i2i4dementia

Innovation to Implementation for Dementia:
A Practical Guide for Knowledge Translation in Healthcare
(with examples from dementia and aged care in Australia)

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VERSION NOTES

i2i4Dementia the second revision of this guide for dementia. It is an update to the Goodenough & Young (2014) adaptation of the original produced by the Mental Health Commission of Canada. To cite the original source please refer to: *Innovation to Implementation: A Practical Guide to Knowledge Translation in Health Care. First published in 2012 by and revised in 2014 by Mental Health Commission of Canada.*

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There is also an Australian adaption in this series for Telehealth (*i2i4Telehealth*).
Please visit https://cretelehealth.centre.uq.edu.au/our-work

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- Dementia Training Study Centres www.dtsc.com.au

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DISCLAIMER

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Look out for this logo!

Whenever you see this logo in the i2i*4Dementia* guide, it is a link to KT resources and tools on the DementiaKT hub (dementiakt.com.au)

knowledge	**innovation**	**implementation**
… learning through • Research, i.e. *Scientific* • Experience, i.e. *Experiential* • Action, i.e. *Pragmatic* • Being, i.e. *Cultural*	… products, actions, services or relationships that have the potential to enhance health outcomes	… the act of bringing a practice or a policy into effect, i.e. "doing".

What is Knowledge Translation (KT)?

After new knowledge becomes available, there can be quite a time lag before it can be put into practice or inform policy.[1] The field of Knowledge Translation (KT) has emerged as part of the response to reducing this time gap.

KT involves relationships between end users and producers of knowledge. In practical terms:

Knowledge translation describes the process of changing what we do to match what we know – it is fact-based decision making, where the "facts" are *best available evidence.*

For more information about KT definitions, visit the toolbox on the DementiaKT hub (dementiakt.com.au)

KT also includes the study of this process, because using new knowledge to change practice can itself create new knowledge. This includes learning about how to plan, disseminate and use evidence in certain contexts, and how to measure, monitor, and maintain changes.[2] [3]

I2i4*Dementia* and the DementiaKT Hub

I2i4*Dementia* is a 7-step guide for planning, driving and documenting change in health settings using knowledge translation (KT) activities. It is an adaptation of the I2I guide originally developed by the *Mental Health Commission of Canada*.[4] **I2i4*Dementia*** includes specific examples from the aged care and dementia settings and was developed by the Knowledge Translation Program for the *Dementia Collaborative Research Centres,* Australia, building on an earlier revision.[1] The Australian series of I2I adaptations also includes the i2i*4Telehealth*.[2]

The I2I approach is built around the concept of innovation: products, actions, services or relationships that can potentially enhance health outcomes. The guide will help you work out how to move from innovation to implementation in a thoughtful manner – to help achieve the desired outcomes of a project or initiative best suited to your context and needs. I2i4Dementia also includes links to other KT resources on the DementiaKT Hub – a website resource developed by the knowledge translation programs for DCRCs and DTSCs to support innovation in the area of dementia and aged care.

The I2I approach and Australian adaptations, are informed by research findings and practical experience which show that a wider range of practices, participants, and knowledge types needed to be incorporated into KT activities.[5] [6]

I2i4*Dementia* is not intended to replace KT frameworks such as PARiHS (Promoting Action on Research Implementation in Health Services) or the Knowledge-to-Action Model. Rather, this guide can facilitate the application of these frameworks with an action-oriented planning tool.[7] [8] [9]

For more information about KT frameworks, visit the toolbox on the DementiaKT hub (dementiakt.com.au)

As a practical goal-oriented guide, **I2i4*Dementia*** highlights the importance of bringing a wide range of participants to the planning table. This is not an academic or theoretical document. It respects diversity and uniqueness, and emphasises the value, creation and contributions of different types of expertise (knowledge).

