A conversation about practice development and knowledge translation as mechanisms to align the academic and clinical contexts for the advancement of nursing practice

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**Summary** Practice development (PD) and knowledge translation (KT) have emerged recently as methodologies which assist advancement in gathering and using evidence in practice. For nursing to benefit from these methodologies there is a need to advance the dialogue between academia and the service sector concerning the use and further development of these methodologies as well as how we create the most effective partnerships between academia and practice. To advance this dialogue and to gain insights into the similarities and differences between KT and PD and between the academic and the service sectors, four conversations from different leaders in these sectors have been gathered and are presented here.

These four discrete narratives are presented to showcase the diversity of sector contexts in relation to PD and KT methodologies. Narrative One focuses on some of the theoretical and policy issues related to creating partnerships between traditional "knowledge creation systems" (universities) and "knowledge utilization systems". Narrative Two discusses how a large school of nursing responded to the challenge of creating partnerships for practice development in an...
Introduction

Practice development and knowledge translation have emerged recently as methodologies which assist advancement in gathering and using evidence in practice. For nursing to benefit from these methodologies there is a need to advance the dialogue between academia and the service sector concerning the use and further development of these methodologies in order achieve the best outcomes.

As a group of nurses committed to improving practice and patient care, we believe it is time to more actively and collaboratively embrace the challenges of reducing academic and clinical divides. Our intention is to work together to establish more effective ways of getting knowledge into practice. Service users in health care systems need health professionals and academics to systematically work through these challenges to create better models. Indeed, it is our responsibility as academic and service leaders to model this in our behaviour and actions. Failure to enact changes in this direction will result in the provision of care that is not up to date with the current state of knowledge and renders practice as a poor cousin to knowledge generation.

Knowledge translation as the assessment, review, and utilization of research, in order to put knowledge into action (CIHR, 2004), is on the lips of many health professionals yet the common ground across the various contexts of academia, nursing practice and practice development (the systematic process of developing effective and person-centred cultures in health services) remains somewhat elusive. The lack of clarity and level of disquiet around the concepts of knowledge translation (KT) and practice development (PD) indicates that these are important topics for key professional organisations (such as Councils of Deans of Nursing and Midwifery) and journals in order to stimulate debate about these issues and highlight the national and international imperatives to lead the way forward.

Questions arise for nursing about how we create the most effective partnerships between academia and practice and how we accommodate different worldviews around language, method and product. To advance insights into the similarities and differences, four conversations from different leaders in the sectors have been gathered and are presented here. Drawing from this, recommendations for further dialogue and professional strategy are advanced.

Background

The ideas for this paper emerged from a workshop hosted by the Council of Deans of Nursing and Midwifery (Australia and New Zealand) in September 2009. The purpose of the workshop was to stimulate debate around the nature of the methodologies of practice development and translational research. Following the workshop, a small group was convened to construct a paper which explicates the multiple perspectives operating within the health service and education sectors in relation to these methodologies and the advancement of practice.

Four discrete narratives are presented to showcase the diversity of sector contexts in relation to PD and KT methodologies. In each of the narratives the authors reveal genuine commitments to the advancement of practice using practice development and KT methodologies situated within their respective contexts. As a group of writers studying the perspectives we were struck by the extent to which context influenced the emphases and strategies in relation to what was considered important. The narratives are reproduced in the paper without overt analytic framing to allow the contextual elements to be expressed in a more naturalistic way. In this way it is anticipated that readers will think about these in relation to their own contexts and consider mechanisms that may help to align higher education research and teaching and health service policy and provision.

Narrative One focuses on some of the theoretical and policy issues related to creating partnerships between traditional “knowledge creation systems” (universities) and “knowledge utilization systems” (in this case healthcare facilities) as well as exploring more fully the link between PD and KT. Narrative Two discusses how a large school of nursing responded to the challenge of creating partnerships for practice development in an attempt to bridge the academic/service divide and produce benefits to both organisations. This narrative comments on the difficulties of embedding PD activity as part of the overall academic agenda and the strategies used to achieve this. Narratives Three and Four describe the view of practice development from the service side. Narrative Three explores the implementation of a state-wide PD program aimed at bringing about evidence based and person-centred practice change. Factors contributing to the successful implementation are explored. Narrative Four explores a nurse executive’s view of the benefits of implementing PD ways of working and provides a framework for its implementation. The final section of the paper presents an agenda for discussion and action based on the emerging set of principles.

