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Résumé

Comprendre les connaissances essentielles dans le cadre de la pratique infirmière : les apprentissages tirés d'une étude portant sur l'application des connaissances

Joan M. Anderson, Annette J. Browne, Sheryl Reimer-Kirkham, M. Judith Lynam, Paddy Rodney, Colleen Varcoe, Sabrina Wong, Elsie Tan, Victoria Smye, Heather McDonald, Jennifer Baumbusch, Koushambhi Basu Khan, Joanne Reimer, Adrienne Peltonen, Anureet Brar

Issu d'une étude consacrée à l'application des connaissances (AC) sur la transition des patients de l'hôpital au domicile, cet article se penche sur les apprentissages relatifs aux défis liés à l'application des connaissances essentielles tirées de la recherche en milieux infirmiers. Les auteures se penchent sur le discours actuel afférent à l'application des connaissances, discutent de leurs positions concernant la nature des connaissances critiques et présentent des thèmes tirés du corpus de leur recherche, notamment des connaissances appliquées. Les résultats de l'étude offrent certaines possibilités quant à l'encadrement de futures recherches en matière d'AC portant sur le recensement des connaissances essentielles liées à la pratique infirmière.

Mots clés : application des connaissances, connaissances essentielles, pratique infirmière

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Uptake of Critical Knowledge in Nursing Practice: Lessons Learned From a Knowledge Translation Study

Joan M. Anderson, Annette J. Browne, Sheryl Reimer-Kirkham, M. Judith Lynam, Paddy Rodney, Colleen Varcoe, Sabrina Wong, Elsie Tan, Victoria Smye, Heather McDonald, Jennifer Baumbusch, Koushambhi Basu Khan, Joanne Reimer, Adrienne Peltonen, Anureet Brar

This article is based on a knowledge translation (KT) study of the transition of patients from hospital to home. It focuses on the lessons learned about the challenges of translating research-derived critical knowledge in practice settings. The authors situate the article in current discourses about KT; discuss their understanding of the nature of critical knowledge; and present themes from their body of research, which comprises the knowledge that was translated. The findings have the potential to guide future KT research that focuses on the uptake of critical knowledge in nursing practice.

Keywords: knowledge translation, critical knowledge, integrated knowledge, health-care delivery, nursing practice, postcolonial, Black feminist epistemologies

Introduction

Knowledge translation (KT) with the goal of guiding nursing practice is now a key objective in nursing research. Since its founding, the Canadian Institutes of Health Research, Canada's premier government funding agency for health research, has stressed its commitment to the creation of new knowledge and the translation of this knowledge into practice and policy (Canadian Institutes of Health Research, 2000). The discipline of nursing shares this commitment, and has made major advances in KT science within the past 10 years. *CJNR*'s focus issue on Knowledge Translation in the Health Sciences in 2008 demonstrates the range of approaches to KT. The articles in that issue, some of which were intended to "challenge readers to think outside of their usual comfort zones" (Estabrooks, 2008, p. 13), open up a discursive space for philosophic and empirical inquiry into existing approaches to KT, the substance of the knowledge to be translated, and what counts as evidence to inform

nursing practice (e.g., Kavanagh, Stevens, Seers, Sidani, & Watt-Watson, 2008; Poole, 2008).

Following upon the work of these scholars, in this article we engage with the nature of the knowledge that informs nursing practice within the genre of critical, postcolonial, and Black feminist epistemologies and how this "critical" knowledge[1] is translated into practice. We do so by drawing on a recently completed KT study of patient transition from hospital to home (Anderson et al., 2008, 2009; Browne et al., 2009; Reimer-Kirkham et al., 2009). This article focuses on selected findings on lessons learned about the processes and challenges of translating critical knowledge in the practice setting. We begin by situating our study in the KT discourse. We then present an overview of the KT study, including strategies for engaging with KT in the practice setting. Next, we focus on the nature of critical knowledge and three key themes from our body of work and the extant literature — the knowledge for translation. Finally, we present our findings, which highlight the challenges and the lessons learned.

