Pursuing Common Agendas: A Collaborative Model for Knowledge Translation between Research and Practice in Clinical Settings

Jennifer L. Baumbusch,1* Sheryl Reimer Kirkham,2† Koushambhi Basu Khan,4‡ Heather McDonald,1§ Pat Semeniuk,3# Elsie Tan,1# Joan M. Anderson1,4,5**

1School of Nursing, University of British Columbia, British Columbia, Canada
2Nursing Department, Trinity Western University, British Columbia, Canada
3Learning and Career Development, Vancouver Coastal Health, British Columbia, Canada
4Culture, Gender and Health Research Unit, School of Nursing, University of British Columbia, British Columbia, Canada
5Office of the Vice President Research, University of British Columbia, British Columbia, Canada

Accepted 30 July 2007

Abstract: There is an emerging discourse of knowledge translation that advocates a shift away from unidirectional research utilization and evidence-based practice models toward more interactive models of knowledge transfer. In this paper, we describe how our participatory approach to knowledge translation developed during an ongoing program of research concerning equitable care for diverse populations. At the core of our approach is a collaborative relationship between researchers and practitioners, which underpins the knowledge translation cycle, and occurs simultaneously with data collection/analysis/synthesis. We discuss lessons learned including: the
complexities of translating knowledge within the political landscape of healthcare delivery, the need to negotiate the agendas of researchers and practitioners in a collaborative approach, and the kinds of resources needed to support this process.© 2008 Wiley Periodicals, Inc. Res Nurs Health 31:130–140, 2008

Keywords: qualitative; social and economic aspects of illness; utilization of services; care of minority groups/patients

Over the past few decades, the transfer of research findings into practice has been a subject of interest for researchers, practitioners, and policy-makers. The transfer of research findings was approached with knowledge-driven and, later, problem-solving models (such as research utilization and evidence-based practice [EBP]) that typically entail a linear, unidirectional, and passive flow of information from research to practice. In recent years, a growing number of scholars have noted that such models have not addressed well the gap between research and practice (Jacobson, Butterill, & Goering, 2003). This situation has led some researchers to advocate for broad and interactive models of knowledge translation. Key to this approach is the understanding that research findings must be translated into information that is meaningful to practitioners. Activities thus focus as much on process as on product, and emphasize the crucial elements of reciprocity and exchange between the producers and users of knowledge (Jacobson et al., 2003; Lomas, 2000).

We have engaged with the knowledge translation discourse in Canada by drawing upon this growing body of scholarship (Canadian Institutes of Health Research [CIHR], 2004; Estabrooks, 2003; Jacobson et al., 2003; Lavis et al., 2003). Our work evolved within an ongoing program of research, Hospitalization, and Helpseeking Experiences of Diverse Ethnocultural Groups: Phases I & II (1998–2005), the aims of which were to examine patients’ experiences in the hospital, what happened when they were discharged home, and the mediating life circumstances that influenced how they were able to manage their care at home. Briefly, we found that many patients experienced gaps in the continuity of care and had issues with language and communication. Underscoring these issues were discourses around efficiency in healthcare and the allocation of resources. These discourses influenced how health care professionals interacted with patients, especially patients who were seen to require more time because of language barriers. For more about the findings from the program of research see: Anderson et al., 2003; Baumbusch et al., 2007; Lynam et al., 2003; Perry, Lynam, & Anderson, 2006. The purpose of this article is to describe how we engaged in the ongoing discourse of knowledge translation during this program of research through the development of a collaborative model of knowledge translation between research and practice in clinical settings (see Fig. 1).

