my obligations to protect the rights and welfare of my study participants. According to Dalton (2013), identification, scoping, planning, gathering, evaluating, managing, and presenting are seven pillars of information used as bias mitigation tools to help avoid biases during the data collection phase of research. I used these bias mitigation tools to guide my data collection, analysis, and reporting processes.

In qualitative research, reflexivity is the ability to evaluate oneself, and bracketing is the capacity to exclude personal experiences, biases, and preconceived notions about

the research topic (Tufford & Newman, 2012). I used reflexivity and bracketing techniques to reflect on my biases and avoid making biased interpretations of data and information. I made the research process a focus of my inquiry. When I received an unexpected response from the participants during the interview process, I applied the experience to reflect and set aside any preconceived notions from my personal beliefs and professional experience. I committed to having an open mind to acknowledge situational dynamics that arose, and I kept a researcher's journal of my ideas and thoughts. According to Merriam (2009), a researcher journal is a document created by the researcher to track activities, ideas, and thoughts relevant to the phenomenon during the research process.

To ensure validity, reliability, and integrity of my research, I captured my experiences and past knowledge relevant to middle managers' role in innovation implementation in a researcher's journal to help me manage and mitigate any personal biases. Additionally, I identified, managed, and mitigated any bias the participants' feedback might uncover during member checking. Next, I reviewed my notes during data collection, data analysis, and when I wrote my final report. When I sensed that bias or preconceived notions arose, I took note in my researcher's journal and reflected on the research progress.

When writing my report, I included notes from my researcher's journal to make the readers aware of my biases as they read the results and interpretations of the data. I was responsible for data analysis, interpretation, concluding, and reporting of the results. To remain professional and demonstrate integrity throughout my research, I practiced the

three guiding principles identified in the Belmont Report. According to Musoba, Jacob, and Robinson (2014), researchers avoid ethical issues relating to study participants when they follow the Belmont Report guiding principles.

Participants

I selected four middle managers from two hospitals in the southwestern region of the United States that received a Magnet designation, the Malcolm Baldrige National Quality Award (MBNQA), or CMS performance-based monetary award. I contacted an executive leader from each of the selected organizations, such as the chief nursing officer, director of nursing research and professional services, or vice president of quality or performance excellence to identify participants, collect contact information, and gain permission to contact the participants. According to Algeo (2012), the two steps to engage participants in a study are identification of participants and gaining participants' trust. I used the purposeful criterion sampling method to select potential participants. Palinkas et al. (2015) noted purposeful criterion sampling as an appropriate participant selection method for implementation research used by researchers with limited resources.

The participants in my study were middle managers who have effectively implemented innovation as determined through my analysis of organizational performance metrics or internal audit results for each hospital with designations that meet my selection criteria (e.g., Magnet status, MBNQA recipience, CMS-based monetary award recipience). According to Erlingsson and Brysiewicz (2013), researchers using a purposeful selection of participants mostly select individuals who have knowledge and experience of the study phenomenon. I worked with the hospitals' leadership teams to

identify participants based on my predefined selection criteria and the study purpose. Researchers need to follow the organization chain-of-command process when trying to gain access to study participants (Merchant, Halkett, & O'Connor, 2012). I presented a high-level summary of my proposal to leaders and asked to introduce the study to participants. My contact leader at the partner organizations sent an email to possible participants letting them know to expect an email from me, the researcher.

I sent the email that included the purpose and scope of the study and a request for the participants' availability for a 30-minute interview. After making initial contact, I followed up with a formal invitation including the informed consent form and a phone call to confirm the date, time, and duration of the interview. Before the interview, the study participants received information about the research and a privacy and confidentiality consent form for their protection. Sonne et al. (2013) noted that the informed consent process is ethical and used when researchers use humans as research subjects. The practice is in alignment with the ethical requirements related to human subjects' participation in research as noted by the NIH and the Walden University Institutional Review Board (IRB).

The participant pool included only inpatient nursing units' middle managers to avoid introducing variation in the sample. According to Palinkas et al. (2015), homogeneous sampling reduces the probability of introducing variation. Additionally, Baskarada (2014) and Hyett, Kenny, and Dickson-Swift (2014) noted researchers using homogenous purposeful sampling for participant selection could collect a small sample and perform an in-depth exploration of the study topic. The homogeneous sample from

multiple distinguished hospitals allowed me to collect data and information about different strategies, perspectives, viewpoints, and implementation processes related to middle managers' strategies for innovation implementation. I selected distinguished hospitals within a 200-mile radius driving distance from my home, which allowed me to conduct face-to-face interviews.

Research Method and Design

The research method and design are an overall strategy that includes various elements of the study in a consistent and coherent approach to addressing the central research problem (Long, 2014; Parylo, 2012). A researcher has a choice of selecting among qualitative, quantitative, or mixed method (Parylo, 2012). Also, the researcher's philosophical worldview has an effect on the effectiveness of the research process. I chose the qualitative research method for this study. According to Hayes, Bonner, and Douglas (2015), identification of a research method and design are crucial steps and a practical approach to achieving the study goals and capture information to answer the central research question. The researcher has the responsibility to select an appropriate research method and design that align with the study's central research question (Long, 2014).

Five of the most commonly used qualitative research designs are phenomenology, case study, narrative, ethnography, and grounded theory (Marshall & Rossman, 2016; Parylo, 2012). For this study, I selected the multiple case study design. A case study was the appropriate research design that answered the central study question. The grounded theory was not an appropriate alternative--no logic supports consideration

of the grounded theory design for exploratory research. Narrative, ethnography, and phenomenology were reasonable alternatives to a case study design for this research. The research method and design are the blueprints that describe the steps needed by researchers to conduct research and capture valuable insight about the phenomenon under study.

Research Method

In this study, I used a qualitative method because of the exploratory nature of my research question. Khan (2014) suggested qualitative method as an appropriate method for research questions of explorative nature. I seek to explore and gain a deeper understanding of the strategies used by hospital middle managers when integrating innovation in bedside care, improving the quality of care, and reducing financial losses. According to Miner-Romanoff (2012), researchers using qualitative research method captured participants' experiences and perspectives of the phenomenon in their original environment. Gale et al. (2013) agreed with Kaczynski et al. (2013) regarding the usefulness of the qualitative method to explore phenomenon and to elucidate the significance attributed to individuals' experiences and realities. I used the inductive approach to understanding hospital middle managers' strategies to implement innovation at bedside care. Bergdahl and Bertero (2015) noted the application of inductive approach helped qualitative researchers gain an in-depth understanding of the participants' experiences and perspective of the phenomenon.

The quantitative method was not appropriate for this study. According to Upjohn et al. (2013), the quantitative method is the logical experimental investigation and

analysis of data through statistical tests to verify hypotheses and determine causal relationships among variables. Balkin (2014) noted quantitative method researchers check the correlation or relationship among and between the variables, test theory, and predict outcomes. Quantitative researchers collect a sample of numerical data representing a particular population without interaction with the study population (Fassinger & Morrow, 2013). Therefore, quantitative researchers are observers, who conclude from the statistical data analysis result without understanding participants' perspectives, or viewpoint. Researchers' protocols for using the quantitative method are not in alignment with the purpose of the study to explore the clinical practice innovation strategies hospital middle managers use to improve the quality of care and profitability.

The mixed method was not appropriate for this study. Researchers use the mixed method to integrate qualitative and quantitative methods in a single study (Creswell, 2016). Thus, integrating qualitative and quantitative method does not align with the purpose of this study. Long (2014) stated that mixed-method researchers take a pluralistic approach by combining quantitative and qualitative method to answer a central research question. I did not select the mixed method because the quantitative component of the mixed method would not provide an in-depth understanding of the middle managers' strategies. The mixed method is time consuming and requires collecting both qualitative and quantitative data, thus increasing the duration and cost of the research; therefore, due to the limited resource and time allocated for completion of the study, I chose not to use the mixed method.

However, for a follow-up study, the integration of quantitative performance data and qualitative interview data could yield powerful, persuasive evidence about the value of innovation implementation. For this study, I planned to perform in-depth semistructured, open-ended interviews and content analysis of organizations' documents from multiple data sources during data collection. Thus, the qualitative method was the appropriate approach for this study because of the explorative nature of the research.

Research Design

According to Chambers et al. (2013), Ketokivi and Choi (2014), and Yin (2014), case study design assists the researcher in exploring and explaining phenomenon within the original context. In case study design, the researcher uses different sources of information to elucidate business practices through organizational processes such as policies, procedures, and protocols. The appropriateness of the design is dependent on the nature of the study, the time available, and resources allocated for the investigation (Yin, 2014). My selection of case study design aligned with Baxter and Jack’s (2008) observation that case study is a valuable design for health science research when evaluating programs and developing interventions. According to De Massis and Kotlar (2014), case study design is a framework for researchers to gain an in-depth understanding of phenomenon within the original context.

The researcher can choose to conduct a single or multiple case study design. For this study, I decided to perform a multiple case study. The advantage of using multiple case study instead of a single-case study is the opportunity to collect information about the phenomenon from participants in multiple settings and be able to perform data

triangulation (Cronin, 2014; Houghton, Casey, Shaw, & Murphy, 2013). Because I was exploring a phenomenon within the hospital context and using different sources of information such as semistructured interviews and document reviews to explore the phenomenon, the case study design was an appropriate design for my study.

Researchers select the correct research design as a prevention measure to avoid wasting time and collecting inappropriate data and to maximize efficiency, accuracy, validity, and reliability (Yin, 2014). The research design serves as a compass to guide the researcher in answering the central research question (Lewis, 2015). Researchers select the research design based on the type of resources required regarding the budget, staff, effort, and time. According to Bernard (2013), researchers could achieve data saturation with a small sample size when using a case study design. Marshall and Rossman (2016) suggested that qualitative case study researchers could select one participant as the smallest sample size. I continued to collect data until I reached data saturation when additional interviews and document reviews yielded no new information.

Cronin (2014) suggested that researchers should consider a variety of lenses to discover and understand multiple aspects of the phenomenon under study. I formulated my interview questions around *what*, *why*, and *how* of Pettigrew's theory (Pettigrew & Whipp, 1991) to acquire an understanding of the strategies used by hospital middle managers to implement innovation in clinical practice in bedside care. Phenomenology, narrative, and ethnography were not appropriate qualitative designs for this study. Researchers use the phenomenological design when they want to explore the participants’

lived experiences, perceptions, and their interface with the environments (Lien, Pauleen, Kuo, & Wang, 2014).

The goal of a researcher using phenomenology design is to understand the social and psychological phenomenon from the research participants' viewpoint (Merriam & Tisdell, 2015). Grossoehme (2014) argued that researchers who choose to use phenomenological design seek to understand the meaning participants attribute to the phenomenon they have experienced. For example, a researcher can use phenomenology when investigating the phenomenon of employee turnover. I did not consider the phenomenological design because of the nature of the study, which was to explore the clinical practice innovation strategies hospital middle managers use to improve the quality of care and profitability, and my desire to explore multiple cases related to the participants’ strategies and not their lived perceptions or experiences.

According to Green (2014), narrative design can be used in a particular case when exploring the life experience of an individual and a narrative design was not an appropriate design to use for business problems. The primary goal of narrative design, which is a historical process, is to develop a business story and promote internal conversation (Green, 2014). Wolgemuth (2014) and Bold (2012) noted that researchers use narrative design to capture details of individuals’ experience as told by individual participants regarding their experiences of the phenomenon. I did not select narrative design because my problem statement, purpose statement, and central research question do not center on collecting stories of the participants’ lives and experiences.

Researchers using the ethnographic design receive participants' observations, experience the culture of the group, and require extensive fieldwork to understand the organizational culture (Floersch, Longhofer, & Suskewicz, 2014; Robinson, 2013). For example, the ethnographer can study the effect of businesses practice on different countries and understand the organizational or societal culture within the global market economy. According to Marshall and Rossman (2016), researchers examining the cultural uniqueness of society or community use ethnographic design within a qualitative research method. The ethnographic design was not appropriate because the purpose of this study was not to explore human behavior within a cultural context, but rather, to explore strategies hospital middle managers use to implement innovation in bedside care.

Population and Sampling

The targeted population was middle managers from two hospitals in the Southwestern region of the United States, who use clinical practice innovation strategies successfully to improve the quality of care and profitability. I decided to explore effective strategies used by middle managers when implementing innovation in bedside care based on previous researchers' studies that established the correlation between middle managers and innovation implementation failure rates. According to several researchers, middle managers have an important role in the high rate of innovation implementation failure rate (Birken et al., 2016; Birken et al., 2014; Jacobs et al., 2015; and Lavoie-Tremblay et al., 2015).

Middle managers' daily activities reflect a complex relationship to power resulting from their position between upper management and frontline employees (Birken

et al., 2016). Birken et al. (2012) noted poor healthcare innovation implementation as a key factor influencing the gap between the quality of care and clinical practice. The purpose of this study was to explore the clinical practice innovation strategies hospital middle managers use to improve the quality of care and profitability. Middle managers' role in influencing successful innovation implementation was the reason this population was appropriate for this study.

The study participants' selection criteria include (a) participants are from organizations that are MBNQA recipients, Magnet hospitals, or CMS performance-based monetary award recipients, (b) participants are middle managers in a clinical setting, and (c) participants have led successful innovation implementation projects. The participants are significant contributors to this study; therefore, by using the selection criteria, I selected middle managers that could provide useful information about the phenomenon under study. Exploration of multiple cases and data sources such as (a) interview transcript, (b) organizations documents, and (c) notes will help increase the study validity. I used methodological triangulation, which involved using multiple sources of data to construct understanding and corroborate findings to test the validity of the study.

I applied methodological triangulation technique to check the consistency of findings generated from the different data sources. Methodological triangulation was the appropriate method for this qualitative multiple case study design because the technique elucidated complementary features of the same phenomenon and points of data convergence and divergence. Fusch and Ness (2015) noted methodological triangulation as an appropriate technique for comparing data from multiple data sources. Rubin and

Rubin (2012) suggested researchers select appropriate cases about the phenomenon to achieve high-quality information from the participants' perspectives and experiences.

I used stratified purposeful sampling to select participants for this study. Participants was selected based on their knowledge and expertise about innovation implementation in clinical practices and in compliance with the selection criteria. According to Patton (2014) and Robinson (2014), sampling was a critical step in conducting valid, reliable, and high-quality research; participants' selection process using purposeful sampling was nonrandom. According to Emmel (2013), a reflexive researcher recognizes his/her role in the research, and when using purposive sampling, could draw conclusions based on the participants' responses captured during the interviews, observations, and documents review process. Patton (2014) suggested purposeful sampling was a logical and powerful sampling method for researchers wanting to capture in-depth and useful information to help answer the central research question.

Guetterman (2015) noted that qualitative sampling involves an iterative series of decisions made by the researcher(s) throughout the research process, unlike the quantitative sampling in which the researchers calculate the appropriate sample size using statistical method before conducting the study. Qualitative researchers do not infer the result from a sample to the population, but rather, concentrate on the interpretation, description, and explanation of the phenomenon as described by the participants (Maxwell, 2013). The appropriateness and the power of the information collected during the data collection process determined the sample size for this study.

The sample size in a qualitative study is unpredictable and dependent on the phenomenon under study and the researchers' level of knowledge (Dworkin, 2012). According to Robinson (2014), the sample size in a qualitative case study ranges from 1-16 participants and depends on the type of data analysis, conceptual framework, and data saturation. In this purposeful sampling study, data saturation occurred when no new information or themes emerge from interviews, document review, and when no additional information or coding was needed to reproduce the study. I interviewed participants individually by location to facilitate identification of redundant information. Morse (2015), Dworkin (2012), Fusch and Ness (2015), and Houghton et al. (2013) noted failure to reach data saturation impacted a qualitative research negatively and rendered the study invalid.

Ethical Research

Khan (2014) noted researchers have a moral obligation to protect study participants against potential harm. I submitted to the Walden University Institution Review Board (IRB) a completed electronic copy of the IRB application form. I started my data collection only after obtaining approval #11-29-17-0232196 from the Walden University IRB, which is the body whose members ensure all studies comply with the University's ethical standards, the United States government regulations, and appropriate international standards related to humans participating in research. Additionally, I sought permission from the leadership of each of the three selected hospitals for approval to provide participants for this study. I emailed the consent form that included an explanation of the study objectives and the nature of the study to each participant. As a

researcher, I was obligated to assure participant protection against any harm from the research.