Narratives

The contribution of different players within nursing to the development of practice is shaped directly by the concerns and mandates associated with their roles and sector imperatives. If we are to afford strategic development across nursing as new methodologies evolve it is critical that an understanding of the perspectives and experiences is achieved before seeking to identify a forward strategy that involves all players in a way that is mindful of their contexts. Strategic alliances will only work if the conditions are
suitable. The narratives presented here highlight how the context affects the ways in which the methodologies are identified, discussed and operationalised.

Narrative one: the importance of PD and KT methodologies to practice (A Leading Researcher’s View)

The development of research strategy requires analysis and differentiation of methodologies in order to progress knowledge generation. In this narrative the discourse revolves around theoretical and practice distinctions of the two methodologies (KU and PD). Continued working with this perspective would enable progression and testing of the methodologies theoretically and practically in terms of their relevance in progressing practice.

There are many descriptions of the different ways that knowledge is created and tested in the world. Nursing, as a relative latecomer to the debates concerning the nature of reality (ontology) and how that reality might be known (epistemology) has drawn from a range of philosophical traditions. Some theorists and practitioners would argue that the development of knowledge related to nursing practice has been overly influenced by the positivist school of thought while others argue that nursing is best understood and explained within an interpretivist approach. Other philosophical positions include critical theory which assumes an inherent tension between different groups within the social and political (and knowledge) order and integrative theory which argues that the multiple realities and tensions that exist all need to be shaped and constrained by people involved in using knowledge, making decisions and working together (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004) provide a comprehensive overview of these different approaches and how they influence our view of knowledge and effectiveness.

From this broad perspective it is important to consider the philosophical antecedents of the PD and KT movements respectively. On the surface both movements are trying to achieve the same broad goal: increasing the uptake and use of evidence to improve patient care. PD however, embraces a more collaborative approach to achieving this ultimate goal by reinforcing the importance of the person in context and addressing power relations. PD also has a broader interpretation of what counts as knowledge, who creates it and how it is validated. Such philosophical stances are evident from the early developments of the PD movement. For example, the first clinical practice development research institute to be established in the UK (Kitson, Ahmed, Harvey, Seers, & Thompson, 1996) took this theoretical stance, arguing that in the knowledge generation and application cycle, the appropriate method for generating new knowledge was informed by the clinical question being asked. The academics/researchers were the technical experts in terms of what approach to use to help elucidate the practice problem but the clinicians were the key stakeholders in terms of owning the question and being responsible for the subsequent introduction of this new knowledge into practice. The conceptual frameworks used in PD were, and to a large extent, still are broad and diffuse, ranging from action research (Titchen & Binnie, 1993) to critical social science (Manley & McCormack, 2003), through quality improvement and leadership theory (Antrobus & Kitson, 1999; Kitson et al., 2011) to distinguishing between emancipatory practice development (ePD) to other more structured approaches (Manley & McCormack, 2003; Walsh & Moss, 2010).

In contrast to these PD approaches, the KT discourse begins with a “given”: there is knowledge to implement into practice. The new knowledge is robust, rigorously derived, and waiting to be introduced. The question, of course, is how to optimise the potential of this new knowledge. Are there quicker, better, easier, more effective ways of getting this new knowledge into practice? The KT movement has grown from and gained momentum from the evidence based practice movement (EBP). EBP has its philosophical roots in positivism: there is an answer, a gold standard for practice and the job of the researcher is to provide this evidence to the clinical team. With the establishment of organisations such as the Cochrane and Campbell Collaborations and Joanna Briggs Institute (JBI) there is more and more information to push out to clinicians. The question is how to do this and not surprisingly, given the genesis of KT the traditional solution seems to be more positivist in its orientation than interpretative, critical or integrative. What is interesting is that the previous 50+ years of critical social science theory, action science, collaborative research and most recently practice development activity seems to have made little impression upon the mindssets of the advocates of implementation science. The rhetoric, until quite recently, has been about introducing the new knowledge and getting practitioners to modify their behaviour, attitudes and actions to accommodate it. Of course, this approach does little to improve practice and indeed, has the unintended consequence of often making practitioners more resistant to new ideas (Walsh, Crisp, & Moss, 2011; Walsh, McAllister, Morgan, & Thornhill, 2004; Walsh, Moss, & Fitzgerald, 2006).