**DISCOURSES OF KNOWLEDGE TRANSFER**

The gap between the generation of evidence and its uptake in practice highlights the need for effective models for the transfer of research findings into practice. This gap has attracted the attention of practitioners, researchers, policy-makers, and administrators. Nurses have struggled with the tension between research and practice (Dean, 1995). Several scholars have sought to explore barriers to the uptake of nursing research in practice. Some focused on the lack of abilities of individual nurses to draw upon research (Bircumshaw, 1990; Ohlsson, 2002). Others highlighted the presence of an organizational structure and/or work culture that does not value or promote research utilization (Kitson, Ahmed, Harvey, Seers, & Thompson, 1996; MacGuire, 1990; Pearcey & Draper, 1996; Retsas, 2000; Sitzia, 2002). In response to these barriers, scholars have made efforts to develop processes or models to overcome the barriers between research and practice. For example, considerable energy was put into establishing models for research utilization whereby front-line professionals and supervisors work together to identify research-based answers to specific practice problems (LoBiondo-Wood & Haber, 2002; Stetler, 1994, 2001; Titler & Goode, 1995). However, there are few studies evaluating the relative impact of different research utilization interventions on either nursing or patient outcomes (Davies, 2002), and the gap persists.

In the 1990s, the EBP movement became a popular solution for addressing the research-practice gap. The EBP movement in nursing was derived from the evidence-based medicine movement. The Sackett, Rosenberg, Gray, Haynes, and Richardson (1996, p. 71) definition
of evidence-based medicine has been widely adopted and applied to the concept of EBP, as follows: “Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.” Within most frameworks for EBP, there is a clear hierarchy of evidence with randomized controlled trials (RCTs) ranked as the gold standard followed by other forms of quantitative research and systematic reviews (Sackett, 1997). Whereas research utilization models often floundered because of lack of organizational support (Sitzia, 2002), the EBP model has been promoted at organizational levels. EBP is often enacted as procedures, typically referred to as clinical pathways, or best practices, which use evidence to set guidelines for practice.

There have been critiques of EBP. With regards to the definition of best evidence, theoretical and methodological approaches that are used in nursing research, such as qualitative research, participatory action research, research underpinned by critical inquiry, are often not included or fall at the bottom of EBP hierarchies. Concerns regarding the definition of evidence collectively point to the socially derived nature of all knowledge, and the shortcomings of unquestioningly putting forward evidence, as defined in EBP, as a preferred, reliable, and objective approach to clinical practice without developing a broader interpretation of the notion of “evidence” (Goldenberg, 2006; Lambert, 2006). Moreover, nurses not only rely on research findings for practice but also on a range of knowledges largely excluded in EBP, such as philosophic, aesthetic, theoretical, personal, and practice knowledge (Reimer Kirkham, Baumbusch, Schultz, & Anderson, 2007). As well, the approaches to research that are central to EBP hierarchies often lead to context-stripped findings, thus limiting their relevance for the context-rich practice environments of nursing (Goldenberg, 2006; Reimer Kirkham et al.). While EBP guidelines may decrease variation of care across settings (Youngblut & Brooten, 2001), this homogenization of care can ignore the needs of individual patients (Ingersoll, 2000; Kravitz, Duan, & Braslow, 2004) and the care needs of the diverse populations that exist in healthcare settings (Reimer Kirkham et al.). Economic rationalization and managerialism have also been identified as ideologies that drive EBP (Traynor, 2002; 

![Figure 1](image.png)

**FIGURE 1.** A collaborative model of knowledge translation between research and practice in clinical settings.
Walker, 2003; Winch, Creedy, & Chaboyer, 2002) with questionable outcomes. Together, these critiques raise concerns that “autonomy is eroded if nurses use evidence as recipes, without drawing on their professional knowledge and clinical judgment to interpret evidence, and make decision about best evidence in context—this is the core of professional practice” (Reimer Kirkham et al., p. 29).

With recognition of these ongoing challenges and critiques, many scholars have now turned to the notion of knowledge translation, which involves interactions between potential users of knowledge for clinical application, such as policy makers, decision makers, and researchers, with timely responses by researchers to knowledge needs identified by the users (Lavis, 2006). Although there is no overarching theoretical framework for knowledge translation, most approaches provide an expanded view of evidence (Estabrooks, Thompson, Lovely, & Hofmeyer, 2006; Graham et al., 2006), shifting away from the hierarchies put forth by proponents of EBP. Moreover, the knowledge translation process occurs within a complex social system, which needs to be taken into account during initiatives. The complexity requires that researchers tailor their activities to the needs of the potential users (Graham et al.). Successful translation, therefore, is a function of the relationships among the nature of the evidence, the context of the proposed change, and the mechanisms by which change will be facilitated (Davies, 2002). The relationship among the components is not linear, instead all dimensions are active simultaneously. Thus, knowledge translation has the potential to address the research-practice gap by bringing together researchers, who are typically academically based, and clinically based practitioners in a dynamic process. The following sections describe our experiences and evolving approach to knowledge translation, which had its genesis in Phase II (2002–2005) of the Hospitalization and Help-seeking program of research and is being refined in an on-going study.¹