Researchers have the responsibility to ensure the organization and participant confidentiality and privacy and protect the organization's data (Khan, 2014; Morse & Coulehan, 2015). To ensure compliance with regulations, I coded hospitals and participants using alphanumeric nomenclatures such as Hx_1 . . . Hx_2 for hospitals, and Px_1 . . . Px_4 for participants. I protected paper documents containing data and information related to this study in a locked cabinet for 5 years, and I maintained all electronic artifacts in a login- and password- protected personal computer backup in my extended encrypted hard drive. According to Yin (2014) and Lunnay, Borlagdan, McNaughton, and Ward (2015), research artifacts need to be secure and protected to maintain confidentiality and privacy of the organization and research participants.

After receiving IRB approval, I forwarded an introductory email message to the identified participants using the contact information I received from their respective hospital administrators. As participants respond to my email, I followed up with a phone call to discuss concerns they may have regarding the study, and I confirmed the date, time, and duration of the interview. I sent the participants an electronic copy of the consent form for their signatures. The participants were asked to read, sign, and date the consent form, returned a signed copy to me before the interview started.

I collected the signed copy of the consent forms the day of the interview. All consent forms were received before I started the interview process. I explained to the participants they are free to withdraw from the interview process and the study at any

time they become uncomfortable by the line of inquiry. I offered no financial or enticement for participating in this study. Instead, I explained the social implications of this study to improve the quality of care and save lives.

Data Collection Instruments

The purpose of this qualitative multiple case study was to explore the clinical practice innovation strategies that hospital middle managers use to improve the quality of care and profitability. The results from my study can provide leaders and managers with effective strategies to improve the quality of care. Effective processes can lead to cost containment, efficiency, and productivity improvement. Therefore, the potential of my study to bring about positive change is the opportunity to improve the quality of care and save lives. According to Stacey (2013), improving the quality of care saves lives.

Yin (2014) noted the researcher is a valuable resource and a principal instrument for data collection for qualitative research. Pezalla et al. (2012) agreed with Yin (2014) that the qualitative researcher is the data collection instrument during the data collection phase of the study. I was the primary data collection instrument; I conducted participant selection and the interview processes. As a data collection instrument for this study, I contacted the three hospital administrators to identify the study participants after receiving approval from the Walden IRB. To allow the study participants to express themselves, I used in-depth semistructured, open-ended interview questions. The interview is the preferred instrument for data collection when using qualitative method (Rowley, 2014). I used publicly reported organization performance data and information

to enhance triangulation and my ability to establish the reliability and credibility of the study findings.

Xu and Storr (2012) argued that the semistructured interview technique is resource intensive and time consuming, which can be a disadvantage because of the flexibility of the interview and may compromise reliability. I mitigated the time factor by managing the interview process and completing each interview within 30 minutes. I used a stopwatch as an instrument to monitor the duration of each interview. I used my Apple Pro computer QuickTime program to record the audio portion of the interview. Additional instruments needed to conduct the interviews include a conference room, my researcher's journal, pencil, and notebook.

Data Collection Techniques

The Walden University IRB approval was my cue to start the data collection process. I contacted the leaders from each partner organization and received a letter of cooperation, which I forwarded to the Walden University IRB. The partners provided me with participants information. I sent each participant a letter of invitation (see Appendix D) and follow up with a phone call. The day of the prescheduled interview, I met with the participants individually, and I informed each participant of his/her rights and the interview process. I collected the participant’s signed consent form; the interview protocol started with an exchange of introductions between the researcher and participant; an explanation of the operational definitions and terms, such as member checking; and continue with the researcher asking the participant the interview questions

(see Appendix B). To protect the participants' identities, I used unique identifiers for each participant, as described in the Participants component.

I performed face-to-face semistructured interviews using open-ended questions. Xu and Storr (2012) noted that the advantage to using open-ended questions is the researcher can ask the same questions of each participant, which reduces variation in the responses. My interview protocol included nine semistructured interview questions aligned to Pettigrew's conceptual framework. By using a semistructured interview technique, I had the flexibility to explore the interview questions in-depth to enhance the quality of the responses. Within 48 hours of completing the interview, I sent each of the participants a thank you email.

I used member checking technique to increase the validity of the study. Member checking and transcript review were two different techniques to increase the validity of a qualitative study (Harvey, 2015). Birt, Scott, Cavers, Campbell, and Walter (2016) noted member-checking, known as participant validation is an approach used by qualitative researchers for exploring the integrity, reliability, and trustworthiness of the study. Member checking is an interactive process between the researcher and the participants with the objective to achieve consensus and accuracy of the information collected during the interview process (Koelsch, 2013).

The iterative process of deliberation, elucidation, and synthesis used in qualitative data analysis generates second- and third-order constructs distant from the original interview responses (Birt et al., 2016). According to Carlson (2010), planting misperception to trap participants is common among qualitative researchers. I avoided

such ethical issues during member checking by clearly defining the procedure, providing clear direction, and explaining the importance of the procedure to participants. I also included member checking process on the consent form to uphold participants' engagement, trust, and respect.

Qualitative researchers eliminate misrepresentation or misinterpretation of interview data by using member checking technique (Carroll & Huxtable, 2014). I processed and interpreted the interview information mentally for codes and emerging themes and patterns. I generated themes based on similar patterns and shared the interpretation with participants for validation. I send a thank you email to each participant for participating in the process of member checking (see Appendix E). After receiving clarification for any discrepancies, I performed data triangulation. According to Birt et al. (2016) and Anney (2014), executing a member-checking technique adds validity and reliability to the study information.

Member checking is a collaborative technique used in qualitative research to ensure the validity of the study results (Archibald, 2015). I used member checking and methodological triangulation as techniques to ensure validity and trustworthiness of my study. According to Birt et al. (2016), the trustworthiness of research findings is the foundation of high-quality research. Thus, a researcher cannot overlook the importance of returning data or sharing findings with participants to confirm the accuracy of interpretation of information's shared or ensure alignment to the participants' views.

Researchers are responsible for maintaining the integrity of their research (Anney, 2014). I used the participants' approved interview transcripts, notes captured during the

interviews, and organizational documents as a source of data triangulation. Yin (2014) and Fusch and Ness (2015) noted that collecting data from multiple sources increased the validity of the study through data triangulation. I followed the case study protocol described by Yin (2014), which includes purpose of the case study and research questions, case study review and procedures, schedule for conducting the study, case study protocol review, and an outline of the case study report

Bredart, Marrel, Abetz-Webb, Lasch, and Acquadro (2014) summarized the importance of preparing for the interviews, and the establishment of a comfortable interview environment depends on the researcher's competency on performing interviews. During the interview, I stayed open minded and applied active listening skills. I also used time-management skills and maintained eye contact with the participant, which had a positive impact on participant engagement. The participants were contacted the day before the scheduled interview to confirm the interview date and time. According to Yin (2014), the summary of data-collection techniques, data-analysis tools, validity, credibility, dependability, and transferability are components of a case study protocol.

Additionally, I used the benchmarking process approach to analyze publicly reported organizations documents. Benchmarking is systematic, data-driven, and an essential element of the continuous improvement process that can be used in the Lean Six Sigma methodology to improve performance (Tomelero, Ferreira, & Kumar, 2017). According to Watson (1992), out of the 32 criteria of the MBNQA, 12 criteria refer to benchmarking as a critical component of quality assurance and process improvement. The guiding principle of benchmarking is the measuring of the organization’s internal

processes, identifying, understanding and adapting outstanding practices from best-in-class organizations (Wind & Harten, 2017).

I adapted the benchmarking process as seen in Figure 2 because of the alignment with my objective to identify high performing innovative organizations as potential research partners for my study. Benchmarking offered the added advantage of comparing performance data among competitors. Taylor, Clay-Williams, Hogden, Braitwaite, and Groene (2015) suggested the following characteristics for a high performing hospital (a) senior management support, (b) effective leaders across the organization, (c) positive organizational culture, (d) effective performance monitoring, (e) building and maintaining a proficient workforce, (f) expertise-driven practice, and (g) interdisciplinary teamwork.

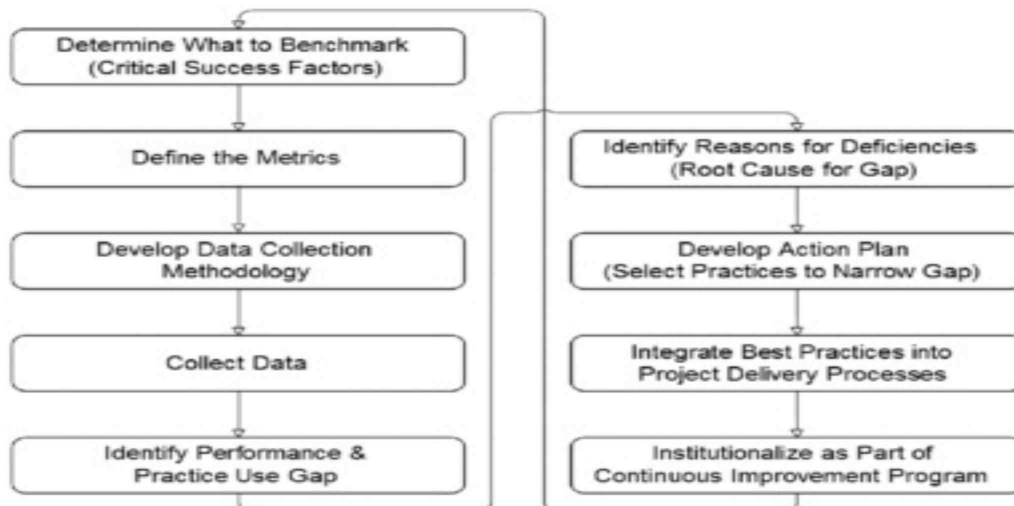

Figure 2. Benchmarking roadmap. Adapted from Camp, 1989. Camp, R. C. (1989). *Benchmarking: The search for industry best practices that lead to superior performance*. Milwaukee, WI: Quality Press.

Data Organization Techniques

I created a case study database to capture all the artifacts from the research and organize the data for ease of organization, manipulation, interpretation, and usability. Houghton et al. (2013) emphasized the ease of data manipulation when storing data in electronic formats. Upon completion of all the interviews, I transcribed the recorded interviews and added notes from my researcher's journal and enter into the spreadsheet. I organized the data manually by using flipchart and color-coded sticky notes on flipcharts, and I developed themes aligned to the themes discovered during the literature review under the lens of Pettigrew’s theory. I used a qualitative data-analysis software program NVivo to organize, analyze the data, and validate the result of my manual textual analysis.

The exportation of data into software such as NVivo 12© facilitates coding and thematic analysis of large amount of data (Casteleberry, 2014; McCullough et al., 2015). Data organization steps when using software are: (a) data organization in distinctive categories, (b) synchronization of categories with sources of evidence, and (c) creation of algorithm (Yin, 2014). I tabulated the frequency of words, and simultaneously examine word relationships. The electronic copies are password protected, and hard copies documents kept in a securely locked cabinet in my home office. I plan to destroy the research artifacts after 5 years.

Data Analysis

In the planning stage of data analysis, I established a data analysis plan as a time management tool that helped me to facilitate the execution of the data analysis phase of

the research project. Qualitative researchers collect a large amount of data, which requires analysis, coding, and organization to establish linkage between the research participants' experience and existing literature (Bloomberg & Volpe, 2012). The data analysis can be overwhelming and time-consuming, and the researcher may not understand how to process the data without a preestablished data analysis plan (Petty, Thomson, & Stew, 2012b; Yin, 2014). According to Yin (2014) and Petty et al. (2012b), researchers need to develop a data analysis plan during the planning phases of the study. According to Fade and Swift (2011), researchers should transcribe interview information to avoid issues with data accuracy, interpretation, and reliability. Stringer (2014) suggested that researchers code and use thematic techniques to analyze qualitative data. To facilitate thematic analysis, I transcribed the information collected during the interview.

I performed methodological triangulation to improve data credibility by showing alignment among interview data, document review, literature review, and the conceptual framework. I also used personal journal notes as an additional source. According to Yin (2014), interviews and personal journal notes are the primary sources of data. I used methodological triangulation to test validity and reliability through the convergence of information from multiple sources and to check the consistency of the findings. Because data collection was from multiple data sources, the data triangulation technique was appropriate to ensure the study validity and reliability.

My data analysis process was as follows: I used the interview question protocol to create an electronic spreadsheet template; I transcribed the interview audio responses

from each participant and entered interview notes in the template. The template included the participant's identifier and appropriate demographic information, which I kept secure in a locked file cabinet. I read the transcripts while writing comments on color-coded electronic sticky notes placed in the margins. I started data analysis by reading the updated document and adding comments in the margin. I compared the transcript data to document reviews and literature review information using the lens of the Pettigrew's theoretical concept of content, process, and context constructs.

I coded the data and performed the thematic analysis. According to Petty et al. (2012b), thematic analysis is the standard method qualitative researchers use to organize the interview information. I highlighted key phrases in different colors based on similarity. Cole and Harbour (2015),and Snyder et al. (2012) used similar approaches to data analysis and development of codes and themes. Cole and Harbour (2015) generated codes from interview transcripts by mapping the information using color-coded sticky notes with relevant data inserted on the margin. Snyder et al.'s (2012) process for data analysis was to cut and sort sections of the transcripts. I used Cole and Harbour's approach to develop coding, and I also considered Synder et al.'s method, when applicable.

I processed and interpreted the interview information mentally for codes and emerging themes and patterns. I generated themes based on similar patterns. My systematic process for data analysis included transcription of the interview information, identifying similar words, or phrases, and developing themes. The themes elucidated the study's specific business problem that some hospital middle managers lack clinical

practice innovation strategies to improve the quality of care and profitability. I compared the emerging themes to the literature review, conceptual framework, and organization documents. According to Bloomberg and Volpe (2012), evaluating the study findings through multiple lenses supports the discovery of concepts and themes reflective of the organizational framework and the literature related to the participants' experiences. I applied thematic technique and coded the information to reflect the perspectives of the research participants.

Data analysis happened in parallel with data collection, which allows for coding adjustments. Data collection and analysis occurred continually throughout the implementation of research using the qualitative method research (Yin, 2014; Petty et al., 2012b). Yin (2014) noted data accuracy and interpretation increase when data collection is from multiple data sources. According to Houghton, Murphy, Shaw, and Casey (2015), member checking technique increases the research credibility. I shared my interpretation with participants for member checking and validation. The participants agreed with the emerging themes and subthemes. I ensured coding, themes, and conclusions were in alignment with the central research question of this study. I refrained from prejudging and drawing conclusions prematurely. I reflected on each interview and entered my reflection in my research journal, which helped me to identify and eliminate any prejudice or preconceived perceptions. I performed member checking, data triangulation, data coding, and theme identification to determine strategies that hospital middle managers use to effectively implement innovation in clinical practices to improve the quality of care and profitability.

Reliability and Validity

Reliability and validity of qualitative research depend on the researcher's ability to establish rigor by using multiple data sources to mitigate researcher bias and pre-conceived notions (Pettigrew, 2013). According to Smith and Chudleigh (2015), reliability and validity of research are achievable and depend on the level of discipline on the part of the researcher. Foley and O'Connor (2013), and Street and Ward (2012) noted reliability and validity among the difficulties experienced by most qualitative researchers. Houghton et al. (2013) and Onwuegbuzie, Leech, and Collins (2012) noted four criteria to consider when assessing a research for validity and reliability (a) credibility, (b) dependability, (c) confirmability, and (d) transferability. Marshall and Rossman (2016) noted approaches to internal and external validity, reliability, and objectivity as alternative processes to consider when assessing quantitative research.

The concept of validity in a qualitative study is different from the internal and external validity in a quantitative study. According to Elo et al. (2014), and Saldaña (2016), the qualitative researcher uses credibility and transferability in gauging the validity of the study based on the perspective of credibility and trustworthiness. Because of the interpretive nature of the qualitative study, the researchers' attempts to understand the phenomenon through the large amount of data collected during the interview process (Yin, 2015).

According to Markee (2015), replications of qualitative research happen when the interview protocol requirement is to use consistent questions to all participants, and data collection is from different sources, which increases dependability and triangulation of

the findings. Kapoulas and Mitic (2012) posited that different types of data collected from multiple sources used in methodological triangulation reveal similar results. I used the interview protocol (Appendix B) to collect data while ensuring reliability, credibility, confirmability, and transferability of the information.

Reliability

According to Brutus, Aguinis, and Wassmer (2013), research is reliable when other researchers can repeat the study and achieve the same results. I focused to ensure dependability, confirmability, transferability, and credibility of the study so that other researchers can replicate the study results. I emphasized the study design, which included the purpose of the study, participants' selection, data collection description and instruments, data analysis, interpretations, and conclusions. I focused the articulation of the research results on validity and reliability of the study. I aligned the interview questions to the central research question and the conceptual framework, and protection of the study artifacts in a secured and locked drawer for 5 years ensure the reliability of this study.