More recently the KT discourse is catching up with the broader critical social science debates: in particular, Gibbons et al. (1994), and Nowotny, Scott, & Gibbons (2001) have been challenging the traditional knowledge generation communities by suggesting that the whole knowledge production process is as much a social process as it is a scientific one. They argue very cogently for a new collaborative approach to knowledge generation that is around the “co-production of knowledge” and one that engages stakeholders in every step of the process. The theoretical arguments of Gibbons et al. require the identification and active involvement of multiple stakeholders, all engaged in the business of “knowledge production”.

Such a paradigm shift redefines the roles of those engaged in the research process (Kitson & Bisby, 2008). Stakeholders are found at all levels of the system — at the political and policy level; at the academic level; at executive management level and at the level of front line action and interpretation. In a more structured interpretation to this agenda, the KT community have begun to describe the range of roles that constitute the necessary KT elements, “Boundary spanners”, “Knowledge brokers”, “opinion leaders”, “translation experts” and “KT facilitators” are just a few of the terms bring used to describe the roles that are developing. Equally, the roles inhabit new
worlds of “communities of practice”, social and learning networks” and “virtual communities”, mysterious artefacts of a world that is increasingly complex.

Where then does the practice development (PD) movement fit into these broader developments? As stated earlier, the PD movement had its origins in the significant changes that were happening in nursing in the late 1980s/early 1990s, starting in the UK and spreading out to Australia and New Zealand in particular and to Canada more recently. None of the developments was exceptional in itself: what was significant however, was the integration of a set of processes and interventions that tried to combine patient centred-care processes that could transform workplace cultures and introduce new innovations (improvements) in care. The PD movement defined “improvement” around standard elements of clinical effectiveness (or evidence of effect); explicit nursing interventions (derived from the best evidence); embracing a philosophy of person-centeredness and an on-going commitment to evaluation of effect.

So, is there any possibility of the worlds of KT and PD coming together to enhance the uptake of new innovations into clinical practice? Is there any chance that the academic community could take on board the intrinsic messages of KT and PD and begin to create a climate and culture more conducive to greater integration and involvement around identifying and solving clinical problems? Do the two worlds in fact come together through the mechanism of facilitation? And is facilitation — the process of making it easier for others to do their job — the mediating process through which all these complex theoretical positions can be examined and tested (Kitson, 2009; Kitson & Bilsby, 2008)?

**Narrative two: creating partnerships between academe and service (A Head of School’s View)**

This narrative offers a perspective of a leading head of school on the importance of PD and KT methodologies for practice. The development of an academic strategy requires an analysis of the different levels of take-up and integration within the university school and of the functioning of the school in partnership with other external professional stakeholders (e.g. policy and service). In this narrative the discourse revolves around the state of development and the evolution of strategy for the maturation and sustainability of PD/KU. Continued working with this perspective would enable progression of industry/university partnerships and the articulation of teaching, consultancy and research strategies for the advancement of PD in practice.

There is a long history and tradition of collaborative relationships between the academy and clinical service areas. These relationships cover a wide assortment of positions including undergraduate clinical teaching and preceptorship; postgraduate teaching, supervision and mentorship; research nurses, assistants and fellows; adjunct appointments for senior and experienced staff and clinical professors. Moreover, they encompass the breadth of health service activities: clinical care, service evaluation, education, research and community engagement (Livingood, Goldhaen, Little, Garnto, & Hou, 2007).

Livingood et al. (2007) note that however wide-ranging they are, these collaborations rarely afford a holistic or systems approach to the partnership and that there is little evaluation of them from the perspective of the leaders in health services and the value to their organisations. They assessed the status of academic-health service partnerships in Florida (USA) and found that early partnerships revolved around attracting and retaining a skilled workforce and included clinical practice for students and training of staff. Academic institutions served the health services through educational activities, research, infrastructure development and capacity building.