¹The research team is currently conducting a 3-year study “Cultural Safety and Knowledge Uptake in Clinical Settings: A Model for Practice for Culturally Diverse Populations” (Principal Investigator: Joan Anderson; Co-Principal Investigators: Annette Browne, Judith Lynam, Sheryl Reimer Kirkham; Co-Investigators: Paddy Rodney, Pat Semeniuk, Elsie Tan, Colleen Varcoe, Sabrina Wong). Funded by the Canadian Institutes of Health Research (CIHR), 2005–2008.

Push, Pull, and Exchange
The Genesis of the Collaborative Model of Knowledge Translation

Over the past few years, the Canadian federal funding agency for healthcare research has been supporting the translation of research on a wide range of relevant questions, pursued through multiple methodologies and disciplinary perspectives to various target audiences (CIHR, 2004; Lavis et al., 2003). Researchers are coming together with knowledge users for the exchange, synthesis, and ethical application of research findings through the funding of innovative knowledge translation projects (CIHR). Essentially, the dynamic consists of three actions: (a) Push, to signify that researchers need to do a better job of communicating their results to the world of practice; (b) Pull, to signify that practice organizations need to become more evidence-based in their policy making; and, (c) Exchange, to signify that, from the beginning, research is designed to be attentive to the needs of practice (Canadian Health Services Research Foundation [CHSRF], 2000; Lavis, 2006).

Push

During the development of Phase II of the program of research, the CIHR published Knowledge Translation Strategy 2004–2009, which made effective communication of research findings an explicit priority in the conduct of healthcare research in Canada. Researchers took up the CIHR framework as a starting point to develop a model for knowledge translation in clinical settings. In addition to supporting the translation of knowledge from a broad range of research approaches, the CIHR framework emphasizes the value of practitioner input in the process, which fit well with our commitment to social responsibility and praxis-oriented outcomes (Reimer Kirkham & Anderson, 2002). As we began to explore knowledge translation, we anticipated that the process of engaging practitioners with the research findings could potentially provide them with alternative ways of understanding their patients’ experiences and facilitate more thoughtful practice. For instance, in Phase I researchers found that nurses tended to make assumptions about members of some ethnic groups, such as the notion that patients have large extended families able to provide care upon discharge from hospital when, in reality, these patients may not have access to support resources.
in the home. As we “pushed” researched-based knowledge our intention was to move toward transformative knowledge in practice: knowledge that is “undergirded by critical consciousness” (Anderson, 1998, p. 205). This dynamic knowledge is co-constructed by researchers and practitioners, and requires a great degree of intentionality from both. Its construction is therefore contingent upon the next action of knowledge translation: pull from the users.

**Pull**

At the same time that we researchers were exploring innovative ways of communicating findings to the world of practice, practitioners expressed a wish to become more engaged in the research process. In particular, practitioners identified a need for research findings to ground and support clinical initiatives that provide equitable care for diverse populations. For example, our practitioner partners used the findings from Phase I to substantiate the need for a medical interpreter program to ensure that patients had access to trained medical interpreters. Practitioners who had spearheaded that initiative then approached researchers with requests to be more involved in Phase II of the program of research. They wanted quicker access to emerging findings rather than waiting until the conclusion of the study, as is often the case in more traditional approaches to dissemination. This request reflected the fast pace of healthcare and the need to make timely decisions regarding service delivery based on current knowledge, reinforcing researchers’ need to be responsive to user groups (Lavis, 2006). It also signaled an opportunity for researchers to work with practitioners at the organizational level to shift organizational culture through policy and procedure. These requests from the practice environment were a driving force in engaging the team in novel approaches to knowledge translation.