Literature Review

Moving research-derived evidence into practice has concerned health professionals, administrators, policy-makers, and researchers alike for some time (Estabrooks, 2007). In the past decade, KT has been widely adopted, a development that stems from several influences. Pragmatically, it has been recognized that the practice-research gap has persisted after decades of evidence-based medicine (Graham et al., 2006) and that multidimensional exchange processes are required for knowledge-to-action (Rycroft-Malone, 2007). Also, philosophic limitations of the evidence-based practice movement have been identified, such as epistemological concerns about the kinds of knowledge relied upon (Reimer-Kirkham, Baumbusch, Schultz, & Anderson, 2007). KT offers expanded conceptions of the nature of evidence; acknowledgement of context-sensitive knowledge; and multilevel engagement with practitioners, decision-makers, and organizations (Reimer-Kirkham et al., 2009).

In an era of constrained resources, shortened hospitals stays have become commonplace. The transition from hospital to home has been identified as a critical juncture during which nursing interventions can make a significant difference to patient outcomes, including the prevention or delay of hospital readmission through evidence-informed organization of discharge processes and patient education (Dedhia et al., 2009; Parkes & Sheppard, 2004). While not all patients are at risk during this transition, factors such as advanced age, frailty, lack of social support,

[1] We explain later in the article what we mean by "critical" knowledge.

and language barriers make some people particularly vulnerable (Graham, Ivey, & Neuhauser, 2009). The matter of transition from hospital to home therefore requires knowledge generation and translation for interventions that contribute to a smooth continuum of care with improved patient outcomes.

Overview of the Knowledge Translation Study

Purposes of the Study

The purposes were to synthesize knowledge from studies on the help-seeking and hospitalization experiences of ethno-culturally diverse patients, including Aboriginal peoples, Canadian-born non-Aboriginal people, and people who came to Canada as immigrants and refugees; translate this knowledge into practice; and evaluate the outcomes.[2] These purposes were explored by focusing on a critical health-care juncture: the transition from hospital to home. Our intent was to use this case to advance the theory of KT, to refine our theoretical insights into the nature of critical knowledge, and to foster understanding of how to promote the uptake of critical knowledge to enhance nursing practice.

Strategies for Engaging With Knowledge Translation in Practice

This KT study was conducted in four inpatient units of a large teaching hospital in a western Canadian city from September 2005 to October 2007. The study marked the culmination of several years of collaborative research among university researchers, administrators in the hospital setting, and practising clinicians. During the project we established additional relationships, specifically among the two doctoral nursing students (DNSs) who were employed as graduate research assistants, unit-specific nursing leaders, and point-of-care nursing staff from the units. The DNSs were immersed in the units for a period of 8 to 10 hours per week, one over 12 months and the other over 18 months. During this time they engaged with practitioners for the purpose of translating knowledge into practice. The key processes for translating knowledge were: (1) establishing collaborative relationships built on the principles of accountability, reciprocity, and respect; (2) developing and implementing specific projects ("action plans") related to the transition from hospital to home; and (3) engaging in responsive dialogue with practitioners to foster reflective practice (Anderson et al., 2008). These processes derive from a col - laborative KT model[3] (Baumbusch et al., 2008) developed earlier in our

[2] This article focuses on a particular aspect of the study. Other aspects are discussed elsewhere (Anderson et al., 2009; Browne et al., 2009; Reimer-Kirkham et al., 2009).

[3] The study on which this model was based, Hospitalization and Help-Seeking Experiences of Diverse Ethnocultural Populations, was funded by the Canadian Institutes of Health Research.

program of research emphasizing the concepts of respect, reciprocity, and accountability. We also drew on concepts from the extant KT literature regarding "just in time teaching" and "credible messengers" to deliver "actionable messages" in the workplace (Canadian Health Services Research Foundation, 2002; Lavis et al., 2003). The DNSs, both experienced nurse clinicians, were ideally positioned as "credible messengers" in the four units, based on their strong clinical knowledge and their understanding of the specific research methodologies used in this project. We now present the knowledge we intended to translate into practice through implementation of these KT strategies.