With regard to research, Livingood et al. (2007) found that health services needed the collaboration to advance their research skills and to build confidence in the public that reputable researchers were undertaking research.

Dedicated research positions are often embedded in the role of the clinical chair in nursing (Duke, McBride-Henry, Walsh, & Foureur, 2009). These chairs have been appointed in “generic” positions such as “Professor of Nursing Research” or more specific positions such as “Professor of Paediatric Nursing” (Duke et al., 2009; Lumbly, 1996). Whatever the focus, they have mainly concentrated on knowledge generation through research rather than knowledge utilization and translation. Lumbly (1996, p. 3) argues that research is the main focus for some but for many it is just “one part of a gestalt of roles and responsibilities”.

In addition, many of these positions are conjoint, creating challenges for the incumbent in serving two masters. The issues include conflicting organisational goals and expectations as well as acrimony between the academy and clinical leaders (Darbyshire, 2010; Dunn & Yates, 2000).

Dunn and Yates (2000) state that the issues will be minimised with clear role definitions and contractual obligations. Wallis (2007) extends this and argues that performance indicators for these positions need to be relevant for both organisations, and that the academic standard is benchmarked at that of the professor and reflects the outputs expected of an academic of that rank especially in light of research quality benchmarking assessments. Furthermore, the resources allocated to the position must reflect the extent to which the position is focused on knowledge generation, knowledge evaluation and knowledge translation. Clinically based academics are well placed to enhance nursing research in all domains (Wallis, 2007).

Nevertheless, there is still a paucity of evidence that academic-health service partnerships are assisting with knowledge utilisation, translation and evidence based practice agendas. Weiss (2007) argues that the billions of dollars spent on research must be justified in terms of useful, patient outcomes: whether in terms of illness reduction or health system improvements. Output based measures such as grants and publications contribute to the efficacy-effectiveness gap. An outcomes based focus enhances the translation of evidence into practice and leads to improvements in outcomes for both patient and health services (Weiss, 2007).

Cash and Tate (2008) describe a community development project that was undertaken in Canada designed to improve nurse educators’ scholarship. The goal of the project was to not only build scholarship but also to develop a culture of communities of practice (Lave & Wenger, 1991; Wenger,
McDermott, & Snyder, 2002) where academics and clinicians worked together to research and importantly, translate research into practice. Cash and Tate (2008, p. 8) note the initial fears of the participants of “doing research” but found that the process of collaboration and partnership ameliorated these concerns and demystified the work.

Another partnership undertaken in Canada was between McGill University and the University of Montreal (Pringle, 2007). They created a research partnership focussed on translating nursing knowledge into interventions with clinical outcomes. Again, creating the right environment for knowledge generation and translation was crucial for success. Building research capacity is enabled through targeted research-skills training, mentorship for novice researchers, creating teams of researchers with complementary interests, skills and knowledge, and engaging strong leaders (Lansang & Dennis, 2004). Each of these enablers is central to the philosophy of practice development (PD).

In Australia, and previously in New Zealand there are conjoint professorial positions in specific integrated roles that combine PD and scholarship/research (Duke et al., 2009). These tend to promote integration but such roles are not widespread. Importantly, a systematic approach to this agenda is required from academy as well. This includes a structured education and support program to grow practice developers to engage in culture change activities that improve the opportunities for knowledge translation. For example, Monash University has been occupied in PD work and a member of the International Practice Development Collaboration (IPDC) since the early 2000s and has partnered with many health services to utilise PD as the methodology for knowledge utilisation for practice change.

Monash focused on education and facilitation. This included the five-day PD schools, Roundtables and the establishment of the Master of PD course in collaboration with the University of Ulster. Despite this seemingly long history, the academy struggled to embed PD in the core business of the School. In 2007, the School restructured and reviewed its operations. PD was firmly placed in core business. The confounding issues related to: insufficient key staff identifying with PD; minimal output (evidence) over the time period that was directly related to the effectiveness of PD activities; variability in interest by industry partners around PD initiatives with minimal formal partnerships for PD (despite other long-standing agreements between the sectors); a general lack of “buy in” from academic staff despite individual good will by interested staff that utilised their own clinical networks and partnerships to work with PD in clinical settings; a significant measure of cynicism and scepticism from nurse executives and other academics related to the perception that PD was not “real” and that there were no demonstrable outcomes; and finally concern about the evidence base of PD interventions and how these were being tested.