[1] Reference note for I2I-A 2014
[2] Reference to i2i4Teleheath

The Guide structure – and how to use it

There are 7 main steps in the **I2i4*Dementia*** guide:

STEP 1	State the purpose of this KT plan
STEP 2	Select the innovation around which the KT plan will be built
STEP 3	Specify the people and actions: who needs to do what differently?
STEP 4	Identify the best agents of change: who should be delivering knowledge about this innovation?
STEP 5	Design the KT plan
STEP 6	Implement the KT plan.
STEP 7	Evaluate the success

The **I2i4*Dementia*** guide will explain the purpose of each step, and walk you through a series of guided questions to help you complete the step.

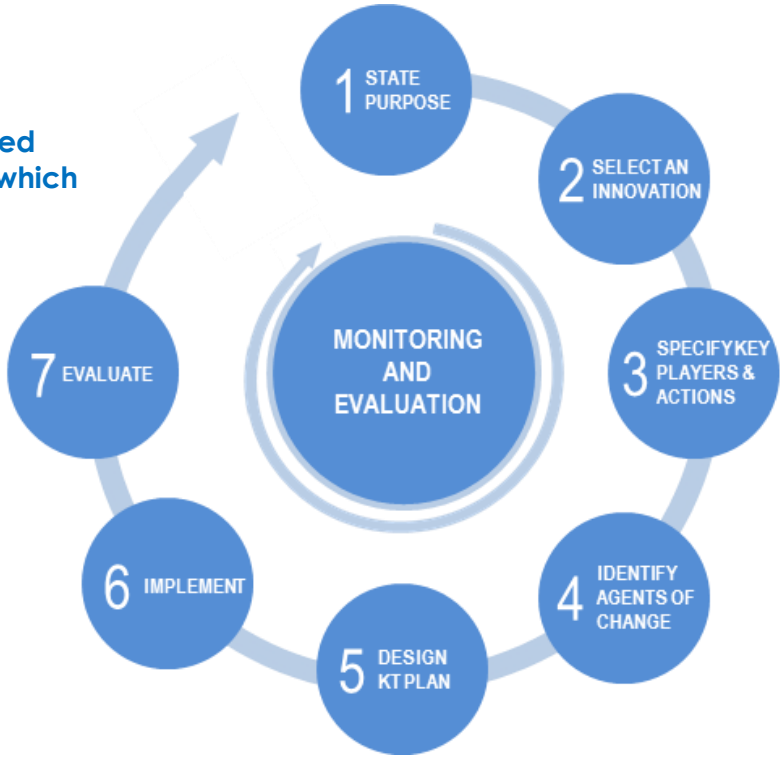
These steps are intended to be undertaken in the order listed, in an activity cycle –

You'll notice that designing the actual KT plan does not come until step 5! There is a lot of planning in successful KT initiatives. This guide provides helpful tips, with space for you to make notes about your own work and action cycle.

By the time the last step is completed, you will have implemented and evaluated a sophisticated KT plan. And potentially, created and documented new knowledge!

This Australian adaptation for dementia/aged care includes an additional topics section which contains further information about:

A. **Is this Innovation "KT ready"**
B. **Readiness for change**
C. **Disseminating new knowledge**



STEP 1. State the purpose of this KT Plan

It is important to begin a KT planning process by describing the goal you would like to achieve. What is the main reason for doing KT … and what would success look like?
To start some clear goal-related thinking, consider these key questions:

Key Questions

1.1. What is the main issue this KT plan is trying to address? [see Box 1]

1.2. What is the practice you are hoping to improve or introduce?

1.3. What will be different when this new knowledge is translated?

1.4. What will "success" look like and how would it be measured as knowledge translation?
*Read Step 7 about **Evaluation** before you begin your KT process. It will help you to think about and potentially identify KT outcome measures from the start.*

Box 1. Reasons and experts

Most KT plans in aged care and dementia will be prompted by a

- **problem**
  (i.e. an issue needs a fix)
- **opportunity**
  (e.g. a new idea to try)
- **requirement**
  (e.g. accreditation)

New knowledge includes expertise and experiences shared by colleagues or clients. You will explore these more fully at **Step 2**.

Examples

1A. General Practitioners will use cognitive impairment screening once a year in care of patients aged 75 years and older.