Knowledge to Be Translated: The Nature of Critical Knowledge

Simultaneously with building on existing practice-academic relationships, negotiating which hospital units would participate in the KT study, and identifying practice champions, an early task in the implementation of the project was to synthesize the concepts from our body of work "into 'practice-ready' knowledge" (Anderson et al., 2008, 2009, p. 284). Informed by critical inquiry — critical feminist theory, Black feminist epistemology, postcolonial and decolonizing theories, and critical race theory — we refer to this knowledge as critical knowledge[4] (Reimer-Kirkham et al., 2009).

We conceptualize critical knowledge as constructed through methods of critical inquiry and as fostering an understanding of historical, political, economic, and other social processes that can be drawn on as explanatory resources as we engage with patients in promoting health and ameliorating the suffering of illness. Critical knowledge is both social and reflexive in nature, prompting us to question our assumptions, the status quo, and the taken-for-granted. It is linked to praxis as the dialectical relationship among knowledge, theory, research, and action. Among its outcomes are equity and critical social justice[5] in health and health-care delivery. The concept of *intersectionality* is pivotal to our understanding of critical

[4] The preceding list of theoretical perspectives is not meant to be exclusive to the development of critical knowledge. These are the theoretical perspectives on which we have drawn. Critical knowledge is not incompatible with "contextual knowledge" (Anderson et al., 2009). In Anderson et al. (2009), which is written within a global health context, we use "contextual" to mean knowledge that is "constructed at the intersection of different layers of contexts" and that "informs us of how the social is embodied in individual experience" (p. 287). The KT project and the knowledges derived from our programs of research were used as "a springboard for examining the kinds of knowledge and critical engagement that might move us towards social justice as a global priority" (p. 285).

[5] Critical interpretations of social justice address issues of equity; conceptualize health as a human right; and draw attention to issues of racialization, culturalism, and discrimination as factors constraining social justice (Browne & Tarlier, 2008).

knowledge. Intersectionality refers to the ways in which class, race, gender, age, and other dimensions associated with inequities operate simultaneously and as interlocking systems (Brewer, 1993; Collins, 2000). Weber and Parra-Medina (2003) state that research incorporating intersectionality "is particularly well-suited to addressing the question of disparities in our social worlds" (p. 185).

Given the diverse populations with whom we have conducted research, the concept of *culture* is central to our work. From a critical perspective, culture is conceptualized as dynamic and as involving "processes and practices constantly occurring within power-laden social contexts and locations to create fluid, contested, negotiable, ambiguous meanings" (Dorazio-Migliore, Migliore, & Anderson, 2005, p. 344). The concept of "cultural safety," located within postcolonial, critical theorizing, aligns with our conceptualization of culture. Introduced by Maori nurse leaders in New Zealand, cultural safety orients the education and practices of health professionals to a critical understanding of the impact of colonialism and related historical inequities and the structural underpinnings of current health and social inequities (Ramsden, 1991, 1993). Cultural safety, as a way of framing knowledge, prompts critical reflection on issues of equity and critical social justice in nursing practice (Browne et al., 2009); the nurse's own positioning (with respect to class, "race," and economic status) in relation to patients; and how these social relations operate to shape nursing and health-care practice (Smye & Browne, 2002). This theoretical orientation to critical knowledge, in which our conceptualizations of culture and cultural safety are embedded, has informed our programs of research and, subsequently, the themes of our research (the "knowledge" for "translation"), which we aimed to translate in practice.

We did not undertake a secondary analysis of our research data to identify the themes. Rather, we drew on salient findings from our published and unpublished work and from the extant literature related to our main concern — patient transitions from hospital to home and the social experiences that shape these transitions. We now present a synopsis of three *themes* from our body of work and the extant literature that formed the knowledge for translation.