**Exchange**

As Phase II was developed, there was ongoing commitment from researchers to involve practitioners (in this case, directors and managers) in the design of the research, with a number of practitioners named as co-investigators. As the aim of this program of research was to bring in-depth descriptions of patient experiences to practitioners, the researchers found it invaluable to collaborate in knowledge translation and capitalize on practitioners’ desire to take up emerging findings in practice. Together, researchers and practitioners fostered an atmosphere in which there was a sense of shared ownership of emerging findings, and where research findings were central to discussions of how to provide care to diverse populations, both at a systems level and at the individual practitioner level. This focus on meaningful and authentic exchange continued throughout the knowledge translation process, as described in the following sections.

**DESCRIBING THE COLLABORATIVE MODEL FOR KNOWLEDGE TRANSLATION IN CLINICAL SETTINGS**

From the outset of Phase II, our approach to knowledge translation was underpinned by an understanding that it is an interactive and reciprocal process: “a synthesis and ethically sound application of knowledge within a complex system of interactions among researchers and [knowledge] users” (CIHR, 2004, Section 2; Estabrooks, 2003; Jacobson et al., 2003; Lavis et al., 2003). We conceptualize knowledge translation as a dialogic, collaborative engagement between researchers and practitioners through which people come to reflect on what they do, and its consequences, and identify what they might do differently by drawing on research-based knowledge (see also: Baumbusch et al., 2006, 2007). We articulate our approach using the concepts of process (translation) and content (knowledge). The process dimension has two main components: (a) a collaborative relationship between researchers and practitioners, and (b) the knowledge translation cycle that embodies its dynamic nature. The process dimension is embedded within the content dimension, which involves an ongoing cycle of data collection/analysis/synthesis of knowledge. Figure 1 illustrates the complexity of these simultaneous dimensions, and, as with our understanding of
knowledge translation, this visual representation of the model continues to evolve.

**The Process Dimension: Core Elements of the Model**

At the core of our approach is the relationship between researchers and practitioners. The key elements of this relationship are: accountability, reciprocity, and respect for one another’s knowledge. Accountability, or “...meeting legitimate standards, fulfilling legitimate commitments...” (Stein, 2001, p. 74), is shared between researchers and practitioners. “Reciprocity implies give and take, a mutual negotiation of meaning and power” (Lather, 1991, p. 57) and is key to using research for praxis. Shared accountability and reciprocity would not be possible without a respect for the different types of knowledge that researchers and practitioners bring to this process.

The aim of the collaborative relationship is to break down traditional barriers between researchers and practitioners by promoting a shift away from the typical roles of each in the research process. Researchers strove to embrace the role of credible messenger (Lavis et al., 2003) in communicating the value and relevance of the research to clinical practice. We endorsed the commonly accepted accountabilities that come with conducting rigorous research while nurturing relationships with practitioners. Similarly, practitioners took on more active roles, with some individuals becoming research champions by demonstrating enduring commitment to the project and advocating for nursing research in their clinical areas. Accountabilities that were taken up by the research champions included establishing and maintaining connections between the researchers and practitioners, helping researchers navigate the complexities of the healthcare system, negotiating entry into various clinical areas, and providing ongoing feedback on how research was perceived and applied in the practice setting. A challenge was maintaining continuity, as research champions commonly had their areas of organizational responsibility changed or moved into other positions.

Because of the challenges created by personnel changes, organizational commitment to knowledge translation is essential for its success. We sought an environment where researchers and practitioners, who had the capacity to facilitate organizational change, could freely discuss and then act upon findings from the program of research. Organizational characteristics that enable knowledge translation activities include a culture of learning, leadership support, and available resources (Stetler, 2003). Our practice partners in this study worked for a research-oriented organization with a long history as a teaching and research center. As such, our clinical partners were able to integrate innovations emerging from the knowledge translation process within the system.