I crossed check the themes discovered from the interview with the literature review themes to increase the credibility of the study. According to Miles, Huberman, and Saldaña (2014) and Yin (2014), using the principle of convergence in which themes discovered from the research interview questions are cross checked with secondary data sources helps to uncover divergence in the data collected, and improve study credibility. I was transparent and share the research design by clearly describing data collection, coding, and type of analysis performed. Appropriate use of qualitative methods, design,

data collection and instruments, notes, and researchers' journal establishes the reliability of the research (Maxwell, 2013; Patton, 2014).

When the researchers use multiple sources of information and data analysis, which may include triangulation, member checking, and review of the transcript, it results in increased research dependability (Merriam & Tisdell, 2015; Patton, 2014). I used member checking during data analysis to assure that I presented the interview responses and the interpretation of the data accurately and increased the study credibility. I used data triangulation to establish dependability. According to Patton (2014) and Yin (2015), triangulation establishes dependability of qualitative research.

Validity

Qualitative researchers identify the need for objective measures through transferability and external applicability based on data saturation, triangulation, and consistency of information. Quantitative researchers use internal and external validity as research quality measure, while qualitative researchers implement credibility and transferability measures to safeguard the study integrity (Marshall & Rossman, 2016). According to Bekhet and Zauszniewski (2012), to ensure study validity, the researcher needs to use the predefined measures aligned to the research method. Researchers use member checking, an interactive process between the participants and the researcher, and data triangulation to help ensure the study is valid.

For example, participants can review the interview transcript and provide feedback to the researchers to improve the accuracy and validity of the interview transcript. According to Fusch and Ness (2015), Harper and Cole (2012), and Houghton

et al. (2015), sharing the interview transcript with the participant for member checking increases the validity, credibility, and accuracy of the data captured during the interview. I collected and reviewed company documents, collected interview data, and used multiple data sources to increase transparency, credibility, and trustworthiness of the study.

I used multiple data sources to understand middle managers' strategies through multiple lenses to discover the emergence of themes and findings. I used data triangulation as a strategy to ensure validation of the study results. The evidence from Bekhet and Zauszniewski (2012), and Archibald (2015) indicated data triangulation ensures thoroughness of the information and serves in the discovery of similarities and differences in the study findings. The inclusion of multiple cases study allowed examination and emergence of each case concepts and codes leading to replication logic, which increased external validity by comparing and confirming cases (Morse, Lowery, & Steury, 2014; Roy, Zvonkovic, Goldberg, Sharp, & LaRossa, 2015; Yin, 2014). I achieved data saturation when no new themes and or concepts emerge from the data collected. According to Birchall (2014), Onwuegbuzie and Byers (2014), and Robinson (2013), data saturation shows the researcher apply due diligence when conducting the analysis and validate the credibility of the analysis.

Credibility. According to Marshall and Rossman (2016), Maxwell (2013), and Onwuegbuzie et al. (2012), researchers increase accuracy and reduce bias in data interpretation via a review of the organizations' documents, interview notes, member checking, and the researcher's journal. Additionally, the researcher's use of these processes increases the credibility, dependability, and reliability of the study. The use of

semistructured audio-recorded interviews to revisit the information, verbatim transcription of the interview, member checking of emerging themes and the participants' agreement with my interpretation of what the participants said increased the credibility of the research data and results.

Transferability. According to Houghton et al. (2013), qualitative researchers need to use substantial descriptions to establish transferability. Even though generalizability is not the focus of this study, transferability is important. The extent to which the phenomenon from a specific context is transferable to other environments under similar situations or conditions determines the transferability of the research (Bloomberg & Volpe, 2012). Anney (2014) and Houghton et al. (2013) agreed with Bloomberg and Volpe (2012) and specified that transferability happen when a researcher reproduces similar results as a previous study when given the same population, design, and interview questions. I ensured transferability through the substantial and affluent description of the participants and the research context, and by providing clear operational definitions and study's protocols. As a result, the readers could appropriately evaluate transferability of the study results and conclusions.

Confirmability. According to Bloomberg and Volpe (2012), the quantitative research concept of objectivity is similar to confirmability concept in qualitative research. Bloomberg and Volpe (2012) noted that the study conclusion should reflect the findings and not the researcher's reflections of biases and subjectivity. Researchers use confirmability to evaluate the accuracy and rationality of the results derived from the interview process (Houghton et al., 2013). To achieve confirmability, I truthfully

presented the phenomenon under study so that future scholars can corroborate the study results. I demonstrated the true representation of the phenomenon under study to help future scholars to corroborate the study results. Also, I used multiple data sources and ensure the results reflect the participants' perceptive and experience. According to Boesch, Schwaninger, Weber, and Scholz (2013), researchers need to ensure the study results mirror the participants' perceptive and experience, and not the researchers' preferences.

According to Grossoehme (2014), each researcher brings his or her individuality to the research. The approaches taken to explore the central research question depend on the researcher's unique experience, comprehension, environment, and philosophical worldview (Houghton et al., 2013). To ensure other researchers confirm or agree with the study findings, I recorded each interview and maintain an audit trail for traceability. I collected data from multiple cases and used member-checking procedures for checking the accuracy of the information. I was transparent with the design, interview questions, data collection, and analysis protocols as described in Section 1 and Section 2 of this document.

Transition and Summary

In Section 2, I introduced the purpose of the study, the research method and design, data collection instruments, data collection technique, and data organization. Also, I presented data analysis protocol, reliability, and validity of the research project. The purpose of this qualitative case study was to explore the clinical practice innovation strategies that hospital middle managers use to improve the quality of care and

profitability. I conducted face-to-face semistructured interviews with participants meeting the selection criteria and have a signed consent form for each participant. I followed data collection and analysis protocols to generate themes discuss in Section 3 of this document. In Section 3, I discussed the study findings and present a summary of the themes resulted from data analysis. Also, I discussed the application of study findings to professional practice, the implications of social change, and made a recommendation for future research.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative multiple-case study was to explore the clinical practice innovation strategies hospital middle managers use to improve quality of care and profitability. Quality work is a result of employees' excellence, which starts and finishes with the individual doing the work (Malhi, 2013). Some middle managers face the challenge of identifying successful clinical practice innovation strategies to improve quality of care (Guerrero, 2012). Healthcare is a complex environment with many different functions and leadership structures that require collective behavior changes, systems redesigns, and new business models to improve patient outcomes (Martinez-Garcia & Hernandez-Lemus, 2013).

In this section, I present the findings of this multiple-case study of two high-performing hospitals in the southwestern region of the United States with performance outcomes that indicate successful clinical practice innovation strategies used by middle managers to improve quality of care and profitability. The study sample of eight middle managers consisted of four participants from each of the two hospital sites. The application of Pettigrew's theory as the conceptual framework allowed for the discovery of middle managers' strategies.

I conducted data analysis and interpretation manually using pen and papers. The steps used for data analysis included transcription of the interviews, coding, cyclical review for themes, and data synthesis. I repeated the review process as each interview progressed. I transcribed the eight interviews, noting possible codes and themes. I

performed data analysis using open and axial coding via a combination of inductive and deductive reasoning. I also used a systematic approach to categorize the themes based on similar properties and dimensions. I used a systematic approach to organize the codes into categories. Through the analysis of the transcripts, themes emerged. The findings show that the emergent themes and subthemes supported my central research question. All the participants agreed on all the themes and subthemes. I organized the data using NVivo 12 software, and I also used the software to check my analysis. Participants' willingness to share their knowledge and experience was crucial to answering the overarching research question.

Presentation of the Findings

After receiving approval from IRB, I identified high-performing hospitals as potential partner organizations. I used benchmarking and collected the following hospitals' publicly reported performance data: a list of hospitals with magnet designation, a list of hospital pay-for-performance information, a list of MBNQA recipients and hospitals' Baldrige application summaries, and a review of publicly reported documents. I coded the documents to maintain confidentiality. The abbreviation Doc and the numbers 1 to 9 represent the alphanumeric code for the reviewed documents (see Table 2).

Content analysis of the documents resulted in the identification of the following characteristics of high-performing organizations: having high-quality leadership and management, being open and action-oriented, being goal-oriented and having a long-term focus, promoting continuous improvement and innovation, having competent employees with a high level of education, and having an employee-focused and high-performance

culture. These characteristics guided my selection of hospital sites. Taylor et al. (2015) highlighted the need to use assessment approaches to understand factors associated with high performance and how to improve those factors. High-performing healthcare organizations have demonstrated innovation at the bedside.

Table 2

Code Name of Documents Reviewed

Documents	Documents Code
Hospitals that received Magnet designation in the southwestern region of the United States	Doc1
CMS hospitals' pay-for-performance program	Doc2
MBNQA Recipients in Southwestern region of the United States	Doc3
Reward and Recognition Program	Doc4
Vision and Mission statements	Doc5
The Center of Nursing Excellence strategies on caring, innovation, and leadership to transform lives	Doc6
Hospitals' Websites–publicly reported leadership structure	Doc7
Hospitals' list of Award and Recognition	Doc8
MBNQA Application Summaries	Doc9

To ensure confidentiality and privacy of the study participants, I masked their identity with the following codes: H1P1, H1P2, H1P3, H1P4, H2P5, H2P6, H2P7, and H2P8, where H1 and H2 refer to hospitals and P1 through P8 refers to participants.

Doody and Noonan (2013) noted that qualitative researchers use predetermined sets of questions during interviews, but the inquiring order depends on the participants and how the conversations unfold. Because of the nature of the interviews, in addition to my predetermined questions, I asked probing and prompting questions to enhance the quality of data collected. Data collected during this study were confidential; therefore, research data will be stored securely in a locked cabinet in my home office for 5 years, and subsequently destroyed.

I followed the qualitative method and interviewed eight middle managers from two high-performing hospitals, which enabled me to gain in-depth knowledge of the clinical practice innovation strategies used by hospital middle managers to improve quality of care and profitability. The overarching research question was to identify clinical practice innovation strategies that hospital middle managers used to improve quality of care and profitability. The themes that emerged align with the conceptual framework I used for this study. I analyzed my research question from multiple perspectives by comparing the themes, literature review, and conceptual framework to assess the validity and reliability of the study.

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The data analysis steps included interview transcription, open and axial coding, cyclical review for coding, themes, synthesis, member checking, and data triangulation. Figure 3 shows the logical steps I followed during data analysis of the interview transcripts. The analysis revealed 23 themes, and I used a systematic approach to create four categories or key themes: organizational culture, leadership, management by

objective, and staff engagement. I compared the results of the document review, literature review, and conceptual frameworks with the themes and subthemes to assess the reliability of the study.

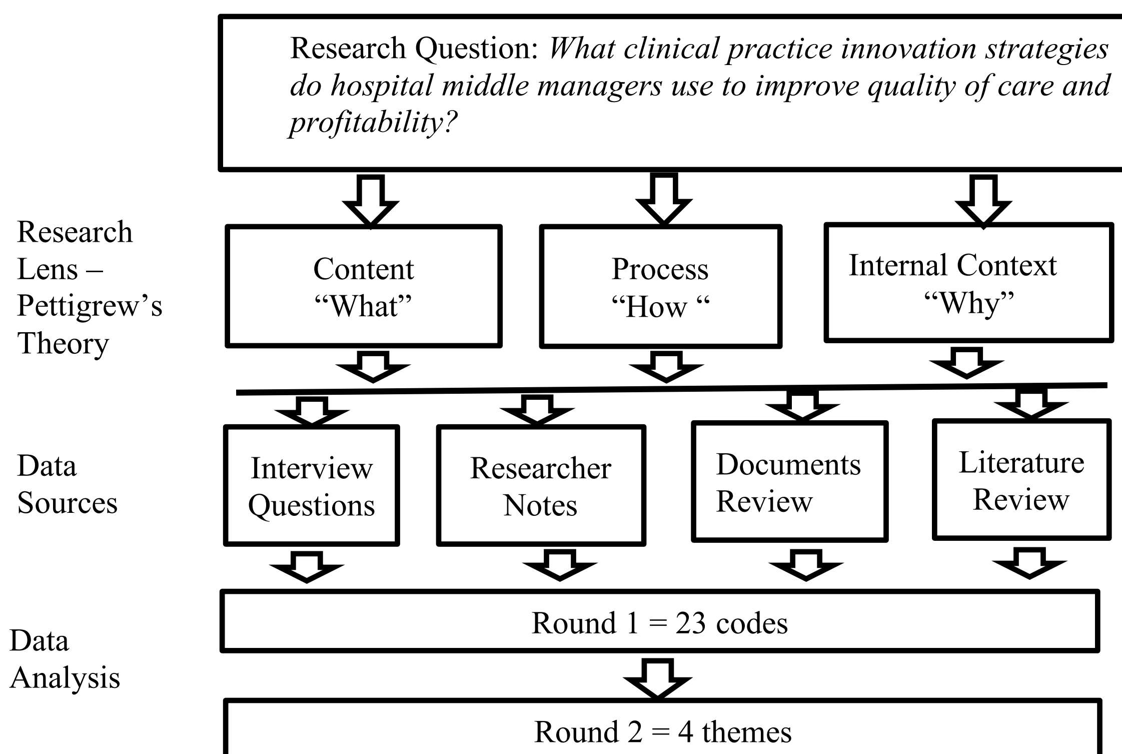

Figure 3. Logic sequence of steps to answer the central research question in relation to data sources and data analysis framework and Pettigrew's lens.

I achieved both data and inductive thematic saturation after six interviews. Saunders et al. (2017) noted a researcher identifies data saturation when analysis of responses from the interview participants reveals no new data or information; and inductive thematic saturation happens during data analysis when the researcher is unable to generate additional codes or themes. I reached data saturation with six participants but continued data collection with all eight participants in compliance with the study

protocol. According to Fusch and Ness (2015), researchers use member checking to validate interpretation of the data collected during the interview process. I used the member-checking protocol to validate my interpretation of participants' answers and improve the quality of the information, credibility, and validity of the data.

Key Themes

The purpose of this qualitative multiple case study was to explore the clinical practice innovation strategies hospital middle managers use to improve quality of care and profitability. I mapped the four emergent key themes within the conceptual framework model as seen in Figure 4. Middle managers interviewed in this study develop strategies based on the internal context of organizational culture, leadership, the content of management by objectives, and the process of staff engagement. Table 3 shows the frequency of references to the key themes that were referenced from the data triangulation process, which included the documents review, middle managers interviews, personal notes, and the literature.

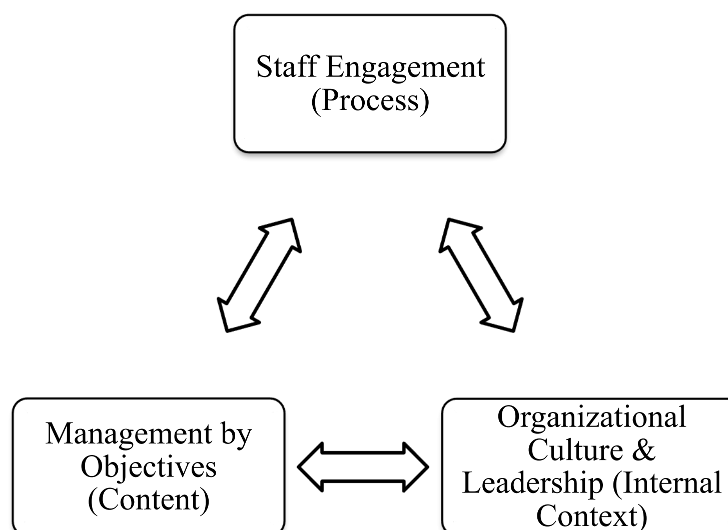

Figure 4. Key themes through the lens of Pettigrew's theory.

Table 3

Frequency of Key Theme References from the Data Triangulation Process

Key Themes	Frequency of theme Reference	% of Reference
Organization Culture	340	41
Leadership	252	31
Management by Objective	136	17
Staff Engagement	94	11

Theme 1: Organizational Culture

Organizational culture emerged as a predominant theme. All eight participants and Doc3, Doc6, and Doc9 described the organizational culture as an input to the strategy development process and a precondition for a successful implementation of clinical

practice innovation strategy. Five of the participants described the organization-branded program used to promote the organizational culture as a framework that enables the maintenance of the organization standard for quality care, which facilitates a synergy between patients and their caregiver team to create excellent outcomes (H1P1, H1P3, H1P4, H2P5, H2P6). The culture generates a synergy between patients and their caregiver team to achieve excellent outcomes.

H1P4 stated, “Organization culture is like the glue that binds us together and helps us accomplish our strategic goals and deliver excellent performance.” The participant’s statement aligned with the evidence presented by Ratnapalan and Uleryk (2014) and Hartnell et al. (2011) that organizational culture is a cohesive element and a precondition for teamwork and successful innovation implementation. Four of the participants discussed the organizational culture as an enabler to workforce members’ motivation to deliver patient-centered care (H1P3, H1P4, H2P5, H2P8).