On reviewing the situation, Monash Nursing and Midwifery developed a strategic plan for PD that included capacity building for health services. Therefore the education focus would remain but would also include a research and knowledge translation agenda. As a result schools, roundtables, and facilitation master classes were reviewed revised and continued. An Associate Professor with a PD background was appointed. This position was also linked with a position of community engagement within the School. Several Adjunct appointments with health services clinicians strengthened the partnerships and improved avenues for practice change leading to deeper discussions about research and scholarship and compatible research programs. Development of strong partnerships with industry, other schools/centres, other faculties and other universities were initiated and are all underpinned by agreements and memoranda.

It is clear from this narrative that whilst a university might seek to engage with PD and its associated activities, the mechanisms for its success rest with the appropriate formalised partnerships that are developed between the academy and the service sector and a definite strategy that brings the key stakeholders into the decision-making domains. PD methodologies are an excellent vehicle for academics and clinicians to work together to generate new knowledge and to translate that knowledge into clinical care. As a result we will also develop the nursing-specific indices that will impact leadership, workforce and health outcomes.

The next two narratives present the other side of the coin: the health service perspective. The first presents the view from a chief nurse around knowledge transfer, knowledge utilisation and a large State-wide PD initiative with collaboration from academia. The second is the perspective of a nursing executive who has experience in working with PD to bring about effective, person-centred workplace cultures.

Narrative three: views from the point of care
(A Chief Nurse’s View)

The service sector perhaps has a tendency to see the academic world as artificial or lacking a real connectedness to the everyday world of work at the unit level. The contribution of research to practice may be recognised in an abstract manner but the application of the research findings in the everyday setting may be delayed as a clearer understanding of how to accommodate the complexities of the work world within the research outcomes is reached. The likelihood of transfer or uptake may be enhanced by a variety of factors.

People in leadership roles who understand, participate in and value research can help to champion the integration of research findings into the workplace. They can support the relevant framework to enable staff to engage with research findings, debate their application and demonstrate and model the role of research and the implementation of research into practice. Therefore identification and engagement with such individuals may enhance the uptake of research findings.

There is a need to understand the political environment and different relationships that exist within organisations and how these will impact on the ability of staff to implement research findings. At times the adoption of some may almost appear to be serendipitous. There is a necessity to always be aware of the changing environment and a preparedness to move quickly should the appropriate opportunity present. At the same time a level of pragmatism may mean that the introduction of some knowledge from research may occur for what can appear to be a relatively...
A unconnected reason — getting research into practice may depend more on knowledge of how organisations work than on the importance of the research itself.

Considerable time must be invested in order to achieve the changes desired or implement the research outcomes. Health systems all over the world experience continual change, which it is suggested can contribute to a reluctance to incorporate new information and ways of delivering care — 'change fatigue'. For nurses, PD appears to enhance the level of control they feel they have over their environment which could imply some feeling of 'stability' yet this then appears to enable them to take on more change in a more open way — and it could be argued makes them more open to accepting and implementing research findings.

In New South Wales (NSW) a statewide PD program known as Essentials of Care (EOC) has been implemented (Nursing and Midwifery Office (NAMO), 2010). One factor contributing to its implementation included high-level leadership and support for the program of work. This high level leadership assisted in presenting the case to the health executive: demonstrating how the work relates to the day to day operational delivery of care; managing the expectations and convincing people of the need to not move too fast. Health systems and political systems typically function on a budgetary cycle so solutions are often sought that will fit within that cycle. Implementation and integration of research into practice does not always fit neatly into the budgetary or political cycle so it is necessary to have someone at a senior level who can manage that tension.