The notion of consulting has been introduced as an important knowledge translation strategy to bridge the worlds of academia and the clinic (Jacobsen, Butterill, & Goering, 2005). Consultants can foster an atmosphere of respect and understanding for the local knowledge of both researcher and practitioner and have an integral role in translating research-based knowledge into tangible changes in practice. Consultants span the roles of both credible messenger and research champion. While in the past, there may have been nurse leaders employed by the organization to fill this role, many of these positions have been eliminated over years of healthcare restructuring (Shamian & Lightstone, 1997). To fill this void, we created a role for a doctoral student in nursing who was an experienced manager and clinician, and new researcher, and was able to speak the languages of research and of practice. The purpose of this role was to bring the worlds of practice and research together: to serve as a cultural broker (Norriss et al., 2005). Because of her qualifications and skills, the doctoral student was able to facilitate dialogue by the judicious use of language and, when necessary, by reframing issues to make them accessible to the entire team. This student was initially supported through funds from the Principal Investigator’s endowed professorship and, later, by funds from the clinical organization to support knowledge translation activities.

**The Process Dimension: The Knowledge Translation Cycle**

Once the groundwork for the collaborative relationship was established, the researchers and practitioners engaged in activities that enacted reciprocity in the knowledge translation cycle. This cycle reflects the dynamic, dialogical process of knowledge translation and is marked by knowledge translation in real-time: an ongoing dialogue around emerging findings that allows practitioners to use findings in a rapidly evolving healthcare system while helping researchers ensure that the study remains relevant to the practice setting (CHSRF, 2000; Health Research Transfer Network of Alberta, 2002).
Listening is a key aspect of knowledge translation, as exemplified by researchers seeking out practitioners’ perspectives on research priorities (Lomas, Fulop, Gagnon, & Allen, 2003). In our efforts, listening was foundational to reciprocity, and real-time communication provided the platform for it. Throughout the data collection process, researchers worked with practitioners to identify research questions that were relevant to their practice areas. Data collection then reflected these questions, allowing the researchers to share findings related to specific questions during ongoing feedback sessions. Regular face-to-face meetings between researchers and practitioners were an essential forum for exchange of ideas. These meetings were similar to the “safe harbors” described by Lavis (2006, p. 41) at which practitioners were able to respond to emerging findings. This approach fostered an open and productive dialogue within the context of a respectful relationship. We held regular meetings, over breakfast at convenient locations, with a group of clinical leaders. During these meetings, researchers shared emerging issues from the data and together with practitioners considered how resources, already available in the system, could be used more effectively to address these issues. The discussions informed ongoing efforts to improve the provision of equitable care to diverse groups.

Although we have had success with real-time knowledge translation at the leadership level, the team’s current study focuses explicitly on knowledge translation with front-line staff. As Lavis et al. (2003, p. 224) suggested: “the specifics of a knowledge-transfer strategy must be fine-tuned to the types of decisions [practitioners] face and the types of decision-making environments in which they live or work”; working with a new group of practitioners has, therefore, pushed the researchers to explore a new set of knowledge translation initiatives. As researchers, we have drawn primarily on the strategy of just-in-time teaching, which engages practitioners at the point of care, aiming to build knowledge uptake activities and influence clinical decision-making (CHSRF, 2000). With our praxis-oriented approach, we have reframed just-in-time teaching as responsive dialogue, which pushes the notion of engagement to include concerted attention to the feedback and ideas of practitioners. Responsive dialogue engages clinical decision-makers, at the point of care, in discussions about issues from the program of research that are immediately relevant to them and encourages reflection on the decision-making process to heighten awareness of the determinants of inequities in care.

We spent several months, at the beginning of the current study, establishing collaborative relationships with nurses on four units in an acute care setting. Two doctoral students, who had strong foundations in clinical practice and were immersed in the program of research, took up the consultative role. Activities during the knowledge translation process included facilitated discussions of context-rich case studies, small group discussions between point of care staff and academically based co-investigators, and one to one time with staff to allow for more in-depth reflection on practice. In addition to these activities, which emphasized individual reflection on care provision, we also worked with small groups of staff on the units to develop clinical pathways (and associated patient education materials) that included attention to social contexts and mediating factors in patients’ lives.

For knowledge translation to have a lasting impact, it needs to become part of institutional practice (Stetler, 2003). In our approach, we refer to institutional-level projects described above as action plans. Based on findings from the program of research in concert with clinical priorities, projects are developed that have a direct impact on care, resulting in sustainable transformations in practice. For example, the medical interpreter program established from Phase I findings was a practitioner-driven action plan; in Phase II, we developed several action plans (for a detailed description, see Baumbusch et al., 2007); and, in the current study, we are working on unit-specific projects with staff, focusing on expanding clinical pathways and patient education materials. As with any shift in practice that involves innovative approaches to challenging issues, “adoption is a process rather than an event” (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004, p. 600), and many of the projects continue to evolve within the practice setting. Future studies need to include greater evaluation of the outcomes of knowledge translation projects such as these.