Martinez-Canas and Ruiz-Palomino (2014) defined organizational culture as the common underlying assumptions, values, and beliefs shared by members of the organization. All eight participants attested that organizational culture enabled them to develop and implement successful clinical practice innovation strategies that improve quality of care and profitability. All eight participants explained the organizational culture as participative and employee-centered; for example, H1P2 stated, “I have been in this organization for over 20 years. We have a culture of respect, fairness, integrity, trust. We have a participative, employee-focused organizational culture receptive to change.”

The influence of organizational culture may depend on a manager's competency and management of the leaders' need for control and flexibility. H1P3 stated, "We have a culture supportive of employees; we have yearly employee engagement surveys to capture feedback. We have a participative and employee-focused organizational culture that is inclusive." H2P7 explained, "Organization culture plays a significant role in individual engagement, attitudes, and emotional responses to aspects of change. We have an inclusive, participative, and employee-focused organizational culture." H2P8 indicated, "The employee-focused organizational culture is the driver for the clinical practice innovation implementation success." When I asked how the organizational culture drives successful innovation implementation, H2P8 responded "through the promotion of behaviors that encourage innovation, open communication among members, creation of safe climate, teamwork, and acknowledgement of diversity."

Gochhayat, Giri, and Suar (2017) recognized the role and importance of culture on organizational performance and effectiveness. Organizational culture is predictive of success in change implementation seen through employees' perceptions of readiness for change (Whelan, 2015). Four participants described organizational readiness as a crucial step before proceeding to the implementation phase regardless of the strategy (H1P3, H1P4, H2P5, H2P7). Two of the participants emphasized the importance of employees' awareness of change as a precursor to the implementation process (H2P5, H2P8). H2P8 stated, "We always assess the organization and employees' level of awareness and readiness to change before implementing change."

H1P4 indicated, “Organization readiness to change is a precursor to achieving successful implementation.” The participant’s statement aligns with the organizational readiness for change theory develop by Weiner (2009). Weiner noted that organizational readiness for change increased the probability that members would initiate change, commit to change, show perseverance, and exhibit behaviors that increased the effectiveness of the implementation process. H2P5 added, “Consistent leadership behaviors, transparency of information, open communication, and shared goals about the change increase employees’ readiness to change.” H2P5 statement aligns with evidence presented by Madsen, Miller, and John (2005), which showed similar elements as significant to increase employees’ readiness to change.

Managers need to examine the importance of the organizational readiness for innovation implementation at the individual and organizational level (Jones, Jimmieson, & Griffiths, 2005). Organizational readiness for change increases the probability for frontline staff to initiate change, commit to change, and show perseverance and cooperative behaviors as significant precursors to increasing the effectiveness of the implementation of change (Sharma et al., 2014; Weiner, Lewis, & Linnan, 2009). Doc1, Doc2, Doc3, Doc8, and Doc9 showed evidence of the effects of organizational culture on the organization performance outcomes in quality of care, financial, customer satisfaction, and innovation.

Seven participants indicated that (in their role as managers) they maintained and promoted a unifying, participative, and supportive organizational culture (H1P2, H1P3, H1P4, H2P5, H2P6, H2P7, H2P8). A study conducted by Lljins, Skvarciany, and Gaile-

Sarkane (2015) showed that changes in the organizational culture have an impact on organization effectiveness, performance, and innovation implementation. Six of the eight participants explained the importance of maintaining employee-focused organizational culture to improve the effectiveness of the team, employees' satisfaction and retention (H1P2, H1P3, H1P4, H2P5, H2P6, H2P7).

H2P7 indicated, "I promote our organizational culture, which allows me to develop successful strategies receptive by my team." Five participants linked organizational culture to the success of their department and the overall hospital, and an input to workforce engagement (H1P1, H1P2, H1P4, H2P5, H2P7). H2P7 explained:

> We promote a unifying, participate, and supportive environment where everyone knows their role and responsibility and how it aligns to the department and organizational strategic goals. We create an environment conducive to the team accepting our strategies, which leads to successful implementation.
> Organizational culture is a critical factor to achieve success in clinical practice innovation implementation.

Organizational culture impacts the implementation of interventions in hospitals, hence the components of organizational culture need to be explored to improve implementation processes (Dodek, Cahill, & Heyland, 2010). The eight participants shared six components of organizational culture as important inputs to creating successful clinical practice strategies that improve the implementation process. The findings contribute to the body of knowledge by providing organizational culture components that augment the findings of previous studies. For example, hospital managers who focus on

improving organizational culture can enhance the quality of care (Ukawa, Tanaka, Morishima, & Imanaka, 2015). According to Yunus and Tadisina (2016), in a high-performing organization, business managers use organizational culture to improve performance and productivity.

Table 4

Subthemes Related to Organization Culture

Subthemes	Frequency of reference	% of responses
Senior leaders' support	68	22
Manager support structure	62	20
Building a safe climate	30	9
Promoting collaboration	59	19
Encouraging teamwork	50	16
Reward and recognition system	45	14

Table 4 shows the six subthemes or components related to organizational culture in relation to middle managers' strategies, and the frequency of times the participants' references to the subthemes. All six subthemes influence participants in the development and implementation of the clinical practice innovation strategies. All eight participants attested to considering all six components of the organizational culture while developing their strategies.

Subtheme 1: Executive leadership support. All eight participants spoke of strong executive leadership team support and recognized the significant role senior

leaders have in the success of the innovation implementation. The eight participants described the senior leaders as effective in communicating a clear vision and promoting a culture supportive of innovation that grant participants' autonomy to implement evidence-based innovation. Three of the participants also observed opportunities for improvement on the number and prioritization of innovations (H1P4, H2P5, H2P6).

H2P5 stated, "We have competing priorities, and when everything is priority, in reality, nothing is priority." Six of the eight participants noted that healthcare providers exhibit signs of burnout driven by over-burdened schedules that hinder the opportunity to incorporate innovation at the bedside (H1P1, H1P2, H1P4, H2P5, H2P6, H2P7). The use of managers' support structure by partner organizations helps participants to dedicate time to embed clinical practice innovation at the bedside to improve quality of care.

Four of the eight participants acknowledged lack of time as a hindrance to implementing clinical practice innovation strategies because of the influx of regulations and competing priorities (H1P2, H1P4, H2P5, H2P7). Five of the eight participants noted senior leaders as supportive and promoting compassionate care, managers' empowerment and ownership, which build managers' trust and autonomy to manage change (H1P2, H1P4, H2P5, H2P6, H2P8). H2P5 indicated, "Our executive leaders are very supportive, and we are fortunate our leaders are innovative and futuristic." H1P3 stated, "Our executive team recognize middle managers' role and responsibilities to the success of change initiatives implementation, and make resources, tools, and support available".

All eight participants were passionate about their nursing profession, their position as the intermediary between senior leaders and frontline staff. For example,

H1P3 stated, “Nursing is an inspiring and rewarding career. Every day is a different experience. We encounter amazing people who are sick, vulnerable, and in need of help on a daily basis. Despite the long hours and stress, we make the sacrifice to save a life.”

Four of the participants attested to the challenges of operationalizing organizational culture to a new hire. For example, H2P6 stated, “Organizational culture is not easy to operationalize and a difficult factor to measure. Nonetheless, we can observe the culture application through actions and behaviors.” H2P8 described the role of senior leaders in facilitating change, “Our executive team is outstanding in helping us make the change happen smoothly. They always show up at our meeting to show their support and to explain what is going on in the organization.”

Additionally, two of the eight participants talked about transparency at all levels of the organization (H2P5, H2P7). H1P4 stated:

> We are very fortunate to have transparent senior leadership team who promote transparency and ethical behaviors across the organization, and ready to provide support. The executive team is approachable, and we are comfortable asking them questions. They promote a healthy working environment and give us full autonomy to make decision.

In describing an example of senior leader support, H2P5 described the chief nursing officer as follows:

> Our chief nursing officer (CNO) is hands on and very supportive. She created a night shift council, one of my nurses chairs it. It is an interprofessional team to gathered what is working well and what is not working. She is quick to fix any

> issues coming from the frontline. The level of trust between the executive team, middle managers, and the frontline staff is strong. The CNO is present, always visible and approachable.

The participants indicated the trust level they have for their senior leaders and senior leaders' support as enablers of clinical practice innovation implementation success and their organizations exhibit a high-performance culture. This study's finding is in alignment with Kazlauskiene and Bartuseviciene (2013) who showed employees' trust in leadership as the anchor of a successful organization. The executive-leadership-support finding aligns with an earlier study by Ovretveit et al. (2012), who performed a longitudinal cross-case survey on innovation implementation in Swedish hospitals, which showed senior leaders support as crucial in the success of the innovation implementation.

All eight participants spoke with passion about senior leaders exhibiting consistent behaviors, being accessible, transparent, and always available for a conversation or to help. According to Madsen, Miller, and John (2005), consistent leadership behaviors, open communication, transparency of information, and shared knowledge about past initiatives promote a shared vision in organizational members' readiness to change. H2P5 stated, "I align every strategy to the mission, vision, and goals of my department and the organization." The participant approach is in alignment with Mousavi et al. (2015) who noted business managers use mission and vision statements to establish their strategic direction.

Subtheme 2: Managers' support structure. Birken et al. (2016), Engle et al. (2016), and Pannick et al. (2015) highlighted the limitations middle managers face in

hospitals when implementing innovation because of their role of managing staff, performing administrative duties, and helping at beside simultaneously. The two high-performing hospitals in this study have applied the manager's support structure to create a balanced approach to managers' management responsibilities. The organizations have redistributed some of the managers' responsibilities to the unit support leadership team. All eight participants took pride in explaining the departmental support structure as a balanced approach to management of a nursing unit as seen in Figure 5. For example, H2P7 stated:

> Each manager has a department leadership support structure composed of Leads and Advanced Clinical Nurses (ACN). The number of leads, ACN, and district depend on the number of employees in the department. The leads are responsible for coaching and supervising everyone in the districts assigned to them. The ACNs are accountable for the education of the staff in their districts. Managers delegate tasks to the department extended leadership team. The structure allows the participants to have time to develop and implement meaningful clinical practice innovation strategies to improve quality of care.

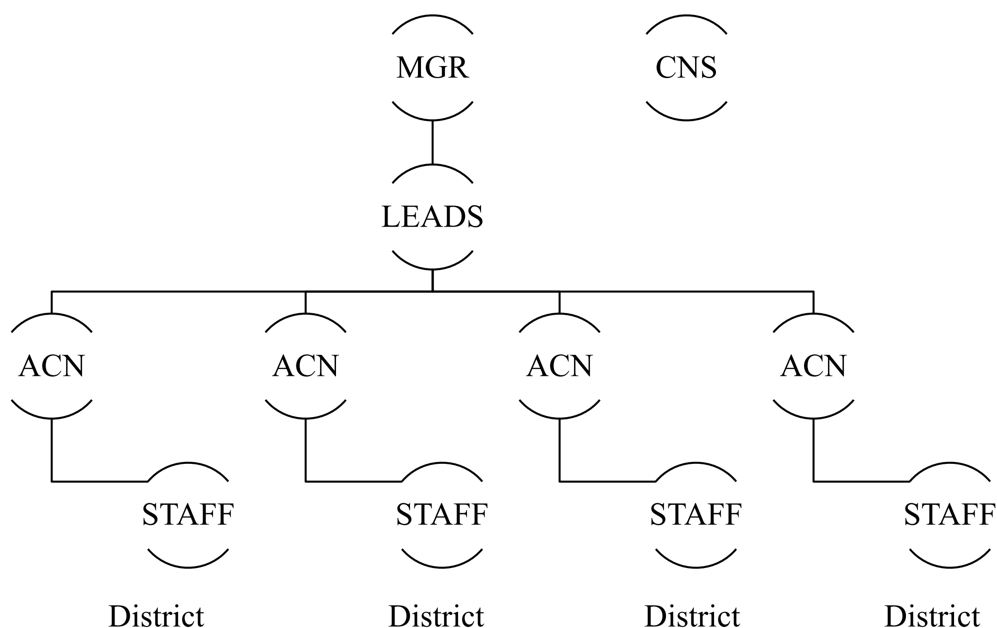

Figure 5. Balanced approach to management of nursing unit. The unit is divided into district with Advanced Clinical Nurse (ACN) reporting to Lead who act as mentor and supervisor, and report to the manager. The Certified Nurse Specialist (CNS) work in the Nursing Center of Excellence

All eight participants identified organizational structures that included appropriate and effective district structures. H2P6 stated, “I need to get used to it. I never used one before in my previous organizations. The leads and ACNs are between me and the front line to capture the voice of the frontline staff and bring it to me. I like the balanced approach to management of the department.” The participants attested to the effectiveness of having competent departmental extended leadership team, which they engage in departmental strategy development. As a result, middle managers focus on appropriate strategies to impact change that is supported by active senior leaders and extended leadership teams.

Two participants attested that the support structure helps managers focus on developing strategies to improve the quality of care at the bedside (H1P3, H2P5). Eight

of the participants described the support structure as having a transparent distribution of tasks, role and responsibilities, and line of authority. This finding is in alignment with Kwamie (2015) who suggested the organization should establish a balanced approach to management and leadership to be able to deliver expected outcomes. H2P7 stated, “The manager support structure works well because of our flat organization structure.”

All eight participants indicated the value of a flat organization structure in which everyone has direct access to the senior leaders without layers of management in the chain of command. The flat organizational structure allows participants to get the approval of their strategies quickly. A flat organization structure has few or no multiple levels of management between the senior leaders and the frontline staff (Qi, Tang, & Zhang, 2014). When everyone in the organization can communicate with different levels, these actions can compress the chain of command and increase communication between employees and management. (Steiger, Hammou, & Galib, 2014). For example, three of the participants noted that even though they report to the nursing unit director, they communicate with the chief nursing officer directly (H1P1, H2P5, H2P7)

According to Friis, Holmgren, and Eskildsen (2016), the flat organizational structure strategy has a significant impact on performance, and middle managers’ ability to execute and achieve the most significant impact, which depends on the organizational capacity to be (a) flexible, (b) innovative, and (c) productive. H1P1 and H2P5 stated, “We are fortunate to have managers’ support structure and a flat organization structure. Manager’s support structure supported by our flat organization structure promotes creativity and innovation. Um with a hierarchical structure, we will not be as successful

as we are now." H1P1 and H2P5 statement aligned with Buschgens, Bausch, and Balkin (2013) and Gutberg & Berta (2017) who noted an organization with hierarchical structure emphasizes control and focus internally and is less likely to promote innovation.

H2P8 stated, "The manager support structure is helpful because the unit leadership team who report to me can focus on day-to-day operations, while I focus on developing innovative strategies for us to achieve our goals and improve the quality of care at the bedside." Organizations promoting innovation have a culture of creativity and a flat organizational structure with leaders devoted to change (Buschgens et al., 2013). All eight participants noted the importance of being able to have access to senior leaders who champion change and support managers.

H2P5 stated "We can interact directly with the executive team, which enable faster decision making, execution, and autonomy to implement appropriate change." When I asked a probing question to know what the participant meant by autonomy, H2P5 responded, "Autonomy refers to the degree to which we have the discretion, freedom, and independence to schedule work; make a decision in planning and managing resources and the implementation of innovation. H2P5 definition of autonomy aligned with Globocnik and Salomo (2015) who stated that strategic autonomy is the freedom to carry out innovative activities without the supervisory approval.

The CNS work in the Nursing Center of Excellence, which is another source of support for managers. H2P6 stated, "We have a center of nursing excellence with three nurse PhDs that we can consult and learn about evidence-based innovation to implement at the bedside." Four of the participants describe the organizations as a learning

environment with emphasis on research and development (H1P2, H1P4, H2P5, H2P6). The exploration and or development activities presented by the study participants, and the organizational learning theory suggests that middle managers can successfully impact change with an appropriate support structure.

Subtheme 3: Build a safe climate. All eight participants explained their holistic approach to safety as priority number one throughout the organization and H1P1 stated, “I always make sure that my staff feel safe to do their work and to talk to me or anyone in the organization. There is no substitute for feeling safe in the work environment.” Safe climate as a concept derived from individuals' shared perceptions of the various ways that an organization value safety (Griffin & Curcuruto, 2016). Employees’ perceptions of management commitment to safety relate to leaders exhibiting safety behaviors and promoting safe climate within the workplace (Schwatka & Rosecrance, 2016).