Transitions and the Material Context of People's Lives

There is compelling evidence from our research over two decades that the socio-economic, historical contexts of people's lives have considerable influence on their experiences of health, illness, and help-seeking (e.g., Anderson, Blue, & Lau, 1991; Anderson et al., 2003; Browne, 2007; Lynam et al., 2003; Perry, Lynam, & Anderson, 2006). These findings align with a body of knowledge developed in Canada and in other countries

regarding inequities and their impact on people's health through the intersecting factors of poverty, economic inequality, and social exclusion, especially for racialized groups (Beiser & Stewart, 2005; Marmot, 2004; Raphael, 2007). For example, historical and current social, political, and economic inequities shape the health and social status of Aboriginal peoples in Canada, resulting in a disproportionate burden of ill health and social suffering (Adelson, 2005). Research evidence shows how both implicit and explicit discriminatory practices and policies continue to marginalize Aboriginal peoples within the health-care system (e.g., Browne, 2007; Dion Stout, Kipling, & Stout, 2001; Tang & Browne, 2008).

Though rooted in different historical contexts, recent statistics point to the income gap between Canadian-born and foreign-born men and women. Immigrant women are at a particular disadvantage (Statistics Canada, 2008). The evidence shows that it is the income gap between high- and low-income groups that counts; a wide income gap has dire morbidity and mortality consequences for those in the lower income group (see, for example, Marmot, 2004; Raphael, 2007) and hence is an important factor to look at as we examine issues of equity in health-care delivery systems. Low income, especially when combined with social isolation and marginalization, places people at greater risk for poor health and can significantly hamper their ability to manage an illness after they are discharged from hospital (Lynam et al., 2003; Perry et al., 2006). These findings demonstrate how social factors such as race, class, and gender *intersect to produce inequities* that subsequently influence health. Yet these determinants of health and health-care experiences are often not fully understood in practice, with health professionals drawing on unexamined assumptions about culture, "race," and other factors.

Racializing and Marginalizing Practices and How They Can Be Addressed

By critically reflecting on the themes from our collective work, we determined how health professionals' frequent reliance on culturalist discourses[6] created unintentional racializing practices based on assumptions that patients' behavioural characteristics result from their presumed race or culture (Browne, 2007; Reimer-Kirkham, 2003). Such discourses and assumptions do not originate in the psyches of particular nurses; rather, they reflect social discourses about groups of people who are assumed to be different from the norm and often have a powerful influence on health professionals' practices concerning different groups of patients.

[6] By "culturalist" we mean notions of culture as a homogeneous attribute of a particular "race" — for example, "Aboriginal," "Indo-Canadian," "Chinese," or "White" people.

These discourses were therefore pivotal in our knowledge synthesis. We began to focus our attention on how to address them and what would constitute equitable and socially just health care. Critical interpretations of social justice[7] gave coherence to our collective work because they "address issues of equity vs. equality; conceptualize health as a human right . . . [and] draw attention to racialization, cultural devaluing and discrimination as factors constraining social justice" (Browne & Tarlier, 2008, p. 84).

Along with the principle of critical social justice, our work has focused on the concept of equity: Resources ought to be distributed according to people's needs. Equity links directly to the social determinants of health, as outlined in a Canadian Nurses Association (2005) document that underscores the need for nurses to understand how these determinants work and how to incorporate this understanding into their assessments and their choices for practice. But it is not only material context and racializing practices that exert an influence on people's lives; the structure of health-care delivery systems can also contribute to inequities.