1B. Nursing staff in residential care will offer an additional afternoon drink to clients on days which are hotter than 25 degrees.

1C. Family members caring for a person with dementia at home will access respite care services at least once per month.

Helpful Tips

Defining the reason for the KT plan (and mind's eye for the end goal) is the first step – it focuses on the reason for change, not the method for enacting the change. A clear goal (and being able to describe in simple words) will also help in 'selling the vision; to the rest of a team.

It's best to avoid leaping to a particular KT method (selection of KT methods occurs at a later step in this guide). Here are some examples of not-so-helpful purposes or goals for this step which are focused on the what/how (method, rather than the goal (outcome/success):

Need some help on goal setting and developing a practical vision? The awareness-to-adherence framework in the "Your KT Journey" resource might help - visit the toolbox on the DementiaKT hub (dementiaKT.com.au)

- A brochure for GPs will be created.
- A practice guideline will be distributed to nursing staff about hydration in dementia.
- A website will be created for families describing person-centred respite care

YOUR NOTES FOR STEP 1. State the purpose of this KT Plan

Step 2. Select an innovation

An innovation is a product, action, service or relationship that has the potential to enhance health outcomes. Sometimes these outcomes are about better processes as well.

Key Questions

Consider what might be an appropriate innovation by asking (yourself and others) ….

2.1. **Is the innovation specific enough?**
By clearly stating the knowledge and actions that make up the innovation, you're more likely to create an effective KT plan. It can be very difficult to achieve wide uptake of a vaguely explained practice change.

2.2. **Is the innovation feasible?**
Choose an innovation that can be realistically implemented, given available financial, human and organisational resources. There is little advantage in focusing KT efforts on promoting a change so demanding or incompatible with current practice that few would actually implement it.

2.3. **What is the knowledge base for this Innovation?**
Innovations link to several knowledge perspectives: scientific, experiential, pragmatic, and cultural. Different team members can be selected on the basis of being able to contribute differing knowledge expertise **[see Box 2]**

Examples

An innovation is defined broadly and might involve:

2A. a new cognitive screening test,
2B. a change in medication for dementia
2C. a non-pharmacological therapy
2D. a different model of residential nursing care
2E. a new system for record for care accreditation,
2F. an education program for carers and clients about consumer directed care
2G. a leisure activity in an aged care hostel that appears to improve resident-staff engagement

Box 2. Knowledge types

- **Scientific**
(learning through research): A systematic review points to a new practice as better than current care, or a series of qualitative studies highlights benefits from new policy.
- **Experiential**
(learning through experience): A care practice may be endorsed by families based on their own positive experiences.
- **Pragmatic**
(learning through action): Aged care providers may identify a specific practice idea based on daily problem solving. E.g. nursing staff note a specific strategy seems useful for managing wandering or wayfinding behaviours.
- **Cultural**
(learning through being/living):
In certain cultural contexts, KT takes the shape of stories or teachings - including case studies, and personal or organisational histories. E.g., compelling stories are often used by policy makers to communicate vision.

Helpful Tips

- Examine the proposed innovation from several knowledge perspectives and expertise, and potential meaning for a range of audiences e.g ….
    - If based on international scientific research with dementia carers, consider also how it maps onto lived experiences of Australian families caring for a person with dementia
    - If based on the clinical experience of Australian aged care providers, examine whether it is consistent with available research evidence or consumer perspectives
- An innovation can also involve stopping certain practices, such as reducing medications taken by a person with dementia, or helping a family 'let go' of an previous way of caring.

Some Innovations are more "KT ready" than others.
Please read Additional Topic *A "Is this Innovation KT Ready"* (p20.)

YOUR NOTES FOR STEP 2. Select an innovation

STEP 3. Specify key players and actions

If an innovation is to be taken up by your organisation or community, then it is likely that certain stakeholders (KT players or "actors") will need to adopt new behaviours (actions).

Step 3 helps you recognise the key people who may need to change and the actions they need to adopt. Thinking ahead about these people will put you in a stronger position to plan your KT activities: you will know to whom you are presenting the innovation and what you want each person to do.