Lallemand (2012) suggested that organizational leaders should integrate safety into the culture. Safe behaviors were important to H1P4 who explained that everyone in the department feels safe to challenge abnormalities and promote safe behaviors. Everyone can challenge each other when in presence of an unsafe behaviors or activities. For example, H1P4 stated that one of the nurses challenge the participant for not following the hand washing protocol. H2P7 explained, “We have also launched a safety initiative. We discuss safety event daily at our operation briefing at 9:00 am. My job is to promote a safe climate and provide my staff with a healthy work environment.”

In a safe climate, employees are usually committed, engaged, and promote safety practices and behaviors (Gao, Chan, Utama, & Zahoor, 2016). According to Lallemand

(2012), employees' behaviors that promote a safe climate reflect their understanding of the safety strategy as a top priority. Four of the participants associated a positive safety culture with employee engagement, increased job satisfaction, organizational commitment, and retention (H1P1, H1P4, H2P5, H2P7). A study performed by Gao et al. (2016) result showed a positive safety culture established at all level of the organization is an essential element of an innovative organization. A safety culture in healthcare environment may prevent or reduce sentinel events and improve overall quality of care.

Two of the participants mentioned management behaviors and safety-related practices as elements that foster safe climate within the organization (H1P2, H2P5). H1P3 stated, “I focus on building a safe climate because it promotes an open and healthy work environment.” H2P8 added “I view safe climate as more than tracking performance measures such as frequency of accidents, but it is more about the environmental effects on staff behaviors, which can affect performance.” The safe climate finding aligns with previous literature.

The results of studies performed by Gao, Chan, Utama, and Zahoor (2016) and Schneider, Ehrhart, and Macey (2012) showed a favorable safe climate established both at the organizational and departmental levels as an essential element for a high performing organizational. The organization culture theme and the subthemes finding strengthens the body of knowledge on existing business practice by showing strategies that business leaders can leverage in their organizations.

The findings from this study align with prior findings by Ratnapalan and Uleryk (2014), and Hartnell et al. (2011) who suggested that organizational culture is the glue

that holds the team together and a precondition for teamwork for a successful implementation process. According to Chang and Lin (2015), understanding the importance of culture within an organization is essential for the success of innovation implementation. The internal organizational context factors contribute significantly to the development of the strategies which align to previous studies.

Subtheme 4: Promoting collaboration. Collaboration among healthcare professionals is an essential factor leading to high quality of care and patient safety (Romijn, Teunissen, & Bruijne, 2018; Edmondson & Lee, 2014). All eight participants indicated that collaboration is a critical element in patient safety and the entire organization success. For example, H1P1 stated:

> We have a collaborative culture. We collaborate among ourselves and support each other. I promote collaboration in my department by focusing the team on the goals and vision of the department and the overall organization. It is easy to gain cooperation as long individual understand the *Why* and see where it fit within the organization overall goals.

H1P3 stated, “We use social media as a collaboration tool to send messages to all nurses to identify those available to work in an area that is short of staff regardless of their assigned unit.”

Collaboration improved health outcomes by enhancing decision-making process, improving knowledge transfer, sharing of evidence-based information, which are transitional predictors of quality (Morley & Cashell, 2017). Nwibere (2013) noted that managers need to promote collaboration, which is a significant factor in the attainment of

organizational goals. Halonen et al.'s (2017) study showed that through partnership, members of an organization could experience equal opportunities to participate, build teams, and share knowledge. H2P6 explained:

> We have a collaborative culture receptive to change. I collaborate with clinical nurse specialists, other department leaders, physicians, and executive leaders. As nurse managers, we identified a gap between staff professional development and managers development. We felt like a forgotten group with limited opportunities for professional growth. We took control of the problem and created a nurse managers' forum with the objectives to provide each other support, promote collaboration, share our frustrations, and discuss any issues we may face as colleagues. The platform was also to enhance our professional learning and speak with a collective voice. We mentor and coach each other. As partners, we have a common vision and goal. The forum helps me stay afloat. I have camaraderie and lots of collaboration with my colleagues.

Five of the participants emphasized the concept of interprofessional collaboration to improve the quality of care (H1P2, H1P2, H1P3, H2P5, H2P7). H1P4 stated, "When I develop my strategy I usually include everyone who will be affected by the change because we function in an interprofessional and multifunctional environment. I promote synchronization of tasks almost like playing in a symphony." H1P4 expressed that a collaborative work environment had increased the staff morale, engagement, and reduced attribution. H1P2 attested that everybody wants to contribute to the improvement; The

frontline wants to learn and are always ready to assist, which gives them a sense of accomplishment and a chance to collaborate with management, physicians, and peers.

All eight participants attested to focusing the team on the vision and goals of the department and the overall organization by explaining the *Why of change* and how it aligns to the vision and goals and also how the change benefits the frontline staff. Six participants noted collaboration as a shared responsibility and authority among the teams involved, which require coordination, cooperation, shared decision-making and respectful partnership (H1P2, H1P3, H1P4, H2P5, H2P7, H2P8). Three participants stated that collaborative work environment had enabled employees' engagement and retention (H1P3, H1P4, H2P6). All eight participants noted an organizational culture that promotes collaboration at all levels of the organization builds teamwork, comraderies, transparency and improves staff retention. According to Morley and Cashell (2017), collaborative strategy builds teamwork, increases retention, and promotes transparency.

The collaboration strategy strengthens the body of knowledge on existing business practice by showing practical strategies that business leaders may use to establish a productive organizational culture. The inclusion of all members of the organization creates a culture supportive of innovation implementation and change (Larsen, 2015). Collaboration finding aligned with earlier study finding by Korner et al. (2015), Urquhart et al. (2014), and Safdari et al. (2015), who noted that interdisciplinary collaboration in healthcare organizations promoted teamwork and team effectiveness, which has a direct effect on the overall organizational performance, patient safety and satisfaction.

Subtheme 5: Encouraging teamwork. Effective partnership happens when organizations have open communication and mutual trust culture, and everyone works as a team towards a common goal (Yang et al., 2017). All eight participants indicated that teamwork is a critical element in patient safety and the entire organization success. Two participants stated, "The organization culture base on teamwork was one of the organizations' guiding principles" (H1P4, H2P6).

Four of the participants defined teamwork as the interaction among engaged employees performing a specific task to meet a common goal (H1P2, H1P3, H2P5, H2P7). The participants' definition aligned with Shuck et al. (2013) who noted teamwork as engaged employees' interaction with each other as a group to perform a task. H1P2 stated, "Teamwork help open line of communication, and foster relationship both at work and outside work, people respecting each other and working together to achieve a common goal."

Seven of the participants attested to the importance of collaboration in building a teamwork environment (H1P1, H1P2, H1P3, H1P4, H2P6, H2P7, H2P8). H1P4 stated, "When I develop my strategy I usually include everyone who will be affected by the change because we function in an interprofessional and multifunctional environment. I promote synchronization of tasks almost like playing in a symphony." H1P4 expressed that a collaborative work environment had increased the staff morale, engagement, collaboration, teamwork, and reduced attribution. H1P2 provided the following example:

> I include staff in the development of protocols. The frontline wants to learn and are always ready to assist, and it gives them a sense of accomplishment and

> satisfaction. The organization needed to receive a certification for the new location. I got my team involves in the implementation strategy development. We worked as a team and collaborated to ensure we pass our certification inspection. The team worked a full schedule and stay over to make sure they practiced. We simulated the process and performed a test of change. The team showed ownership, commitment, engagement, and pride. Yes, we did get the certification and move into our beautiful location. My staff was happy to learn all the processes as a team.

H1P1 stated, “When somebody got sick on a Friday and was unable to work their weekend shift, three nurses got together and worked it out to cover the weekend shift.” H1P3 stated, “I hosted a wine tasting event as a teambuilding exercise, which included everyone in the value stream involved with taking care of patients. I am a believer in the benefit of diversity that is part of teamwork.” The inclusion of all members of the organization creates a culture supportive of innovation implementation and change (Larsen, 2015). Many researchers across disciplines have discussed teamwork as an element in an active organization (Epstein, 2014; Morley & Cashell, 2017; Parker, Jacobson, McGuire, Zorzi, & Oandasan, 2012).

H2P6 noted, “We work together and have adopted a systems-thinking approach.” In promoting a teamwork culture, H2P6 explained the importance of involving everyone without discrimination and mentioned that Machiavelli's approach has no place in any organizational culture because it takes the diversity of skills and ideas to create a high performing team. The Machiavellian leadership has direct and indirect effects on

employees, which lead to emotional exhaustion and poor performance (Gkorezis, Petridou, & Krouklidou, 2015; Bakker & Costa, 2014). Eaton and Kilby (2015) noted that teamwork is a critical factor in a participative and inclusive organizational culture. According to Yunus and Tadisina (2016), business managers use teamwork strategy to improve performance and productivity in a high-performing organization.

In a hospital environment, different health professionals coordinate activities to deliver safe and efficient care to patients. Baker, Day, and Salas (2006) noted teamwork as a crucial element in the delivery of high-quality care. Eight of the participants shared that the organizations promote team care approach instead of primary care approach, and participants are all advocates and support the innovative approach. Five of the participants indicated that every function within the hospital is essential and all work together to deliver the same goals, so it is vital to work together and adopt a systems-thinking approach (H1P1, H1P2, H2P5, H2P6, H2P7). All participants spoke of building the team and encouraging a teamwork environment. Teamwork is a vital strategy for a high-performing organization (Epstein, 2014)

Subtheme 6: Reward and recognition. A system of reward and recognition is a significant factor used by the organization to motivate and enhance employees' engagement (Ismail & Ahmed, 2015). All eight participants indicated that reward and recognition had a significant impact on the employee's commitment, engagement, and performance with H1P5 stating, “As managers, we always remember to recognize and reward our staff.” Three of the participants indicated that rewarding and recognizing employee that goes above and beyond their duties as a strategy to motivate

underperformers to improve their performance (H1P2, H1P4, H2P5). The three participants' statement supports Bradler et al. (2015) study, which showed top performers' recognition increase performance substantially, but the authors noted that low-performers were mainly responsible for the improvement in performance.

Seven of eight participants believed in acknowledging their staff performance often, and always celebrating success and discussing failure as learning opportunities. H1P1 attested that the organization have an excellent reward and recognition system and shared the following strategies, "I thank my team often. I tell them how much I appreciate their effort and support. After a verbal thank you, I follow up with a thank-you card. I always recognize all the good deeds. Little things go a long way."

Additionally, H1P3 explained:

> I introduced a drawing called the Pickle Award. The winner takes a picture with this obnoxious pickle and we publish the image in the organization newsletter; the staff loves it. I write applause cards, and the cards get highlighted on a daily basis throughout the hospital. I make a point to recognize everyone, and I tell the staff how important they are to the department and our patient. We also have the Daisy Award. One of my nurses won the Daisy Award, I got so emotional, and I felt like one of my children won the prize. I was very proud to see one of my nurses receive the award. I love giving a gift card, movie tickets, massage, and more.

H1P4 added, "Recognized staff attends a luncheon with the executive leadership team. We also do a round of applause outside the cafeteria for all to see, and I post the Star of the Month in the department. It is as simple as telling a staff member who had a

hard day thank you for your service to our patients." Five of the participants noted the significance of recognizing and rewarding staff effort and considering failure as learning opportunities (H1P1, H1P3, H2P5, H2P6, H2P8). H2P5 stated:

> We celebrate everyone birthday; I give wow card at huddle, email thank you card, give candies. I try to meet their needs. We also do the ruffle. I have a prescheduled time on my calendar to step back from putting out a fire to reward and recognize my staff. All failure is a learning opportunity.

Six of the participants indicated that the organizational culture was productive and observed through the employees' behaviors (H1P2, H1P4, H2P5, H2P6, H2P7, H2P8). The reward and recognition component affirm existing business practice in the body of knowledge and adds practical strategies that business leaders may use to establish an effective system of reward and recognition. According to Ismail and Ahmed (2015), reward and recognition are significant factors in employees' motivation. Nurse managers need to have empathy for the frontline and recognize their service to achieve successful change (Yodama& Fukahori, 2017)

Correlation to the conceptual framework. Senior leader support, manager support structure, collaboration, teamwork, reward and recognition, and a safe climate are components of an organizational culture that align with the internal context or *why* of the change dimension of the conceptual framework, which was Pettigrew's theory. The context construct focus is on the structure, organization culture and internal political context within the organization. The internal context dimension is contingent on the management of the content and process of change. The participants' strategy for

promoting awareness and readiness to change aligned with the organizational readiness for change theory.

Theme 2: Leadership

The theory of leadership is dynamic and continues to evolve (Al-Sawai, 2013). Leadership emerged as one of the key themes during the eight participants' interviews. All eight participants attested to the importance of leadership philosophy in the success of clinical practice innovation strategies. Doc3, Doc4, Doc5, Doc6, Doc7, and Doc9 reviews showed an employee-focused leadership approach as the strategy used in the two high performing organizations.

The eight participants attested to the employee-focused leadership is an important factor in the enhancement of organizational performance and profitability. Additionally, four of the participants noted the value of promoting participative leadership to achieve success during innovation implementation process (H1P3, H1P4, H2P5, H2P7). The patients and healthcare professionals consider leadership as an essential component for management and integration of provision of care (Sfantou et al., 2017).

All eight participants explained the practice of employee-focused leadership throughout the organization as an enabler to build trust and staff engagement to achieve best-in-class performance and gain a competitive advantage in the marketplace. H1P4 described a leader as an individual who is a visionary and exemplifies leadership characteristics to influence the subordinates. According to Anonson et al. (2013), an exemplary nurse leader needs to have the following characteristics: (a) passion, (b) optimistic, (c) ability to build relationships with staff, (d) a role model able to mentor and

coach, and (e) be able to manage in time of crisis. Effective clinical leadership is important in ensuring the quality of patient care and in sustaining innovative improvement (Daly et al., 2014).

Four participants attested to participative leadership at the department level in allowing frontline staff some level of autonomy, such that empowered staff nurses made decisions regarding patient care (H1P2, H1P3, H2P6, H2P7). H2P5 stated, "We have a supportive culture, I do not micromanage my staff, I continuously present them with opportunities to improve their leadership skill and ethical decision-making." Engelen et al. (2014) showed that managers working within a supportive organizational culture displayed employee-focused leadership, healthy interpersonal relationships, and ethical decision making.

Employee-focused leadership emerged as a significant component of the internal context of middle managers' strategies. Sinha et al.'s (2016) and Denison's (1990) results confirmed this study participants' statement about the importance of employee-focused leadership to enhance organizational performance and increase profitability. According to Han (2012), employee-focused leadership approach facilitates teamwork and participation, and promotes employees' engagement. In describing leadership, three of the eight participants noted patient-centered care and people-oriented as complement approaches used to achieve a high quality of care. According to Givens (2012), managers practicing in a productive organizational culture encourage excellent customer service and influence their subordinates to innovate.

Table 5 shows the three subthemes or components related to the leadership theme in relation to middle managers strategies, and the frequency of times the participants referenced the subthemes. All three subthemes are equally important and enable participants in the development and implementation of the clinical practice innovation. H1P2 stated, “We are influencers, information diffusers, um sometimes translators, and mediators between strategy and tasks.” Therefore, middle managers need to use appropriate leadership style, be able to communicate and hold staff accountable. A combination of leadership style, communication, and accountability are the significant components of leadership that enable middle managers to effectively influence the frontline staff and implement clinical practice innovation successfully.

Table 5

Subthemes Related to Leadership

Subthemes	Frequency of references	% of references
Leadership Style	95	35
Communication	91	33
Accountability	86	32

Subtheme 1: Leadership style. Seven of the participants noted transformational and servant leadership as prevalent styles used in the management of innovation implementation. Affiliative, democratic, authoritative, and reward contingent component of transactional style complement the two main leadership styles. Four of the eight participants indicated they used different leadership styles based on the situation (H1P2,

H1P4, H2P6, H2P7). Madsen et al. (2005) and Shea et al. (2014) findings depicted the importance of an appropriate leadership style to influence followers to commit and support change. Healthcare professional leadership style and management skills are essential to help improve the quality and integration of care throughout the continuum of care (Sfantou et al., 2017). Participant H2P7 noted:

> I have used transformational style when I implemented a new initiative and needed to influence my team, and reward contingent component of transactional style based on performance for favorable work performance and behaviors. Servant style when in crisis mode and authoritative style when I have a problematic staff member and need to meet a deadline.