The Content Dimension:
Translating Knowledge from a Program of Research

One of the challenges in knowledge translation is taking a large body of research-based knowledge and making it meaningful to the user audience. Researchers had completed the initial stage of data analysis for Phase I and were beginning data collection for Phase II when we began sharing research findings with practitioners during our safe harbor sessions. In an initial session, we
provided data on hospital readmissions, an unanticipated trend that researchers were hearing about during follow-up interviews with patients in their homes. This was concrete information that was directly relevant to decisions practitioners were making every day (specifically around issues of patient flow and costs associated with readmission). Sharing emerging findings in real-time about readmitted patients became a catalyst for the content dimension to engage researchers and practitioners in a broader dialogue around the human suffering experienced by patients and their families when communication is lacking between health care providers across services and their patients. Essential to the reciprocal nature of this dialogue, practitioners were gracious in sharing insights with researchers regarding the complexities embedded in the hospitalization experience, as for example, they juggled workload issues stemming from rising acuities and human resources shortages on a daily basis. These insights then helped to push further analysis of the research.

In our study, the high readmission rate for the sample (16% as compared to the industry standard for selected diagnoses of 7%; Canadian Institute for Health Information, 2002) had clear resource implications for the hospital. Because the study sites often provided tertiary-level care to patients from a large catchment area, patients were sometimes readmitted to other community hospitals, making practitioners at our partner organization unaware of these readmissions. Thus, rates of potentially preventable readmissions were much higher than expected, a finding not identified until the research. For readmitted patients, there were a number of issues affecting their experiences during the transition between hospital and home, including timing and quality of discharge teaching and management of communication when the patient could not speak English. Many of the readmissions seemed to be preventable (patients were readmitted for issues directly related to their original hospitalizations, such as uncontrolled pain, wound complications, and bowel impaction). Although caution must be taken in interpreting this data due to the small sample size, it may be that those patients who avoided readmission used the healthcare system in other ways (such as phoning back to the unit from which they were discharged or visiting the emergency department but not being readmitted).

Case studies of readmitted patients provided rich ground for discussions about potential gaps in care and, ultimately, led to the development of action plans to translate knowledge from these findings into practice, in order to address gaps in services between hospital and home. As researchers, we were able to transmit issues within a message that practitioners found intriguing and relevant. Moreover, our partnership continues to flourish, with practitioners providing ongoing input into the research questions that, once explored, could support front-line staff and clinical leaders to provide equitable care for diverse populations.

LESSONS LEARNED AND FURTHER EXPLORATIONS ON THE ROAD TO KNOWLEDGE TRANSLATION

We have entered into the ongoing discourse of knowledge translation in Canada. Prior to the emergence of knowledge translation, approaches to knowledge transfer (such as EBP and research utilization) placed limited value on research conducted from certain theoretical and methodological perspectives, such as research utilizing qualitative methods. Knowledge translation offers an exciting opportunity to bring knowledge from multiple methodologies and theoretical frameworks into the practice environment. In developing our approach, we drew upon concepts from a number of leading scholars and have demonstrated how these concepts, which are usually applied at broad levels (e.g., public policy making), can be taken up in local settings and at the point of care. Our approach also varied from other efforts, as it attended closely to the effects of larger social factors on the lives of patients as well as on the organization of healthcare practice and research processes. We illustrated how research that features the experiences of patients and health care providers can be a safe platform for change when researchers and practitioners are active in pursuing a common agenda through knowledge translation.