Box 3. Possible Key People

- Person with dementia
- Caregiver / family
- Residential care provider
- Community organisation
- Professional service provider
- Peak body in dementia/ageing
- Government agency
- Researcher
- Intern / trainee/ student
- Policy maker
- Accreditation/ care consultant
- Funder of the innovation
- You

Key Questions

3.1. Who are the key people (players or "actors")?
3.2. Which actions must these key people adopt?

Possible Key people
Box 3 shows people who are often involved in aged and dementia care KT.

Examples

Innovation	Key players*	Actions
3A. Dementia medication change	Medical specialist→	Review/provide prescription
	Nursing staff→	Supervise/document medication
	Caregiver→	Monitor side effects / change
	Person with dementia→	Adhere to medication
3B. New model of residential care	Facility Manager→	Brief / support training of care staff
	Accreditation consultant→	Approve care model
	Policy maker→	Endorse / fund organisational needs
	Residential facility staff→	Implement model of care
3C. Family-delivered strategy for challenging behaviour	Trainer (or Researcher) →	Deliver training (research planning)
	Community agency→	Recommend candidates for program
	Family caregiver→	Consent / participate / feedback

**examples in this table are not necessarily inclusive of all the key people who could be engaged – just a sample to showcase how you might approach this step.*

Helpful Tips

- It is vital to include and consider the full range of possible key players for your KT activity.
- Include all key people – regardless of whether you believe they support the innovation.
- Remember that many of these people are 'key' when they are involved in conversations through which knowledge about your project is exchanged. These conversations may sometimes involve only fragments of knowledge – and your project may need to think about how to ensure this information transmission is accurate, timely and helpful.

For more resources on engaging stakeholders, visit the toolbox on the DementiaKT hub (dementiakt.com.au)

YOUR NOTES FOR STEP 3. Specify key players and actions

STEP 4. Identify agents of change

An agent of change is someone who motivates key players [**Step 3**] to adopt new actions. Agents of change include individuals who can effectively deliver knowledge and foster action. The effectiveness of an agent in creating change often depends upon the key people ("actors") who need to change.

For more resources on understanding, managing, leading, and measuring change, visit the toolbox on the DementiaKT hub (dementiakt.com.au)

Key Questions

4.1. Which agents have the most credibility overall in relation to your innovation?
4.2. Which agents have the most credibility for particular players?
4.3. Which agents are most likely to persuade others to adopt new actions?

Examples

4A. In **Step 3**, Example 3A was an innovation involving a medication change. If the key player is the prescribing medical specialist, and the action is to begin prescribing a new drug for appropriate patients, then effective agents of change might include:

- Senior specialist (e.g. geriatric psychiatrist)
- Physician viewed to be an opinion leader by peers
- Pharmacy researcher who has reviewed evidence about current/new medicines

4B. In **Step 3**, Example 3B is an innovation involving changing a model of residential care. If the key person (actor) is the policy maker – and this could be a decision-maker at a senior executive level in a care network – and the action is to reallocate funding and resources to support new care practices, then effective change agents might include:

- Researcher who can summarise evidence on care models in policy-friendly form
- Decision-maker of equivalent seniority from another care network who has led or endorsed successful implementation of the model;
- Aged care consumer who has experienced the benefits of the care model.
- Expert on cost-effectiveness for the model (relative to current care)

Helpful Tips

It may be most effective to ensure that all agents of change are involved in the KT process at same level – even if it is at the level of 'advisory' or a 'one-off' information forum.
KT agents will often include:

- ***Peer leaders***
  It is powerful when a peer with high credibility is a model and supporter of an innovation. It gives the message that if someone in their role is able to embrace this change, then you can too! It is more effective if an early-adopting peer can also champion ongoing uptake ("sustainability") – supporting these people is vital.
- ***Organisational champions.***
  Innovations are more likely to be acted upon when they are endorsed by organisations of high credibility to the target participants, e.g. a respected authority in aged care or dementia. Where possible, effective agents of change will establish a relationship of respect, engagement, and support with the key people (actors) they seek to influence. The best KT occurs in good conversations; the best conversations occur in the best relationships.
- ***Consumer or end-user advocates.***
  The consumer and end-user voice is important. As aged and dementia care in Australia embraces consumer-directed care philosophies, a powerful change agent can be a representative for care recipients, their family caregivers, and service deliverers.