A transformational leadership style is a top-down approach that promotes nursing satisfaction and a positive working environment (Fischer, 2017). According to Fischer (2017), a transformational leader has a significant influence on follower engagement and teamwork. Six of the eight participants found meaning and purpose in their work by inspiring others to develop into effective leaders (H1P1, H1P3, H1P4, H2P5, H2P6, H2P7). Transformational leaders empower, inspire, motivate, influence, apply intellectual stimulation, communicative, and promote the creativity of ideas (Lin, MacLennan, Hunt, & Cox, 2015). The eight participants described themselves as optimistic, charismatic, passionate, honest, engaging, idealistic, and team oriented; able to communicate clearly and translate the message in a language the frontline can understand; and influencers. The participants practice active listening and empower staff and give the staff autonomy with a level of control. Weibel et al. (2016) suggested control practices indicate the

organization predictability, reliability, fairness, and ability. Controls lead to an organization perceived support and as such facilitate employees to trust the organization (Verburg et al., 2017; Weibel et al., 2016).

H1P3 explained the servant leadership style as a bottom-up approach. According to Savel and Munro (2017), servant leaders emphasize the organization goals and objectives over personal aspirations. Seven of the eight noted that one of their personal goals and mission in life is to serve others (H1P1, H1P3, H1P4, H2P5, H2P6, H2P7, H2P8). H1P4 stated:

> Um. . . servant leadership should come naturally to nurse because of our profession. Democratic style is applicable when I am looking for buy-in, but I notice that it works well with competent team members, or when you run out of ideas and need to make a quick decision. I use democratic style to build respect, commitment, and trust."

Eight of the participants indicated that managers should identify the primary behavioral characteristic they use to make decisions because behaviors determine leadership style and know when to apply different leadership styles. The best way to influence subordinates is to use the right leadership style, which may require using different styles to achieve expected results (Munro, 2017; Spears, 2010). According to Sinha, Garg, Dhingra, and Dhall (2016), including employees in decision-making and applying employee-focused leadership leads to productive organizational culture.

Subtheme 2: Accountability management. A healthy relationship exists between accountability, leadership, and organizational culture (Bustin, 2015). In driving

accountability, five of the eight participants explained using results-based accountability, as having the end in mind and developing ways to achieve the expected results. Seven of the eight participants attested to promoting ownership and empowering and noted a linkage between empowerment and ownership to achieve accountability (H1P1, H1P3, H1P4, H2P5, H2P6, H2P7, H2P8). H2P5 explained, “I assign challenging assignments to staff to give them an opportunity to challenge themselves and achieve their full potential . . . I make sure I know their interests and abilities . . . I don’t hold them accountable for things out of their control.” Accountability is an essential element that can affect organizational culture and performance (Bustin, 2014).

When an organization infuses accountability in the culture, the culture of accountability fosters self-reliance and confidence at every level of the organization (Christie, 2018). H2P5 stated, “I make sure to empower my staff, set clear expectations, they take ownership of the tasks and I hold them accountable.” According to Jamal, Essawi, and Tilchin (2014), accountability is an element of a successful organization where employees are reliable, keep commitments, and exhibit ownership behaviors. Managers have the responsibility to develop an accountability framework that involves empowerment and ownership (Christie, 2018). Takaki’s (2005) study results showed an organization revenue increased by 50% and profitability by 200% after implementing ownership, empowerment, and accountability strategies.

Additionally, two of the participants explained ownership, empowerment, and accountability as the guiding principles in their employee-focused organizational culture. When I asked the how question to participants regarding accountability (probing

question), H1P1 stated, “I coach my staff to take ownership of tasks and encourage them to come up with solutions to problems . . . I focus on their ability and willingness to achieve the best result.” H1P2 noted, “I reduce the noise, focus on the result, staff take ownership of the change and I hold them accountable for the result.” When an organization promotes ownership and empowerment as factors of accountability, the organization achieves a competitive advantage to drive change and innovation (Ongori & Shunda, 2008).

Three of the eight participants noted the actions of employees, choices, and behaviors and indicated the importance of defining specific, measurable, attainable repeatable, and timely (SMART) measures into the innovation implementation process (H1P1, H1P2, H2P5). H2P6 explained:

> We work with our team to set SMART goals and hold them accountable for the result. We teach our leads project management and hold them accountable for the milestones and deliverables, and schedule meeting to meet with each lead to track progress based on the schedule.

Denison (1990) showed employee-focused leadership culture promotes a sense of responsibility and ownership, which leads to improving accountability, employees’ performance, productivity, and profitability.

According to Fernandez, Moldogaziev, and Fernandez (2013), staff empowerment involves sharing of information (goals, objectives, performance, and resources), providing access to job-related knowledge and skills, and sharing authority. H1P2 noted:

> I notice a nurse who always helps other nurses . . . to encourage and empower her, I assigned her to lead a patient family workshop to improve her leadership and presentation skills. She was thankful for the opportunity. I also have seven nurses involve in different committees.

An organization which promotes accountability culture achieves superior performance and quality, and the teams are dynamic with open communications between employees and managers (Jamal & Abu Bakar, 2017).

Subtheme 3: Effective communication. In the healthcare industry communication has a healthy relationship with patient safety, quality of care and patient and families' satisfaction (Engle et al., 2017). All eight participants expressed the importance and value of effective communication strategies to ensure successful implementation of clinical practice innovation at the bedside. The participants attested to using open communication as a strategy to build trust and influence their team towards a common goal. Effective partnership happens when organizations have open communication and mutual trust culture, and everyone working towards a common goal (Yang et al., 2017).

Participant H2P7 indicated, "Competency in communication is essential, which may include active listening, showing empathy for your staff, speaking in a tone and language they can understand." Managers and frontline staff should have no communication gap (Helfat & Peteraf, 2015). H1P2 stated, "Delivering a disrespectful message to the staff has a detrimental effect on the organization." The quality of communication between a leader and the subordinates can affect employees positively or

negatively (Gallagher & Gallagher, 2012). Six of the participants noted that holding the line of communication open is a way to accomplish unity of purpose, department goals, and objectives (H1P1, H1P2, H1P4, H2P5, H2P7, H2P8). The communication theory proposed by Scudder in 1980, stated that all the livings organisms communicate by using different methods.

All eight participants explained using different communications methods, which included e-mail, social media, internal newsletter, training, one-to-one coaching and mentoring, and daily management performance board, department daily huddle, staff meeting, senior leaders townhall, and direct exchanges with patient and families. H1P4 noted, “In a hospital environment, failure to communicate effectively leads to sentinel events and poor quality of care.” H2P7 added, “I include training in communication to emphasize the linkage between staff knowledge level, competency, and excellence in communication.” According to Tench & Moreno (2015), leaders achieve the organizational purpose, goals, and objectives through effective communication with the employees.

Six of the eight participants discussed the importance of communication and explaining the why to their subordinates (H1P1, H1P3, H1P4, H2P5, H2P6, H2P7). H2P8 stated:

> I helped my staff understand the reason for the change. I explain why the change is important, what does the change mean to the frontline? What does it mean to the patient? What does it mean to the doctors? What does it mean to the hospitals? What does it mean to the healthcare? And what does it mean to the world? I can’t

> just tell them to do it but not explain the why. When they understand the why, they are much more responsive to the change.

Leaders at all levels of the organization need to communicate their strategies and the reason for change to the frontline staff effectively (Northouse (2016).

Four of the participants indicated that everyone in the organization is free to share their thoughts, concerns, ideas in a respectful way without fear of retaliation (H1P3, H1P4, H2P6, H2P8). H1P4 stated, “I communicate the change repeatedly to ensure successful implementation.” H2P8 added, “I make sure to deliver a consistent message.” The participants of this study indicated communication as a significant strategy and an enabler of innovation implementation success. Therefore, leaders need to know their audience and translate the message in a language the audience can understand because success depends on the message delivery. Communication is important for the survival and success of innovation implementation (Mayfield & Mayfield, 2017). Leadership style, effective communication, and accountability are significant components of leadership and have a crucial role in employee-focused leadership.

Correlation to the conceptual framework. Leadership style, effective communication, and results-based accountability are components of leadership that aligns with the internal context or *why* of change dimension of the conceptual framework Pettigrew’s theory. The internal context dimension is contingent on the management of the content and process of change. Seven of the eight participants stated the importance of examining their communication from different viewpoints (H1P1, H1P3, H1P4, H2P5, H2P6, H2P7, H2P8). Additionally, the participants’ communication strategy aligns with

communication theory framework, which demonstrated how to examine communication based on mechanistic, psychological, social, systemic, and critical viewpoints.

Theme 3: Management by Objectives (MBO)

Seven of the participants explained using the three components of MBO philosophy: (a) planning, (b) monitoring, and (c) performance appraisal. The participants use the MBO conceptual model as seen in Figure 6. The MBO framework is a robust method for developing team efficiency, productivity and employees' job satisfaction that results in clear expectations, enhance employees' performance, empowerment, and competency (Aggarwal & Thakur, 2013). MBO is a management philosophy developed by Peter F. Drucker in 1954 and was introduced in his book, *The Practice of Management,* emphasizing employees' contributions and accountability to the goals and objectives.

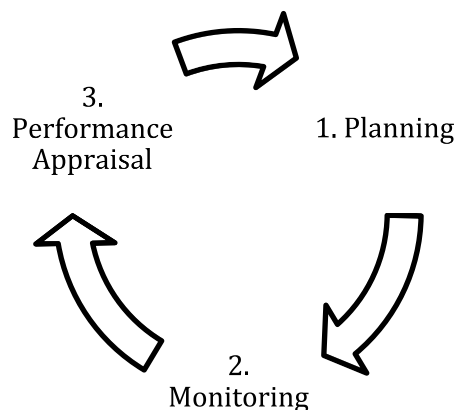

Figure 6. Management by objective (MBO) conceptual model. Adapted from the "Using management by objectives as a performance appraisal tool for employee satisfaction" by X. Islami, E. Mulolli, and N. Mustafa, 2018, *Future Business Journal, 4*, p. 98.

The MBO strategy validates a clear definition of objectives, appropriate allocation of resources, while leaders focus the effort on strategic goals, real-time feedback, and effective communication (Islami, Muloli, & Mustafa, 2018). The two parameters of the MBO appraisal tool are the evaluation of the individual's performance and providing feedback and a clear definition of the expected results (Longenecker, Fink, & Caldwell, 2014). All eight participants encourage real-time constructive feedback and have ground rules and a standard process in place to deal with complaints, with participant H2P8 stating, "Staffs are receptive to real-time constructive feedback and they see it as a learning opportunity."

H2P5 stated, "My staff knows what I expect from them because I involve my staff in establishing expectations." H1P3 added, "I allow my staff to determine how they are going to meet the expectations." H1P3, H2P5, H2P8 described elements of Result Oriented Management (ROM) theory by Schoutenard & van Beers (1996), which purpose is to achieve maximum results based on well-defined measures agreed with the frontline upfront. ROM is a top-down and bottom-up approach to management.

All eight participants described using a systematic approach to MBO (SAMBO) to understand the interdependency among the systems, subsystems, the environment, and the staff. The participants use the SAMBO framework to establish goals and objectives, measure performance, promote effective communications, and enhance employees' development and feeling of empowerment. I asked H2P6 a probing question to understand the SAMBO framework within the participant's strategies. Participant H2P6 responded, "Um, it is important to understand the content or what of change. SAMBO

allowed me to understand the deliverables and the performance measures. Then I am able to develop strategies to engage my staff and achieve the expected goals and objectives." According to de Waal and van der Heijden (2015), a strong and significant correlation exists among all the performance management dimensions and high performing organization factors.

H1P4 stated, "SAMBO is an integrated framework that everyone follows to ensure a balanced and standard approach to management that creates a fair and just environment receptive to change, which is important when initiating change." The performance management system promotes performance-driven behaviors, which is essential and strengthens overall organizational financial and nonfinancial performance measures (de Waal & van der Heijden, 2015). A strong and significant correlation may exist among all the performance management dimensions and high-performing organization factors.

Additionally, participant H2P5 noted, "We use the 360-employee performance assessment tool, while operating under the guideline of SAMBO framework as a systematic approach to defining the expected process results." Organizational leaders use a performance appraisal framework to measure employees' efficiency and effectiveness and develop individual professional development plans (Aggarwal & Thakur, 2013). H2P7 explained the value of skill assessment information, "I use the information from skill needs assessments to create a pocket of experts and excellence within the unit. I share performance result, and I make the time to review and discuss performance

evaluation with each employee." H1P4 added, "Individual professional development plan results from the skill need assessment."

Weihrich introduced SAMBO in 2000 as a systematic approach to the MBO framework, as seen in Figure 7, which includes seven elements: (a) strategic planning, (b) settings goals and objectives, (c) creating action plan, (d) implementation of MBO, (e) control and appraisal, (f) organization sub-systems, and (g) organizational and management development. Weihrich acknowledged the organization's interdependency to its environment from an open systems viewpoint and explained SAMBO as a holistic management system to integrate significant organizational activities while highlighting the interdependency.

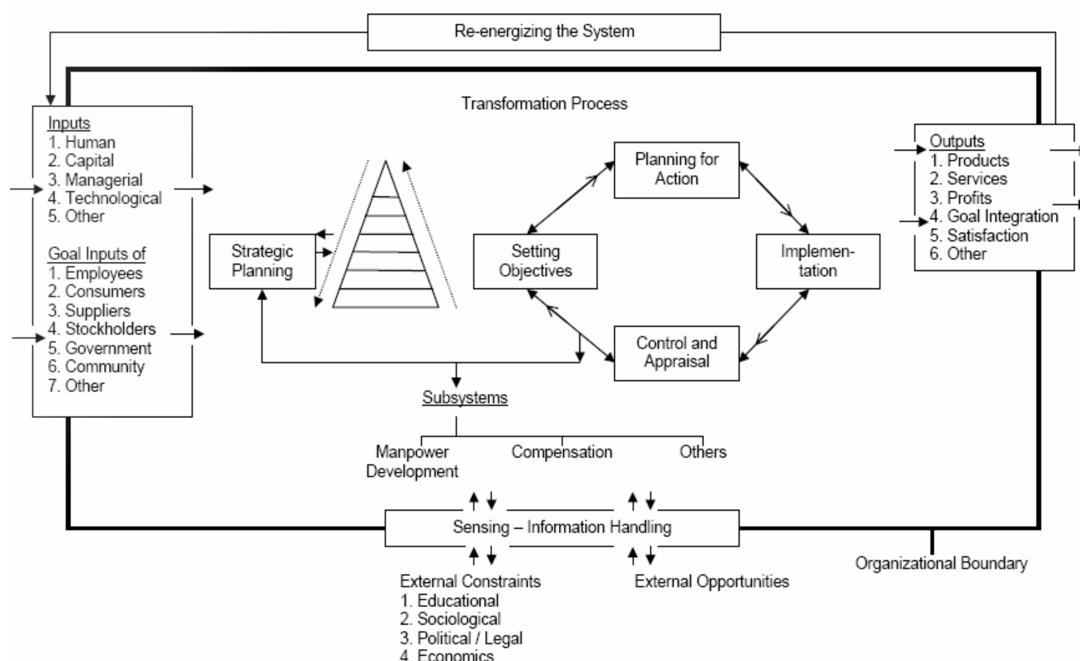

Figure 7. Weihrich's model–SAMBO (source: Weihrich, 2000), Weihrich, H. (2000). *A New Approach to MBO, Updating a Time-Honored Technique*. (PhD thesis), Arizona State University, Tempe, Arizona

High-performing organization leaders using SAMBO as a management philosophy are transparent, promote collaboration, explain the why, clarify expectations and hold the employees accountable (Islami et al., 2018). The advantages of SAMBO include an increase in employee morale, motivation, and participation; improve communication and collaboration, and increase managers' support of the employees (Aggarwal & Thakur 2013). Leaders use planning, control mechanisms, guidelines for performance review, and performance-based employee evaluations with the goal to diagnose employees' competency level (Shaout & Yousif, 2014). Weibel et al. (2016) suggested control practices indicate the organization predictability, reliability, fairness, and ability. Controls lead to an organization perceived support and as such facilitate employees to trust the organization (Verburg et al., 2017; Weibel et al., 2016). High-

performing organizations create competitive advantage through employee's development by enhancing knowledge through sharing, training, performing staff assessment, diagnosing staff competency, and promoting employee empowerment.

Table 6 shows the two subthemes or components related to the management by objectives (MBO) theme in relation to middle managers strategies, and the frequency of times the participants referenced the subthemes. The two subthemes are equally important and were used by the participants in the development and implementation of the clinical practice innovation at the bedside. H1P2 stated, "Know your business, know your patients, know your employees, know your goals and objectives, and use the right management approach." Middle managers need to have an appropriate management framework, have competent employees and promote continuous improvement.