Another important factor was a capacity to describe the research/PD initiative to fit different audiences without losing the integrity of the work. Different groups from within a health system will be seeking slightly different outcomes even though they may all be seen to fit under the overarching heading of improving patient care. Those with primary financial responsibility will need to be reassured that there is at least no additional cost burden and at best some improvement in costs; clinicians will look to see definitive improvements in care outcomes; community members and politicians may want to see specific problem areas addressed.

Sufficient support to enable the work to be undertaken at the local level is crucial. This may mean a number of different types of resources — staff who can lead the work, materials for use in supporting the work and education. Facilitation can be a key element. In the implementation of a large PD program of work — our experience has been that limited facilitation capacity can limit the speed with which implementation can proceed. Further investment in facilitation contributes to the speed of implementation but also builds capacity to support other work at a later date.

There must be 'clarity of purpose' and remaining true to the core principles and tenets of the program of work. There are increasing demands to both incorporate other activities but also to spread even more broadly. There needs to be a very clear and agreed direction among the teams leading the program of work so that they are not easily distracted from the core activities.

As the program of work gained momentum it has become evident that this does bring about a change in the way the people work together to deliver care and engage with patients. Change in the ward cultures is becoming more explicit and evidence of sustainability is growing such that there is an even greater commitment at the senior levels of the organisation to supporting the program of work but also a tendency to view the work as being able to solve more than it perhaps can realistically be expected to do. There is a risk of programs of work of this kind being seen as a 'panacea'.

This narrative outlines the political, operational and practice imperatives necessary to bring about the implementation of a large-scale practice development program. Leadership has been key to this program, especially the ability to understand what was necessary in the multiple contexts including the practice environment and health care politics.

Narrative four: views from the point of care (A Nursing Executive’s View)

This narrative offers a perspective of a leading executive director of nursing on the implementation of PD and KT methodologies in a large metropolitan health service. The development of a health service implementation strategy requires an understanding of the organisation and the resources needed (both human and other) to facilitate the implementation of PD as an intervention.

Continued working with this perspective would enable progressive capacity and culture building for sustainability of PD/KU as interventions for the advancement of care in health services.

For many years now my primary professional drive as a nursing executive has been to develop workplace cultures that effectively and safely care for patients and their families and that are satisfying and stimulating for nurses.

Working in large tertiary institutions with complex management and leadership structures provides challenge to this endeavour as each component of the organisation approaches their work in different ways according to the personal style of the leaders.

For me, the implementation of PD provides an opportunity to engage nurses at all levels of the organisation in developing workplaces that:

- Are safe and progressive evidence based clinical services
- Understand the patient experience and involve patients in decision making
- Have explicit values and purpose statements to guide team behaviours
- Enable front line nurses to be involved in decision-making at the local and organisational level
- Provide opportunities for nurses to be creative and innovative
- Reflect on and develop practice

One of the important principles of PD is that it is a bottom up process, which engages nurses at the clinical unit level in workplace and patient care improvement. This unit-based engagement is fundamentally important to the process of meaningful and sustainable workplace culture transformation. I do however believe that if the senior leaders are not effectively connected to the work at the front line, the work will not necessarily be sustainable.
To enhance PD implementation and sustainability nursing executives have an exciting opportunity to work with nurses to develop an organisational framework that encourages the PD approach and enables the work and the nurses at the unit level to thrive.

The essential components of this framework are:

- The development of the nursing leaders (both clinicians and managers) with leadership skills and understanding of PD
- The development of facilitators within the organisation to lead and support the work
- The development of a shared nursing vision which provides inspirational goals
- The development of communication structures that are inclusive of all levels of nursing which understands, enables and supports the PD work and provides forums for critical dialogue
- An investment of resources to support the work

The first important step when considering the implementation of PD at an organisational level is to encourage and provide opportunities for senior and front line leaders to explore PD and to work together to define high level organisational values and goals related to practice and work place culture. This work connects the team players and provides focus for identifying the essential elements of an organisational PD framework. In my experience this is also an exciting time in the organisation as senior leaders often express their reconnection and passion for their work. It is here that talent of the leaders is often reignited to take the lead in work place culture change and practice improvement.

Having the senior leadership team of the organisation engaged in PD work and in the development of formal structures that support it will result in enhanced sustainability of this way of working.