Box 4. Change Agents

Who to look for:

- Peer
- Opinion-leader
- Champion
- Early-adopter
- Advocate
- (You?)

YOUR NOTES FOR STEP 4. Identify agents of change

STEP 5. Design the KT plan

You're here! Many people – especially the practical 'can do' types – want to start at **Step 5.** KT effort will be most effective when it is carefully planned and has an active rather than passive quality, which is why the first four steps of the I2I-A are in place.

Key Questions

5.1. Which KT methods are available to me?
5.2. Which methods are appropriate for people (targets) meant to adopt this innovation?
5.3. Which methods are proven to be most effective with these kinds of key people?
5.4. Will this KT project need ethics approval?

For ideas on KT activities and tips for writing submission for funding or ethics, visit the toolbox on the DementiaKT hub (dementiaKT.com.au

Examples

It is important to tailor (one or more) specific methods of KT to your setting and resources. The table below gives examples of KT methods that may be used in your plan via a range of key people (and maybe different timepoints) – i.e., the people you identified at **Step 3**:

KT Methods	Description and notes
Meetings	Gathering key people in an interactive context to build capacity • Explore: think-tank, stakeholder forum, webinar
Professional Educational Outreach	Brief engagement intended to change professional behaviour; • Optimal for simple behaviour, e.g. professional prescribing • Consider knowledge broker /academic detailing for senior experts
Educational Materials	Product to convey a key message • Pamphlet, poster, web-page, newsletter, "logo product"
Reminders / Prompts	Print, electronic, telephone or web-based messages to trigger action • Can include app-based/software prompts in electronic records
Social Marketing Campaign / Media	Using marketing techniques to create / sustain behaviour change • A marketing expert may be a useful consultation for this method • Consumers can often readily participate and respond
Audit and Feedback	Performance summary over a period of time to inspire/sustain change. • This can be suitable for group presentation in a staff meeting • Use de-identified summaries, unless consent to do otherwise
Citizen Briefings	Print and web-based materials to address knowledge and skill gaps • Non-jargon summaries of science prepared for 'non-researchers'

Helpful Tips

- Some features for successful KT methods are listed in **see Box 5**.
- 'tailoring' can alter 'fidelity' – consider an independent opinion to check how far an innovation can change before it stops being the intended innovation.
- Organisations, systems or people may not be ready for your innovation, even if proven effective and feasible.[10 11]
  If readiness for change may be a factor in your KT plan, please read additional topic in this planner: "B. Readiness for Change"

Box 5. Features of KT method success

- **Interactive:** Shared expertise is valued, develops comfort with new behaviours
- **Tailored:** Content specifically directed to fit the known need, and flexible to feedback
- **Engaging:** Content delivery is concise, entertaining and persuasive.
- **Endorsed:** Innovation endorsed by high credibility organisation /peer group
- **Championed:** Innovation embraced by a respected early-adopting peer
- **Action-oriented:** Content directly/practically translates to action, given real-life constraint
- **Persuasive:** convincing messages regarding importance / feasibility of implementation

YOUR NOTES FOR STEP 5. Design the KT plan

STEP 6. Implement the KT Plan

You might choose to implement your KT plan all at once or in a gradual manner. Where there is low readiness to adopt the innovation, it may prove best to use a phased approach to implementation, i.e. an innovation is gradually introduced to different parts of the organisation, system or community.[12]

Also, as you implement your plan, it is useful to get feedback about its perceived relevance, acceptability and feasibility. You can do this by consulting representatives of each type of key person [see **Step 3**], e.g. by interview, survey, focus group. Each person will have a unique perspective on appropriate methods and can provide feedback valuable for potentially revising the implementation of the KT plan. When choosing the types of key people ("actors") to involve in this consultation and feedback process, consider:

> **"… which experts possess technical knowledge about the subject, which decision makers can shed light on the issues related to the feasibility or acceptability of the policy, etc. The actors invited may come from the health sector, but they may also come from other sectors concerned by the issue … and represent public, private or community perspectives".**[13]

Key Questions

6.1. Is the KT plan perceived as appropriate and acceptable by the relevant players?
6.2. Are there elements of the plan which are not seen as acceptable or appropriate?
6.3. Is the Innovation perceived to be effective and important?
6.4. Is the Innovation perceived to be feasible for an organisation, system or community?

Examples

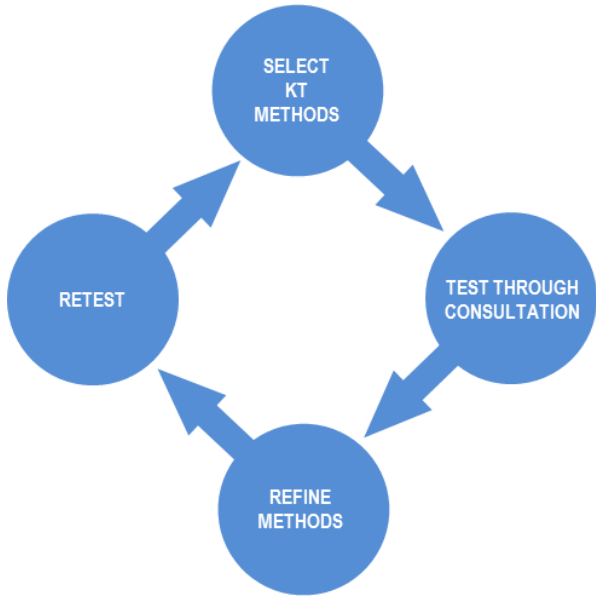
A. In **Step 3**, Example 3A was an innovation for dementia medication changes. The KT plan may depend on medical specialists feeling comfortable with nursing colleagues having roles to monitor side effects and adjust dosage rates. If specialists are reluctant to participate, this feedback could be used to, e.g. develop an additional specialist-approved training model for nursing staff prior to program rollout.

B. In **Step 3**, Example 3C was a family-oriented strategy for challenging behaviours. Caregivers may not unable to attend a half-day coaching session if the person with dementia they care for requires constant supervision. Feasibility feedback from consumers obtained before program roll-out will support resource requests needed in the KT plan.

Helpful Tips

- Based on the feedback from consultations, the KT methods can be modified to increase the likelihood of success. You might allow for a few rounds of testing and refinement of the methods, then retesting.
- This process of refinement (see Box 6) can be done fairly quickly and easily if you have existing relationships with key people who are willing to provide honest input.
- When planning the KT project timeline, factor in the time and resources needed for these refinement phases.
- Consider maintaining an activity or process log (journal) – don't rely on your memory after the project, write it down!

Box 6. Refining KT method



YOUR NOTES FOR STEP 6. Implement the KT plan

STEP 7. Evaluate success of the implemented KT Plan

Many evaluation frameworks have been proposed. This guide applies the **RE-AIM** framework as it emphasises sustainable system-level changes.[14] The five RE-AIM components are overviewed below, with key questions, examples of measurement, and helpful tips.

REACH

To what extent has the KT activity engaged the key players ("actors")?

Example measures: • attendance at training events, • website traffic, • number of carers getting information products	Tip: Establishing partnerships with organisational champions will greatly enhance reach.

EFFECTIVENESS:

What has been the impact on the knowledge and skills of KT participants?

Example measures: • test staff knowledge/skill before and after a KT activity; • survey carer understanding before and after a dementia education initiative	Tip: It is more informative to objectively measure increased knowledge or skill (e.g. quiz) rather than "perceptions" - self-ratings can be affected by confidence or "don't know what you don't know"

ADOPTION:

Have key people ("actors") adopted actions relating to the Innovation?