Table 6

Subthemes Related to Management by Objectives (MBO)

Subthemes	Frequency of Reference	% of Reference
Continuous Improvement	75	51
Competency	71	49

Subtheme 1: Promoting continuous improvement. During the interview, all eight participants used the term performance improvement, process improvement, and continuous improvement interchangeably. Process improvement is an element of Category 6 Section 6.1 in the 2017-2018 Baldrige Criteria for Performance Excellence Categories and Items (U.S. Department of Commerce, 2017). Six of the participants

stated that their organizations have a commitment to evidence-based performance improvement and promote Define, Measure, Analyze, Improve, and Control (DMAIC) roadmap from Six Sigma methodology as the performance improvement process (H1P1, H1P3, H1P4, H2P5, H2P6, H2P7). The organizations enrolled everyone in the continuum of care in their culture of performance improvement to enhance quality of care and safety. Two participants attested to receiving training in Lean and Six Sigma and were either green or black belt certified (H1P4, H2P6).

According to Burgess and Radnor (2013), quality tools applied in manufacturing have emerged in other industries such as healthcare with successful results. The continuous improvement strategies used by the participants contains three elements: (a) Lean Six Sigma, (b) data-driven decision-making, and (c) simulation or test of change. Five of the participants compare DMAIC to the plan do check act (PDCA) framework (H1P1, H1P3, H1P4, H2P6, H2P7). Lean Six Sigma promotes data-driven decision making and discourages assumptions-based decision (Lin et al., 2013). Healthcare professionals used PDCA successfully as a framework to make an incremental improvement, and hospitals have adopted Lean Six Sigma to achieve breakthrough improvement (Gidey et al., 2014).

All eight participants identified leadership, quality tools, project management, change management, benchmarking, high reliability and statistical tools as part of the Lean Six Sigma framework. Lean Six Sigma strategy connects the improvement to the organizational goals, builds ownership, enhances employee morale, improves communication, builds a team and increases employee participation (Watkins et al.,

2014). A high performing organization performs benchmarking and adapts strategies that aligned with the change to achieve their goals with agility and efficiency (Nuchudom & Fongsuwan, 2015). Five of the participants indicated the organizational leaders set goals, and targets after performing external benchmarks with national, state, and regional organizations (H1P2, H1P3, H1P4, H2P5, H2P8). When external benchmarks are not available for comparison, the organization leaders perform internal benchmarks within the healthcare system.

The participants highlighted continuous improvement by providing specific successful clinical practices process innovation examples that have improved patient care and profitability. H1P2 described their handoff process improvement:

> I was having a problem with overtime. I presented the result of my data analysis to the team on how our performance compared to other departments. We were #3 after ICU – for a Medsurg that was not acceptable. I asked the team what we could do so you all can get out on time, and how can I help. I gave the staff a structure data collection template to capture the reason for overtime over a period. Data analysis showed that the handoff process caused the overtime. Using a Lean approach, the team streamlined the handoff process and developed a tool called *Fast*. We performed a test of change. During the implementation, my leadership team and I checked in with the staff every 5 hours to capture their needs, and at that time they can say I do need you to hang this Intravenous (IV) therapy, I do need you to talk to this family. So, we do this check-in, at the end of the day they walk out on time. I collected and analyze the data. The result showing a

> significant drop in overtime. it has only been a week, and it has been amazing. And the staff are feeling happy. I love walking to my car at 7:30 pm.

H1P4 described a streamlined patient assignment process improvement:

> I had nurses that moved quickly and got their patients out, and others were very slow and kept their patients behind the curtain. Five years ago, I streamlined our process of assigning patient. I start working with the coordinators to look at the room, where they needed staff. I look at the schedule and estimate the time of patient arrival, and the team developed a grid where the patient estimated time of patient arrival, so we were able to know which patient should come out and at what time. Then we were able to find out what room to put the patient; I had staff assigned to the room. The improvement was successful; we eliminated the behavior of holding the patient behind the curtain.

H2P5 stated, "We follow an incremental implementation approach to ensure that the team can repeat the change before it becomes a standard process." All eight participants attested in using simulation or test of change before standardizing any new initiative. Five of the participants attested to the importance of data transparency and presentation in a way that everyone can understand and be able to influence positively (H1P1, H1P3, H1P4, H2P5, H2P6). H2P8 stated, "I make sure to explain quality tools I used to display the result of the analyses and help the staff to understand the information I am presenting."

Three participants attested to continuously monitoring performance and adjusting their strategies when needed (H1P4, H2P5, H2P6). H1P1 noted, "I used a visual

management approach. I display performance results on daily management board in support of the organizational commitment to continuous improvement." Six of the eight participants noted the importance of evaluating employees' level of competency and promoting continuous improvement before initiating change (H1P1, H1P3, H1P4, H2P5, H2P6, H2P8).

H2P5 indicated, "We use systematic review of performance as an integrated effort through repeated cycles of improvement as we identified gaps in performance." H1P3 and H2P8 attested that the organizations achieve agility through the frequency of performance-gap reviews and the improvement cycles. Collective wisdom gathered during improvement activities is part of the organization intellectual property used to achieve competitive advantage in the marketplace (Kovach & Fredendall, 2017). According to Calvo-Mora, Navarro-Garcia, and Perianez-Cristobal (2015), organizations can capitalize on the knowledge by standardizing their processes. The finding of this study aligns with Kovach and Fredendall (2017) study findings that showed evidence on the significance of an organizational structure in support of continuous improvement

Subtheme 2: Developing staff competency. Ali et al. (2016) described the concept of competency through assessment of individuals in skills such as problem-solving, decision making, communication, time management, and achieving the result. H1P1 stated:

> I promote leadership position from inside my department because I know my staff competency and I can set expectations based on their capability. I spend the time to develop potential leaders as part of my succession plan. When I hire, I consider

> a candidate based on my department culture, and I look for alignment with the organization and department vision, mission, and objectives.

H2P5 added, “I evaluate the goal by *what* the individual or team can achieve, and competency by ‘how’ the individual or team completed the task.” According to Zaim, Yasar, and Unal (2013) and Prabawati, Meirinawati, and Oktariyanda (2017), competency is a combination of individual or collective tacit and explicit knowledge, capability, behaviors, and skills used by an individual to achieve expected results.

All eight participants acknowledged the responsibilities to hire competent and capable individuals who are able to maximize productivity and deliver value to the organization. Six of the participants noted managers planning to implement clinical practice innovation should consider both the outcomes and staff competencies to achieve the best result (H1P1, H1P3, H1P4, H2P5, H2P6, H2P7). Most organizational leaders develop the competencies of the employees because they consider them human capital and believe the investment has a high return in productivity and profitability in the long term (Kolibáčová, 2014).

Two of the participants noted employees’ competency as an input in any process that delivers high quality of outcomes (H1P1 & H1P4). Four of the participants noted that training was an essential factor to improve employees’ knowledge and competency (H1P1, H1P3, H2P5, H2P6). Additionally, the participants focus on employees’ well-being. As a result, the organizations gain a competitive advantage in the marketplace. All eight participants indicated being part of learning organizations. H1P4 explained, “We promote formal and informal learning opportunities, participation in conferences,

benchmarking high performing organizations, and knowledge sharing as a means to improve employees' capability."

H2P5 added, "We use Real Learning Solutions (RLS) and team members share their projects." Six out of the eight participants attested to knowledge creation and sharing by everyone in the organization (H1P1, H1P3, H1P4, H2P5, H2P6, H2P8). A high performing organization enhances employees' knowledge level (Noe, Clarke, Klein, 2014). Knowledge derives from the transformation of data into information (Hicks, Dattero, & Galup, 2007). All eight participants discussed using the knowledge hierarchy as seen in Figure 8 to transform data into usable information to guide fact-based decisions.

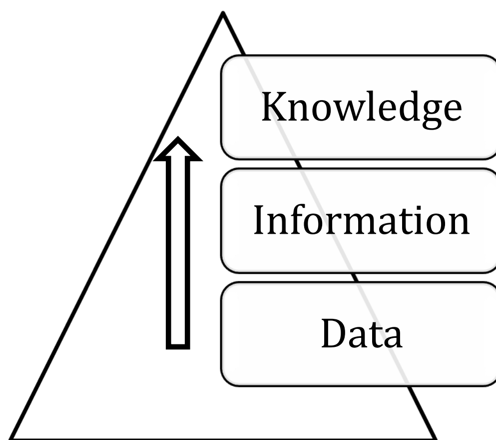

Figure 8. Knowledge Hierarchy. Adapted from the "The Five Tier Knowledge Management Hierarchy" by A. Hicks, S. Galup, and R. Dattero, 2007, *Journal of Knowledge Management, 10*, p. 20.

H1P1 stated, "We have established an environment of trust and respect that encourage individual staff to participate in knowledge building and sharing." According

to Akpotu and Lebari (2014), a significant positive relationship exists between knowledge and employees' performance with knowledge as a predictor of performance. The eight participants confirmed the significance of increasing staff members' knowledge, competency, and awareness of change as contributing factors in employees' performance improvement during the implementation process.

Three participants noted the importance of having a research and development Nursing Center of Excellence staffed with PhD-level individuals as a source of evidence-based innovation, which anyone in the organization can consult and attain knowledge (H1P4, H2P5, H2P6). H1P3 noted, "I found it refreshing having a center of excellence staffed with PhDs whom we can depend on to provide the knowledge we need to improve quality of care. The center of excellence shows commitment from our executive team to building a learning organization." Many learning opportunities emerge from continuous improvement activities, which enhance organizational knowledge (Kovach & Fredendall, 2017).

Correlation to the conceptual framework. Competency and continuous improvement are components of the MBO theme, which aligns with the content or what of change dimension of Pettigrew's theory. The content dimension is contingent on the control of the context and process of change. The context and process dimensions illustrate the content of change. The theorists explained the content construct as a specific area to consider during management of change (Pettigrew & Whip, 1991). Under the Pettigrew's content lens, MBO is an input into the manager's process of clinical practice innovation strategy development.

Additionally, the participants use MBO strategy based on Drucker's MBO theory (1954) framework, targets the alignment of organizational goals, objectives, and those of subordinates throughout the organization to improve organizational performance. Drucker's MBO theory also emphasizes the ongoing monitoring and assessment of processes, staff and feedback loop to the frontline. H2P7 stated, "We use MBO as a precursor to Value Based Management (VBM) approach."

Theme 4: Promoting Staff Engagement

Six of the participants indicated that they used a systematic approach to identify the key factors affecting their staff satisfaction and engagement (H1P1, H1P3, H1P4, H2P5, H2P6, H2P7). H1P4 added, "I integrate improvements that can meet the needs of my staff. Through the application of Lean Six Sigma and organizational culture conducive to high performance, I continuously motivate my workforce." All eight of the participants acknowledged success by inspiring and influencing their staff. The organization provide learning opportunities, knowledge management process, performance management, transparency, effective communication, collaboration, and empower staff to contribute, present solutions and innovate. Strategies that increase staff engagement also increase employees' satisfaction, which raises employees' commitment and leads to an efficient workforce and cost-effectiveness (Holton & Grandy, 2016).

Staff engagement has emerged as an essential management-focused action for maintaining the competitiveness of an organization. An effective engagement strategy is one that involves the leader in leading the process of change (Wutzke, Benton, & Verma, 2016). Five out of eight participants attested that staff engagement and giving staff a level

of autonomy during innovation implementation contribute to improving performance (H1P1, H1P3, H1P4, H2P5, H2P6). Staff engagement contributes to improve performance and create a competitive advantage for the organization (Anitha, 2014; Macey & Schneider, 2008; Nienaber & Martins, 2014). H1P3 stated, "I focus my staff engagement strategy on engaging their hearts and minds. As a result, I gain staff commitment." According to Oldenhof et al. (2016), managers motivate their staff to deliver patient-centered care and inspire them to achieve their full potential when they engage the hearts. Participant H2P5 noted, "Safe climate, ownership, and empowerment lead to higher employees' engagement." Engaged employees invest discretionary effort in achieving organizational goals. H1P1 stated, "Our organization promotes staff engagement activities. As a result, we have the highest employee retention rate."

Staff engagement contributes to organizational productivity and profitability improvement. Staff engagement is an essential factor for an organization to increase productivity, profitability and gain a competitive advantage (Suresh, Manivannan, & Krishnaraj, 2015). Engaged staff exhibit positive work behaviors that contribute to the organization success (Fletcher, 2016). Kaliannan and Adjovu (2015) conducted a comparative study between an organization with engaged staff and one with disengaged staff. Kaliannan and Adjovu's (2015) findings showed the leaders of organizations with engaged staff reported a 10% increase in customer satisfaction, 22% increased profitability, and 48% fewer safety issues than organizations with disengaged staff. Managers need to set expectations, coach and mentor the staff, and hold them accountable for results (Engle et al., 2017). The level of employees' engagement in

healthcare environment affects critical performance measures such as safety, quality, and patients’ and families' satisfaction (Majernik & Patrnchak, 2014). All eight participants stated that they focus on building honest and reliable relationships with their staff. Therefore, they can have honest conversations to identify staff need and elements that can contribute to the enhancement of staff engagement and job performance.

Table 7 shows the three subthemes or components related to the staff engagement theme in relation to middle managers’ strategies, and the frequency of times the participants referenced the subthemes. All eight participants concurred that the three subthemes were significant strategies that facilitated their workforce engagement. Participants’ subthemes strategies to engage staff were (a) building relationships based on trust, (b) building staff commitment, and (c) providing staff reassurance.

Table 7

Subthemes Related to Promoting Staff Engagement

Subthemes	Frequency of References	% of Referenced
Building relationship	34	37
Building commitment	31	34
Providing reassurance	27	29

Subtheme 1: Building relationships. All eight participants indicated they used a pluralistic approach to engagement by promoting a two-way relationship built on trust. Several researchers noted a two-way respectable relationship between the managers and subordinates increase employees’ commitment, built trust, and

enhanced engagement (Vidyarthi et al, 2014; Weibel et al., 2016; Yasir & Mohamad, 2016). H1P4 stated, “I encourage peer-to-peer recognition to increase engagement and productivity. Peer recognition helps build stable relationships, and I have noticed other staff becoming more engaged.” All eight participants stated that they focus on building honest and reliable relationships with their staff. The manager will gain respect from subordinates by acting with integrity, being transparent, and can gain subordinates’ trust (Garavan et al., 2015; Northouse, 2016).

According to Vidyarthi, Anand, and Liden (2014), a manager needs to have outstanding interpersonal and people skills, which are inputs to building a trustworthy relationship that can influence staff job performance. Participant H2P8 noted, “I build relationships by displaying integrity in everything I do, which in turn build engagement. I make sure I keep my commitments and promises. I am ready to roll up my sleeves and help.” Seven of the participants recommended middle managers should focus on building trust, which leads to positive relationships (H1P1, H1P3, H1P4, H2P5, H2P6, H2P7, H2P8). H2P5 stated, “The organization has an open-door policy, which helps to promote open communication, build trust and relationship, and encourage employees’ engagement.” Three of the participants noted:

> We spend most of the awaken time at work thus it is important that we get along with our colleagues and staff. As managers, we rule on relationships. We have increased positive emotional connections with our peers, executive leaders, and frontline staff. We build strong relationships, and we are able to gain commitment most of the time (H1P4, H2P5, H2P7).

Six of the eight participants noted that the organization encourages building relationships and promotes off-site events such as volunteering in the community, trips to an amusement park, a game of football . . . those that cannot play can stand on the sidelines and cheer the players to display *team spirit* and opportunities to build relationships (H1P1, H1P3, H1P4, H2P5, H2P6, H2P8). Bogodistov and Lizneva (2017) noted the importance of establishing boundaries when building relationships to help avoid misunderstanding, thus keep the conversation light until you get to know the person. One must know when they have crossed work-relationship boundaries and quickly pull back because it is more difficult to regain trust (Bogodistov & Lizneva, 2017). Managers who develop relationships with their subordinates to identify issues hindering their job performance is an effective strategy to improve performance (Dainty & Sinclair, 2017; Davenport, 2015).

Subtheme 2: Building staff commitment. All eight participants described the strategy to help build staff commitment should be authentic, transparent, flexible, show respect, and support the staff. H1P4 indicated, “when staff understand the *why* and what is in there for them, it is easier for them to commit.” Participant H2P6 added, “When the staff feel safe and happy, they are quick to commit.” Ongoing employee engagement, a culture of openness, employee-focused leadership, and trust are precursors to building staff commitment (Mangundjaya, 2015; Shin, Seo, Sharpiro, & Taylor, 2015). The happier the staff, the easier it is to get them to commit to working as a team (Chordiya, Sabharwal, & Godman, 2017). Committed staff are more likely to contribute to the organization’s growth and stay longer with the organization.

Another strategy to gain staff commitment is to show compassion, respect, understanding, and practice active listening during conversations with staff (Mangundjaya, 2015; Shin, Seo, Shapiro, & Taylor, 2015; Chordiya et al., 2017). H1P3 stated:

> I build commitment through being present, honest, transparent, and practicing active listening. My nurses said that they hear my voice in their heads while they are working, and it keeps them from making mistakes. [laugh] Is it that funny? I have a committed team ready to go the extra mile.