Our evolving approach to knowledge translation has also highlighted a number of areas requiring further consideration for nursing research. First, there are implications for an expanded understanding of evidence (Reimer Kirkham et al., 2007), particularly ways to incorporate experiences/perspectives of patients and health care providers into institutional practices such as clinical pathways. As other researchers have found, there is a tension for practitioners working in a biomedical paradigm underscored by corporate ideologies to attend to the socio-political context of care (Rodney et al., 2002). Researchers need to be aware of this political landscape in order to support their colleagues to take up research-based knowledge at
individual and systems levels even when it would appear to be in conflict with the agendas driving healthcare delivery. To achieve the kind of engagement needed to support practitioners to do this, researchers need to foster collaborative relationships and create safe harbors, where both researchers and practitioners can speak freely about how to address these tensions.

Second, we researchers found that, although the simultaneous processes of collecting, analyzing, and communicating findings can be flexible and responsive to priorities identified by practitioners, it also presents new challenges. In the example about readmissions described earlier, practitioners requested that the researchers include quantitative, numeric, evaluative data on this group of patient participants and repackage the qualitative data into succinct statements. Researchers had to be open to the kinds of data that clinical leaders needed to support decision-making while maintaining the integrity of the data with its focus on in-depth exploration of patient experiences. Although the two sets of data heightened our understanding of the consequences of the readmission process, we had to be cautious about discussing preliminary findings before we completed in-depth analysis. As researchers, we had to be attentive to the agenda of practitioners—to receive information related to barriers to efficient patient flow and unnecessary costs to the system—without drowning out the complex issues around mediating factors in patients’ lives that influenced their abilities to manage care at home, which was a message at the center of our agenda. The negotiation of research and practice agendas remains an issue we reflect upon continually, particularly as we consider how to embed both agendas in future research studies.

Third, enacting this model demands new approaches toward roles and accountabilities of researchers and practitioners. Each can contribute to closer links between research and practice. Academic researchers may require a new set of skills as they embrace the role of collaborator/partner in addition to the traditional role of analyst. Combining these roles can bring into focus the tensions that exist between them and challenge the researcher to negotiate these roles. Along with this shift are implications for how grants are written, including the resources (time and money) needed to support knowledge translation. For managers and directors in clinical settings, there is a similar need to shift away from an administrative role toward one that supports initiatives that lead to transformations in practice and service delivery so that diverse populations receive equitable care. Critical to this shift is support from an organization that values research-based knowledge as a basis for ethical decision-making. Both groups must have a high degree of interest in pursuing this approach to knowledge translation. Although we conducted the broader program of research at a number of sites, knowledge translation activities took place at only one of the participating organizations. For researchers and practitioners, there is an emphasis on promoting understanding of each other’s worlds. Researchers immersed themselves in the practice setting during the study to gain greater understanding of the practice context and practitioners were study co-investigators, co-authors on academic manuscripts including this article, and co-presenters at national and local research conferences (Dyer & McDonald, 2007; Semeniuk, Baumbusch, & Anderson, 2005).

Finally, there are additional challenges in engaging front-line staff in knowledge translation, including lack of time for staff to engage in the process of reflection and of continuity among staff due to shift work; meaning that even greater resources and creativity are required for successful knowledge translation in this context. This divergence highlights the need to have systems in place that allow front-line staff to have an active role in nursing research. It also illustrates the policy—practice gap that persists in organizations that value the uptake of knowledge from research yet lack mechanisms for staff to be involved in this process in an ongoing manner. This situation underscores the need for researchers to achieve knowledge translation, not only at the policy/program level, but also at the point of care.

**CONCLUSION**

Traditional notions of evidence and concomitant approaches to knowledge transfer have not been sufficient to support the changes needed to achieve more equitable delivery of healthcare services for diverse populations. Unidirectional approaches to the transfer of research-derived knowledge have not solved the persistent research-practice gap. In this article, we have shown how our team of researchers and practitioners addressed these issues through a collaborative approach to knowledge translation that, when appropriately resourced, can have tangible benefits at the individual and at the systems level. As we continue to work within a broader research context, in which funders and policy makers increasingly advocate participatory approaches
to knowledge translation, we see great potential for transformed practice and enriched nursing inquiry.

REFERENCES


Lavis, J., Robertson, D., Woodside, J., McLeod, C., Abelson, J., & Knowledge translation study group. (2003). How can research organizations more effectively transfer research knowledge to...
decision makers? The Milbank Quarterly, 81, 221–248.