The establishment of a formal meeting framework to support the PD work within clinical units and more broadly across the organisation is a fundamental requirement to support the work. Establishing groups, which have like interests and aspirations, is a component of this framework and allows critical dialogue and practice change to occur. These groups may be working on organisational programs or unit based projects. Examples of the organisational groups that have been successful in my recent experience are focussed on quality of patient care and also staff wellbeing in the workplace. Examples of Unit based groups are related to patient care relevant to clinical specialty work and the workplace in which this is conducted.

Facilitation skills are fundamental to conducting PD work. Regular facilitation training workshops to develop this skill amongst the staff will promote different ways of relating and promote critical discussion and exploration of issues in the workplace.

Discussion — the emerging principles and agenda for action

In our common understanding of, and commitment to practice development (PD) and knowledge translation (KT) activity and methods, we all approached the task from very different perspectives. Our experiences and positions within the systems and structures where we work have influenced our perspectives about PD and KT and reflect the diversity of opinions globally. This may not be surprising in itself but it is important in terms of generating an integrated and collaborative agenda that creates a structure and scientific base around academic and service endeavours that are trying to improve practice.

Despite attempts to align PD and KT with each other and with the academic and service context there remains the mystique surrounding these contexts with each, as Lomas puts it, a foreign and potentially unknowable land with strange and arcane practices, customs and beliefs (Lomas, 2007). In describing the differing views between academic researchers and health policy decision makers in relation to research, evidence based practice and policy, Lomas (2007) observes:

Researchers tend to see decision making as an event — they deliver their edicts to the impenetrable cardinals, retreat and await the puff of smoke that signals "decision", whilst grumbling about irrationality within the conclave. Decision makers — the patients, the care providers, the managers and the policy makers — tend to see research as a product they can purchase from the local knowledge store, but too often it is the wrong size, needs some assembly, is on back order, and comes from last year’s fashion line (Lomas, 2007, p. 130).

This resonates with Schön’s well known statement.

In the varied topography of professional practice, there is a high, hard ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing ‘messes’ incapable of technical solution…in the swamp are the problems of greatest human concern (Schön, 1991, p. 42)

Lomas goes on to say that neither side recognises that each is managing a complex process and he is not alone in this view. Sheldon (2005) states that consumers of synthesised research evidence [health service managers and clinicians] “…have not found the outputs sufficiently relevant and useful, and researchers have become frustrated by the lack of uptake of the results of such systematic reviews by policy makers and managers [and one could add — clinicians]” (Sheldon, 2005, S1:1).

Yet despite the differences and difficulties underpinning the academic and service perspective there is a desire for best practice based on sound evidence with sustained implementation within a culture that is enabling. Similarly with KT and PD: they are derived from vastly different philosophical bases but connect at the what/how/when/where interface. It is artificial to separate one from the other as knowledge and its interpretation is static without the vehicle for its wider use.

In summary, the narratives from the two senior nurses reflect the imperative for nursing leaders to strategically position their organizations for rapid and repeated change and to “arm” their nurses at all levels with the skills and capacity to broach and implement such change. The systematized approach taken reflects the rigorous processes of
KT and PD within a person-centred framework. Once more, broad collaboration and inclusion was facilitative.

Being cognizant of all the arguments, the academic perspective in this paper is that PD is firmly positioned within the broader construct of implementation science. In particular, we believe it is imperative to overtly link PD to the workforce reform and knowledge translation/utilisation/evidence agenda; to link PD to management literature and leadership; to improve executive commitment and organisational support within health services; to establish more conjoint appointments and to be involved in an "Australasian" PD collaboration auspiced through key universities that have established PD reputations and named academics in PD roles.

In order to achieve a sustainable and outcomes-focused approach to PD, academic institutions must adopt holistic, integrative, strategic partnerships with service areas. This means more than joint appointments but real shared governance to understanding and working with knowledge that is meaningful and useful to the health service and produces measurable research and publication outputs for universities.