When the staff believes in their managers, they build commitment and become engaged in implementing clinical practice innovation at the bedside successfully.

Managers should provide a platform for the staff to lead meetings, participate in community activities, engage in peer-to-peer mentoring, explore opportunities to precept new hires, and receive coaching to secure commitment (Meyer, & Herscovitch, 2001). When the employees feel a sense of security, they develop commitment and trust (Verburg et al., 2017). H1P4 stated, “My staff are happy and committed. My strategy is to listen to them and to better get to know each one of them. I have my staff birthdays marked in my calendar and make sure we have a cake in the department to celebrate everyone’s birthday.”

H2P7 explained, “My staff have a strong commitment to providing excellent patient-centered care. For example, several of my staff shared with me that they are not going the extra mile because I told them so, but because they feel a calling to serve others. It is really because they understand the *why* . . . I am lucky to have such

committed staff. I assign my staff to champion events, as a result, they build confidence, engagement, and commitment."

Subtheme 3: Providing staff reassurance. Three of the eight participants mentioned leaders' professional behaviors and communication style can instill confidence in the staff and provide some level of reassurance (H1P3, H1P4, H2P5). Professional behavior, feeling listened to, being informed, and communication style are processes that enable reassurance (Tung, Chen, & Schuckert, 2017). Fareed (1996) noted that receiving information, having knowledge of facts, applying interpersonal skills, and being present are components of the fundamental structure of reassurance.

Past researchers agreed that health professionals are under stress and burnout, which place a high demand on managers to have reassurance strategies in place to maintain staff commitment and engagement (Boran et al., 2012; Chou, Li, & Hu, 2014; Khamisa, Oldengurg, Peltzer, & LLic, 2015; Kumar, 2016; Shin & Lee, 2016). Hospitals in the United States are overregulated environments, where employees experience a high level of stress and burnout (Khamisa et al., 2015; Kumar, 2016). H1P4 and H2P5 indicated, "the importance of managers creating a healthy work environment where staff feel safe with lower levels of stress." H1P3, H2P5, and H2P6 identified burnout and stress as limiting factors to the staff engagement.

Three of the eight participants noted the following attributes were important for a manager: (a) always be prepare for the unknown, (b) be consistent, (c) communicate in person, (d) show sympathy, (e) be honest, (f) do not promise what you cannot deliver, (g) always learn from experience, (h) communicate often, and (i) never delegate giving bad

news to subordinates (H1P1, H2P5, H2P6). Additionally, H1P1 stated, “I watch and listen when a staff experiences anxiety. I demonstrate genuine concern at the same time remain positive and look for an opportunity to encourage and motivate my staff.” Reassurance message from leaders had an empowering positive impact on the receiving staff (Wulandari, 2014). According to Mangundjaya (2015), trust enables commitment, which leads to employee engagement. Kaiser (2016) noted the significance of the interpersonal dynamics, empowerment, and relationships in achieving employee engagement.

Correlation to the conceptual framework. Building relationships, building commitment, and providing staff reassurance are components of staff engagement that participants use to improve clinical practice at the bedside. The findings align with the conceptual framework Pettigrew’s theory process dimension of change. The process dimension is contingent on the management of the context and content of change. The participants explained the process of change as the engagements, responses, and relations between the various interested parties as they seek to improve from the current state to a better future state. In this study, relationships, commitment, and reassurance contribute to staff engagement as the team members seek to improve clinical practice at bedside care.

Applications to Professional Practice

The study results are significant to professional practices and contribute knowledge about the strategies used by middle managers to improve the organizational performance, profitability, and gain competitive advantage. The study results reflect the views shared by eight managers from two high-performing organizations in the

Southwestern region of the United States that have successfully used clinical practice innovation strategies to improve the quality of care at the bedside and profitability. Several factors contributed to the middle managers' strategies development process. The eight middle managers have integrated organization culture, leadership, management by objective and staff engagement strategies into a successful platform to improve performance and profitability.

Middle managers are always under pressure to manage trends and staff's development effectively. Therefore, for middle managers to improve their organizations in a focused way; they need to know the elements that contribute to sustainable organizational performance. According to de Waal (2007), managers are responsible for realizing the goals of the organizations and achieving outstanding performance within their departments. Managers have the responsibility to ensure successful implementation of innovation, which requires managers to have a broad understanding of the influence of organizational culture on innovation implementation (Bolboli & Reiche, 2013; Uddin et al., 2013). Organizational culture is predictive of change implementation success as seen through employees' perceptions of readiness for change (Whelan, 2015). Effective organizational culture is a vital component of an innovative organization, and a good reflection on leadership (Childress, 2013). Managers working within a supportive organizational culture display employee-focused leadership, healthy interpersonal relationship, and ethical decision-making (Engelen et al., 2014). Therefore, middle managers should understand the importance of organizational culture, which is fundamental to the success of innovation implementation. The study findings show how

middle managers use a participative employee-centered organizational culture, which includes senior leaders' support, managers support structure, collaboration, teamwork, reward and recognition system, and a safe climate to anchor their strategies to implement innovation successfully.

Leaders who practice employee-focused leadership create a safe and friendly work environment that promotes a sense of responsibility, ownership, productivity, improved employee performance, and profitability. The patients and healthcare professionals consider leadership as an essential component for management and integration of provision of care (Sfantou et al., 2017). According to Madsen, Miller, and John (2005), consistent leadership behaviors, open communication, transparency of information, and shared knowledge about past initiatives; and promote a shared vision and organizational members' readiness to change. Effective and competent clinical leaders are vital to ensure the quality of patient care (Daly et al., 2014). Leaders of organizations who focus on increasing profitability should support the implementation and sustainment of innovation implementation (Givens, 2012). Middle managers who have implemented innovation successfully promote (a) employee-focused leadership built on trust, (b) a balanced approach to management, (c) situation-based leadership style, (d) results-based accountability management, (e) effective communication, and (f) safe culture.

The study finding of a systematic approach to management by objectives includes employees' competency and continuous improvement. The management by objective (MBO) framework is a robust method for developing team efficiency, productivity, and

employees job satisfaction (Aggarwal & Thakur, 2013; Islami et al., 2018). When managers used the system approach to management by objectives (SAMBO), they had a holistic view of the systems and subsystems within the organization (Islami et al., 2018). The strategies generated from this study extend appropriate middle managers' knowledge that may reduce the failure rate of innovation implementation.

Staff engagement strategies used by middle managers to enhance employees' participation delivered best-in-class organizational performance. Ongoing employees' engagement, the culture of openness, employee-focused leadership, and trust are precursors to building employees' commitment (Mangundjaya, 2015; Shin, Seo, Sharpiro, & Taylor, 2015). The happier the employees, the easier it is to get them to commit to working together as a team (Chordiya, Sabharwal, & Godman, 2017). Healthcare leaders who are unable to engage their employees have poor performance, which affects their profitability (Desai et al., 2016). Healthcare organizations receive a penalty for the poor quality of care, which negatively impacts their profitability (Desai et al., 2016). Kaiser (2016) noted the significance of the interpersonal dynamics, empowerment, and relationships in achieving employees' engagement. The findings show various strategies that can be used to improve quality of care and profitability. Middle managers should provide staff reassurance, encourage staff commitment, and built relationships based on trust. Leaders who seek strategies to enhance employees' engagement should focus on the employee needs and promote a mutually beneficial relationship with the employees.

These study findings are relevant for hospital managers lacking strategies to successfully implement clinical practice innovation to improve the quality of care at bedside and profitability. According to Mangundjaya (2015), managers that manage to build trust with their employees gain commitment, which leads to employees' engagement. However, leaders and middle managers from other industries can benchmark these high performing organization and adopt the successful strategies to reduce innovation implementation failure rates, improve organizational performance and profitability. The study results contribute to the body of knowledge about middle managers role in innovation implementation.

Implications for Social Change

The purpose of this qualitative multiple case study was to explore the clinical practice innovation strategies hospital middle managers use to improve quality of care and profitability. One of the PPACA objectives is to improve the quality of care patients receive from hospitals (Logan & Bacon, 2016). According to Kash, Spaulding, Johnson, and Gamm (2014), clinical practice innovation increases the likelihood to improve the quality of care, improves patient outcomes, creates opportunities to reduce mortality rate, and enhances organizational performance. The organization, patient, and the patients' family members are part of the community. Therefore, any successful clinical practice innovation implemented by the organization's leaders will affect the community positively.

The findings show several other implications contributing to social change. For example, middle managers' strategies contribute to the organizational improvement,

employee satisfaction and engagement, and a strong commitment to patient care. According to Hamdan, Dalky, and Al-Ramadneh (2017), managers' support enhances nurses' professional commitment, which leads to improved outcomes and can save a life. Hospital leaders that focus on improving the quality of care also enhance their overall performance and positively contribute to the social well-being of their communities (Mueller, Lipsitz, & Hicks, 2013). Melo's (2012) findings showed that middle managers who use employee-focused leadership strategy values their employees. H1P1 stated that the frontline employees show full commitment to delivering care to the right patient at the right time with fewer sentinel events. According to Westermam-Behaylo, Rebein, and Fort (2015), improving quality of life, health, and the well-being of the society are the outcomes of a safe and friendly work environment. Middle managers created a safe climate, which promoted frontline involvement and improved their receptiveness to change. Therefore, the frontline commitment to delivering high quality of care within a safe and friendly work environment may increase the quality of care and profitability.

High-performing organization leaders provide resources, time and opportunities for employees to improve their knowledge and skill. According to Lund-Thomsen, Lindgreen, and Vanhamme (2016), organizational leaders that positively change society provide education and training to the employees, promote the sharing of the information and ideas openly, and support creativity and innovation. The potential of the study to bring about social change is the opportunity to improve the quality of care, save lives, quality of life, and social well-being of the society.

Recommendations for Action

Hospitals leaders and middle managers may assess their organizational culture, leadership approach, organization performance measurement, and staff engagement strategies. I recommend the following actionable strategies identified in this study to leaders and middle managers:

(a) implement a participative employee-focused organizational culture, which includes the following elements: senior leaders support, manager support structure, collaboration, performance-based rewards and recognition, teamwork, learning, and a safe climate

(b) practice employee-focused leadership, which create a safe, healthy, and friendly work environment, which value employees; use situational-based leadership style, promote employees' ownership, empowerment and results-based accountability, and encourage open communication

(c) implement a performance management system with elements of competency and continuous improvement

(e) build employees' engagement through employees' commitment, trust-based relationship, and reassurance

The strategies defined in the study may be scalable and transferable. Even though the study took place in the healthcare industry, the strategies and learning may be transferable to any industry middle managers. If an organization identified a gap in innovation implementation or performance, middle managers might adapt these strategies to implement change successfully and improve productivity and profitability. The study

findings show that participative employee-focused organizational culture is the foundation that needs to exist in an organization for all the other strategies to work. The integration of all the strategies middle managers may practice improve the frontline employees' engagement and improve the organizational performance and profitability.

Hospital leaders and middle managers should consider the results of this study because knowledge of these strategies used by middle managers from high performing organizations can positively affect the organization performance measures. According to de Waal and van der Heijden (2015), strong and significant correlations exist between all the performance management dimensions and high performing organization factors; performance management system promotes performance-driven behaviors, which is essential and strengthens the overall organizational financial and non-financial performance measures.

Several researchers in prior studies found similar strategies are vital to successful innovation implementation (Davis et al., 2015; Denison, 1990; Madsen et al., 2005; McAlearney et al., 2013; Ratnapalan & Uleryk, 2014; Sharma et al., 2014; Shea et al., 2014; Weiner, 2009). I will disseminate the result of this study through scholarly journals, conferences, open access papers, organizational leadership, and through my professional networks. Additionally, I will collaborate with other scholars and professionals to present a PowerPoint presentation and provide training sessions to disseminate the results of this study.

Recommendations for Further Research

The purpose of this qualitative multiple case study was to explore the clinical practice innovation strategies hospital middle managers use to improve quality of care and profitability. I identified three limitations and two additional future research opportunities in the field of middle managers performance. The limitations were (a) time constraints to conduct the interview and conduct the research, (b) the small sample size that did not include hospitals in another region of the United States, and (c) uncontrollable circumstances that conflicted with the study time frame. Future researchers should (a) investigate the relationship between middle managers strategies and innovation implementation success measures, and (b) explore the frontline staff perceptions of middle managers' strategies effectiveness.

Reflections

As a student at Walden University, I learned how to become a scholar and how to conduct research within the ethical guidelines of the IRB and the Belmont Report. I learned so much during the program. My research committee members were excellent, supportive, and always ready to guide me throughout the research. Attendance at the residency program was necessary to augment my knowledge of the DBA rubric, and better understand the Blackboard technology within the distance learning environment.

I have acquired knowledge on performing doctoral-level research, and I have improved my writing skills with the support of my chair. I have enjoyed the research process; I learned how to conduct qualitative method research using a multiple case study design, and clinical practice innovation strategies used by middle managers from high

performing hospitals to successfully implement innovation. The study participants were open to sharing their tacit knowledge. I was able to capture the participant's experiences and best practices on innovation implementation. The participants enjoyed taking part in the study and exhibited a high level of knowledge regarding the research topic. I enjoyed the interview process because the participants responded to the questions with passion and excitement.

When I selected Pettigrew's theory as the conceptual framework for this study, I was not sure if I made the right selection. As I used the conceptual framework lens to explore the clinical practice innovation strategies hospital middle managers use to improve quality of care and profitability, I realized that indeed successful change resulted from the interaction of the context, content, and process constructs of the Pettigrew's theory. The strategies used by the eight middle managers from the two high performing organizations fit within the three constructs of Pettigrew's theory as seen in Figure 6, page. 81.

The findings show support to Pettigrew and Whipp (1991), who noted that successful change resulted from the interaction between content, process, and context of change. Additionally, these research findings show evidence of similarity with other researchers regarding the application of Pettigrew's theory. Several researchers concluded Pettigrew's theory is appropriate when exploring and considering the implementation of innovation in healthcare (Boonstra, Versluis, & Vos, 2014; Stetler, Ritchie, Rycroft-Malone, Schultz, & Charns, 2007).

Conclusion

The purpose of this qualitative multiple case study was to explore the clinical practice innovation strategies hospital middle managers use to improve quality of care and profitability. The research process encompassed knowing the qualitative research method, case study design, ethical requirements for conducting research with human subjects, and choosing appropriate study participants. I used the benchmarking process to analyze publicly reported data and selected high performing organizations located in the Southwestern region of the United States that met my selection criteria. I chose four participants from each hospital.

The interview protocol was in alignment with the central research question: What clinical practice innovation strategies hospital middle managers use to improve quality of care and profitability? My conceptual framework was Pettigrew's theory, which focused on the context, process, and content constructs of the strategic management of change. To gather credible and reliable data to answer the central research question, I performed semistructured interviews to collect the participants' experiences and practices. I reached data saturation after completing eight interviews. The sample size for this study was eight participants, four from each organization.

I included numerous levels of validity and credibility throughout the analysis and interpretation of the data, and I was careful not to introduce personal biases. With converging information from multiple sources such as the participants' interview transcripts, organizational document reviews, personal notes, and literature review; I was able to perform data triangulation to enhance the credibility of the research. These

research findings show evidence of similarity with the old and new literature, grounded on systematic analysis and synthesis of literature associated with the conceptual framework of Pettigrew' theory.

The study findings illustrate significant middle managers' strategies relevant for business managers looking to improve the organization performance and profitability. Middle managers need to know the significance of having effective practice innovation strategies. The study results are significant to professional practices and contribute knowledge about the strategies used by middle managers to improve the organizational performance and profitability. The results showed clinical practice innovation strategies hospital middle managers used to implement innovation successfully, improve quality of care, and increase profitability. I described the ways the findings confirm, disconfirm, or extend knowledge in the discipline by comparing the results with other peer-reviewed studies from the literature review; document review, and literature added since writing the proposal. The potential of the study to bring about social change is the opportunity to improve the quality of care, save lives, promote employees' quality of life and society well-being. A safe and healthy environment promotes job security and increases retention rate.

The study findings show innovative organization leaders promote an employee-focused organizational culture, employee-focused leadership, system approach management by objectives; and staff engagement to achieve organizational goals and objectives. Middle managers who consider these study findings on appropriate strategies used by high performing hospitals' middle managers can stimulate new insights and

champion change to improve employees' performance and Profitability. The strategies content (SAMBO), the characteristics of internal context (organizational culture and leadership), and the process of staff engagement need to be evaluated for each specific innovation implementation. This study shows the interaction of the internal context, content and process constructs of Pettigrew's theory in middle managers' clinical practice innovation strategies to improve the quality of care at the bedside and profitability.

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