Example measures: • adherence to a medication change; • meeting accreditation standards; • family caregivers use of respite care	Tip: It is easy to get data on knowledge acquisition, attitudes and 'intention to change', but these are poor substitutes for measuring actual behaviour change.

IMPLEMENTATION:

How well was KT carried out, including achieving specified targets and timelines?
Did key people implement the innovation faithfully and with high quality?

Example measures: • participant surveys on perceived acceptability and quality of KT activities; • interview nursing staff on how an Innovative care model has been implemented; • chart audit in residential care to ascertain how well an Innovative practice was delivered.	Tip: Providing cues, such as handouts that briefly summarise the Innovation, may improve implementation by relevant key players.

MAINTENANCE:

Was this Innovation maintained over time, whether following a single KT intervention or in the context of ongoing support for the Innovation?

Example measures: • interview service providers about ongoing delivery of the Innovative practice; • review of GP records to check that memory screening is continuing for >65yo patient	Tip: Reminders about an Innovation, long after an initial KT intervention, are likely to enhance maintenance.

Helpful Tips

Free training and resources for the RE-AIM framework is available from the website www.re-aim.org

For more resources on evaluation, including KT impact measures, visit the toolbox on the DementiaKT hub (dementiaKT.com.au)

NOTES FOR STEP 7. Evaluate success

ADDITIONAL TOPICS

A. Is this Innovation "KT ready"

The decision about whether new knowledge is ready for translation will be necessarily specific for each KT plan and context. In part, the decision about "KT ready" will reflect:

- Quality of evidence (*what is the knowledge collection process for the Innovation?*)
- Balancing potential risk and benefit (*do the benefits outweigh the potential costs?*)

For resources and databases to help you find quality KT research, visit the toolbox on the DementiaKT hub (dementiaKT.com.au)

Evidence Quality

Quality of evidence can be measured in many ways. Some key concepts for KT planning are:

- Source – where does the new knowledge come from and is it credible?
- Design – in the case of research evidence, how good is the science and is there bias?
- Reproducible – is the evidence a 'one off' or has it (or a component) been replicated?

The National Health & Medical Research Council (NHMRC) has a hierarchical guide to assessing evidence quality[15] (ref). Generally speaking, a KT plan based on evidence synthesis (i.e. a recent systematic review of many studies) and/or corroboration (e.g. scientific data plus expert recommendation or local record audit), is preferred to a "single study" Innovation. Roll-out of KT plans based on one study or case report should seriously consider risk and benefit issues.

Risk and Benefit

The field of innovation tends, by nature, to be connected with risk. Some major risk types are:

- risk of harm -
  an innovation is implemented but
  (a) has adverse effects greater than expected or different to 'best evidence', or
  (b) desired outcomes are found be a poor fit with context

- risk of doing nothing –
  this type of risk is a focus of the "knowledge translation time lag"

- risk of poor implementation –
  the Innovation is sound but the application to a specific context is problematic. Insufficient resourcing can be a major culprit for this sort of risk type and underscores the value of rigorous KT planning.

- risk to the organisation –
  from a management perspective, an Innovation which provides modest clinical gain at substantial financial cost or negative staff impact (e.g. dissatisfaction, absenteeism, turnover) may not be a worthwhile return on investment. A KT plan which includes organisational risk may need to provide a business case to relevant management.

Helpful Tips

The importance of documentation

- Judging KT readiness depends on information. Your KT plan and outcomes will be a potentially valuable contribution to knowledge, and assist other people in their decision-making about feasibility and tailoring for other contexts.
  (see Additional Topic C "Disseminating your new knowledge")

ADDITIONAL TOPICS

B. Readiness for Change

Understanding whether the key players in your KT plan are ready for change is crucial to planning your KT project and its success. It is important to distinguish between organisational and individual readiness for change. More recent and rigorous research as targeted the latter.