Partnerships take time to build and maintain. Both health services and universities need to work together. It is a symbiotic relationship. The academic partner works with the service partner to build internal capacity for knowledge utilization through mechanisms such as facilitation and the health service reciprocates by offering access to clinical questions and research problems. This serves to keep academic colleagues engaged and supportive.

Success would be measured differently for each organisation but each has the responsibility to support and celebrate the success of the other. Therefore, improved patient outcomes or models of care for a health service will be equally important as a paper in a quality peer-reviewed journal.

To ensure this optimal integration and productivity both academics and clinicians need to work together seamlessly and contribute to both the clinical and academic outcomes. In-house service outcome reports and evaluations, research reports and publications would all reflect the shared contribution of the team.

Meeting academic standards as well as achieving service objectives is no easy task. Therefore clear agreements must be instituted and time and resources provided to the team to meet the objectives. We suggest that creating ongoing dialogue around these key areas is a vital way to create the needed synergy between academia and practice settings. The questions in Table 1, derived from the narratives are a useful prompt to use.

### Conclusion

In conclusion, it is clear from the narratives that KT is not a one-way street (academia to practice): KT has much to learn from the service sector in terms of political processes, opportunism, timing, and managing complexity. Also, PD is not a serendipitous activity: it is a rigorous, systematised and strategic activity.

Partnerships would appear to be key endeavours in the shared quest to utilise evidence and improve practice however these partnerships need to be mutually beneficial to academia and practice. They need to be made explicit with clear philosophy, ways of working and goals. There is a growing range of skills, attributes and roles that can be identified to make these partnerships work. Part of the maturation process is to systematically describe these roles and test them in different situations.

A whole system approach to improving practice is the preferred way forward as piecemeal is not sustainable. However, despite these insights there remain many questions which would bear further exploration if we align the academic and clinical contexts for the advancement of nursing practice through practice development and knowledge translation. These include: what are the leadership qualities required? How can service timeframes and pressures be used as a lever for change through PD/KT initiatives?

<table>
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<tr>
<th>Questions emerging from narratives</th>
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<tr>
<td>What are the philosophical antecedents of PD and KT?</td>
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<td>What can KT learn from PD? What can PD learn from KT?</td>
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<td>How is knowledge/evidence defined in PD and KT?</td>
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<td>What is the level of engagement between the knowledge producers and users in PD and KT?</td>
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<td>What methods are used to evaluate the effectiveness of PD and KT interventions?</td>
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<td>What common mechanisms are used to facilitate the introduction of evidence into practice in PD and KT?</td>
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<tr>
<td>How does an academic institution adopt a holistic, integrative, strategic partnership approach to PD partnerships with service areas?</td>
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<td>How would the academic and service areas measure success?</td>
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<tr>
<td>How would PD roles be structured to ensure optimal integration and productivity?</td>
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<td>How can the role(s) meet academic standards as well as achieve service objectives?</td>
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<tr>
<td>How are partnerships built and maintained?</td>
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<td>How can the academic partner build internal capacity and keep academic colleagues engaged and supportive?</td>
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<tr>
<td>How do you identify the right leadership in the service executive to ‘champion’ the PD initiative?</td>
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<tr>
<td>What are the leadership qualities we are looking for in this person?</td>
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<tr>
<td>How can service timeframes and pressures be used as a lever for change through PD/KT initiatives?</td>
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<tr>
<td>How do we actively involve key staff within the organisation?</td>
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<td>How is the PD/KT project/partnership communicated?</td>
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<td>How do we identify appropriate financial, physical and human resources to increase the chance of success?</td>
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<tr>
<td>What are the components of an organisational framework that encourages PD?</td>
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<td>How do you set up the right structure and governance frameworks?</td>
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<td>What strategies do you use to develop skilled facilitation at local level?</td>
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<td>How do you sustain the momentum?</td>
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<th>Table 1</th>
<th>Questions to align the academic and clinical contexts for the advancement of nursing practice.</th>
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How is consistency and clarity of purpose maintained given the differences between the academic and service contexts? What are the components of an organisational framework that encourages PD? How do you set up the right structure and governance frameworks? What strategies do you use to develop skilled facilitation at local level? How do you sustain the momentum? The answers will best be found through strategic partnerships between the academic and health service sectors.

References


