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CIHR KNOWLEDGE TRANSLATION PROJECT

Cultural Safety and Knowledge Uptake in Clinical Settings: A Model for Practice for Culturally Diverse Populations (2005-2008)

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**Cultural Safety and Knowledge Uptake in Clinical Settings:
A Model for Practice for Culturally Diverse Populations (2005-2008)**

Executive Summary Submitted to the Canadian Institutes of Health Research (CIHR)

This 3 year knowledge translation pilot project marks the culmination of several years of collaborative research between researchers in the Culture, Gender and Health Research Unit (CGHRU), UBC School of Nursing, and health professionals in various health regions in the Lower Mainland area of British Columbia. The foundational collaborative research, upon which this current project was based, focused on the hospitalization and help-seeking experiences of diverse populations.

At the time the foundational studies were conducted (1998-2005) we found that although some patients in these studies experienced a seamless transition between hospital and home, others had difficulties. Some patients felt inadequately prepared to resume activities of daily living and effectively deal with complications upon discharge home. Some lacked information about community resources or experienced a time lag between discharge and follow-up by the community health care team. These issues were accentuated for patients who were non-English speaking and who experienced difficulty asking questions and receiving answers. Health care professionals identified other barriers to providing care, such as the unavailability of interpreters on short notice, during evenings or week-ends and system pressures to promote more rapid patient flow. In fact, a key finding from one of the studies was that patients experienced a high readmission rate to hospital (16%), related to the reason for their initial admission. This readmission rate is higher than the CIHI documented rate of up to 7% for selected diagnoses (2002). It is important to note, however, that these rates are not directly comparable because of sampling differences. They may nonetheless signify issues across the continuum of care that need to be addressed. These findings, together with related findings from other CGHRU studies, underscored a compelling need for a knowledge translation (KT) study that focused on issues across the continuum of care, and ways of fostering equitable health care to all patients.

The objectives of this pilot project were therefore to: **(1)** Build on established partnerships between researchers and health professionals to co-create knowledge and incorporate that knowledge into practice. **(2)** Synthesize research findings from several studies that contribute to knowledge focused on the social circumstances of patients' lives that impact on transitions; and, engage health professionals in dialogue about how this knowledge can facilitate smooth patient transitions between hospital and home. **(3)** Co-create opportunities for health professionals to critically reflect on their assumptions about patients and the impact of these assumptions on patient care. **(4)** Evaluate the impact and effectiveness of this process of KT on the smooth transition of patients from hospital to home.

To achieve these objectives, we worked in collaboration with four individual hospital units to address issues that disrupt the smooth transition of patients from hospital to home. Our model was to establish one key partner for each unit (e.g., clinical educator, patient services coordinator) as a "champion" for the project. Through these partners, we could then work with nurses at the point of care to influence practice through KT. The key processes for translating knowledge included: (1) establishing collaborative relationships built on the principles of accountability, reciprocity and respect; (2) developing and implementing specific projects ("action plans") related to transition between hospital and home; and, (3) engaging in responsive dialogue with practitioners to foster reflective practice.

Two doctoral nursing candidates (DNCs), who were experienced clinicians and members of the research team, engaged at the point of translation. Their interactions with practitioners focused on

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identifying and discussing barriers and facilitators to safe and appropriate patient transitions, especially for patients who might typically fall through the cracks, such as people who do not speak English, who are unfamiliar with the health care system, or people who may have limited resources. The DNCs also fostered awareness about assumptions that providers hold about some patients, which may influence their perceptions of patients' concerns during discharge. Our purpose was to understand what works and what does not work in translating this kind of knowledge into practice.

As a pilot study, it was important to incorporate evaluation of the KT process. Evaluative data were gathered through three focus groups, interviews with 15 patients at home, and 18 healthcare providers. The field notes kept throughout the project were also important sources of evaluative data. Our experiences with this pilot study suggest that the collaborative processes of knowledge translation we used have important potential for integrating concepts relating to social justice and equity into practice. Working with nurses on the development of a clinical pathway and patient education pamphlet (one of the 'action plans') fostered the integration of some of this knowledge into the tools. Engaging healthcare professionals in dialogue about their practice created a forum where issues could be raised and solutions discussed. While the pilot nature of our study limited extensive impact on patients' smooth transitions, the feedback from one hospital unit indicates that this study was a significant factor in shaping nurse-patient interactions and improving staff morale.

Conclusions

- Knowledge translation is a complex endeavor and happens where and when there is receptiveness to the process. It does not proceed in a linear and predictable pattern and requires considerable support from administrators and clinical leaders to endorse the process and enable point-of-care nurses to engage with researchers. In addition, researchers need to ensure that adequate time for engagement is written into grants.
- In order for KT to work, researchers need to be accepted as an integral and flexible part of the clinical context.
- Similarly, researchers need to be truly engaged with health care professionals, and be receptive and responsive to what they can learn from them.

Recommendations

- Knowledge translation research, grounded in the principles of equity and social justice, within the clinical context ought to address the needs of patients *and* healthcare professions. Indeed, we found that during times of significant distress for nurses, the needs of nurses had to be acknowledged and addressed. Therefore, we recommend that healthcare professionals' issues ought to be addressed concurrently with patient issues. Neither should be addressed in isolation.
- We recommend that this and other models of KT be explored in partnerships between administrators, clinicians, researchers, and educators with a view towards developing sustainable models that can be implemented in practice and education.
- We recommend that continued efforts be made towards understanding how all nurses (point of care nurses, their related leaders, others in management/administration and across the continuum of care, including health professionals who work in the home care setting, and researchers) can engage together in dialogue to address issues that are of common concern.

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