Organisational readiness

Organisational characteristics that contribute to readiness include[16]:

- clear vision and strong leadership,
- workforce and skills development,
- ability to access research (library services),
- fiscal investments,
- acquisition and development of technological resources,
- a knowledge management strategy,
- effective communication,
- a receptive organisational culture, and
- a focus on change management.

For more resources on understanding, managing, leading, and measuring change, visit the toolbox on the DementiaKT hub (dementiaKT.com.au)

Individual readiness

More recent research on "change readiness" has looked at the individuals involved with or affected by a change. In particular, factors that might predict which people may show some resistance to necessary changes in organisational structure, policy, processes or practices.

At one level, individual change readiness is influenced by constitutional factors, such as how a person deals with change of any sort. These sorts of constitutional factors may be out of scope for your KT plan, but will need to be identified, worked with or worked around.
Other individual readiness factors that have greater scope for modification within your KT plan include contextual factors, including:

- personal valence (e.g. "what's in it for me?"),
- self-efficacy (e.g. "can I do this?")
- appropriateness (e.g. "is this relevant or necessary for my organisation/me?").
- perception of contextual factors, particularly management support
  e.g. "this won't work here - are management supporting it?"

Can you measure "change readiness"?

Yes – although the best quality measures address individual rather than organisational readiness variables. These scales tend to be comprehensive and could be considered for a KT plan supported by a researcher as a key player, and/or a rich multi-factor data collection design and write-up. Examples include measures of constitutional characteristics of people relating to change and individual responses to contextual factors surrounding a change.[17] [18]

Helpful Tips

Dealing with a "readiness" barrier

- Get support – from management (at all levels) for proposed change(s) and KT plan
- Communicate - about drivers for change in the KT plan plus desired change outcomes
- Be proactive – work with managers (and/or team leaders) to:
  (a) specify change behaviours for relevant key players;
  (b) identify possible inappropriate responses to change;
  (c) think about best strategies for dealing with issues early.

ADDITIONAL TOPICS

C. Disseminating your new knowledge

Feedback to the stakeholders and participants is courteous and essential. It could also affect the likelihood of follow-up projects. Feedback can be a purpose-specific communication, or could be a personal provision of feedback prepared for another forum (e.g. a copy of a journal publication or newsletter article).

For more resources on communication and dissemination plans, visit the toolbox on the DementiaKT hub (dementiaKT.com.au)

Some ideas -

Local outlets

- Newsletter: if the project has not set up a newsletter as part of the regular communications plan (this is possible for some types of projects), then consider drafting a piece for a relevant stakeholder bulletin
- Stakeholder or consumer forum to share results
- Popular media, including community newspapers
- Social Media

Peer-reviewed outlets

The concept of "peer-review" means that the write-up of your KT experience and outcomes has been assessed by experts and peers in the field. Typically this process is blind (i.e. you do not know the identity of the reviewers) and in some cases (e.g. a journal article) you will have an opportunity to consider the feedback and revise your report in response.

- Conferences: These include scientific symposia (attended by researchers) and professional meetings for continuing education (attended by clinicians)
- Publications: Many journals will consider a well-written case study. For speed of turnaround consider an open access online journal (some do charge a fee, however)

Helpful Tips

- It is a good idea to discuss authorship of publications early in a KT plan. Obtain legal advice for matters relating to product patents an intellectual property
- Dissemination method is not an "either/or" choice – to reach different audiences the take-home message from your KT project may need to use several methods
- If planning a peer-reviewed publication, check whether there are rules about how much public dissemination of your results can occur before submitting your manuscript – e.g. some journals will consider access to the findings on a website as pre-publication of data
- Many journals will require a statement about the ethical review of a project. As a foresight to this issue, check EARLY in your KT planning what the possible ethical issues may be and which organ of governance provides oversight and approval.

In disseminating the results and experience of your KT activity, remember that hindsight is an exact science and you've learnt a lot on this journey. So think about the following question:

What would <u>you</u> have liked to know <u>before</u> you commenced this KT plan?

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Knowledge Translation Partners

Dementia Training Australia

dta.com.au

DCRC
Dementia Centre for
Research Collaboration

dementiaresearch.org.au