Health-Care Delivery Systems Through the Lens of Critical Inquiry

The ongoing effects of health-care restructuring provided a salient context to our KT work — particularly the unintended consequences of restructuring (Lynam et al., 2003). For example, shorter hospital stays, although welcomed by many with adequate resources at their disposal, created hardships for those without the resources needed to assume the added responsibility in the home. Though resources were being put in place to facilitate the transition from hospital to home, there were wide gaps in the continuity of services (Lynam et al., 2003; Perry et al., 2006), including patients and families inadequately prepared to manage self-care, lacking adequate information to assess the severity of complications, and/or experiencing a time lag between discharge and follow-up by the community-care team. The reorganization of practice settings also had implications for the context in which nurses practised and the care that they were able to provide (see Varcoe & Rodney, 2009).

To summarize, a fundamental premise in our research was that the translation of this knowledge into practice would make a unique contribution to nurses' assessments and interventions. The process of translating this knowledge into practice, however, was not linear. Through engagement with one another and with clinical partners, we came to see that the project had a dialectic, non-linear nature. The lessons about the processes of knowledge synthesis and translation were learned concur-

[7] The topic of social justice is explored more fully in Anderson et al. (2009).

rently as we examined and reflected upon the contextual co-construction of knowledge and the grounding of complex concepts in everyday nursing practice.

Findings: Challenges and Lessons Learned

In reflecting on this KT study and what might be considered "findings," we focus on several of the key conceptual and methodological challenges and opportunities encountered when attempting to translate critical knowledge in practice settings.

Congruence Between Translation Methodologies and Knowledge for Translation

While it is true that different kinds of knowledge inform nursing practice, in the KT process we may unwittingly attempt to use the same methodologies for translating different kinds of knowledge. The plan was for the "messengers," two DNSs conversant with the body of knowledge to be translated and with the underpinnings of critical inquiry, to draw upon this knowledge as they engaged with health professionals, and for cultural safety to be integrated into nursing practice through engagement around patients' transition from hospital to home. In the initial framing of the study, we foregrounded the use of actionable messages, as explicated in the extant literature, as one KT strategy for the translation of this knowledge. However, in enacting our study we struggled to write actionable messages from critically oriented knowledge, which requires critical thinking and reflexivity. This struggle prompted us to ask, what is an actionable message from the perspective of critical knowledge? As we reflected on actionable messages, we came to understand that the type of KT in which we were engaged was an "effort to foster understanding, reflection and action" (Reimer-Kirkham et al., 2007, p. 36), so that knowledge, underpinned by the principles of equity and social justice and refracted through the lens of cultural safety, could be co-created and incorporated into practice. This did not mean that we fully understood how this would be done when actionable messages were the starting point of the dialogue. For example, a review of the notes from the various meetings of our research team showed clearly that we grappled with both the explication of the "K" for translation and the crafting of methods suitable for translating the "K."

Turning a concept such as racialization into an actionable message that could be translated in practice was particularly challenging. This dilemma is reflected in a document we created on actionable messages based on the themes identified in our research studies. We concluded that racialization was not an actionable message but, instead, the knowledge

base on which actionable messages could be formulated:

> *The art of translation is to invoke the knowledge in ways that would not demean or belittle the nurses, but rather, help them to reflect on other ways of constructing the patient. . . . So the art of translation will be to guide practitioners to critically examine how they make decisions (process) and at the same time, draw on knowledge that challenges racialized categories (content) without using words such as racialization, which may be very difficult to explain.* [Extract from document on "Actionable Messages"]

At this early stage in our research it became apparent that the notion of actionable messages did not fit with the complexity of the knowledge we were interested in translating; that is, we recognized the epistemological tensions between the kinds of knowledge for translation and the translation strategies that we had initially proposed (Reimer-Kirkham et al., 2009). Furthermore, we eventually came to question what we understood by "just in time teaching." "Just in time" could be read either as a reductionist approach to what we felt others "needed to know" in that moment or as authentic dialogue where we would engage with nurses according to the concerns they were addressing; that is, "just in time" could be the priorities that nurses identify in the immediate context of clinical practice. Further, the emphasis on teaching in this phrase could imply a one-way, expert-to-novice flow of knowledge, whereas our intent was to engage in dialogue to prompt reflection on the assumptions that shape nurses' approaches to practice with a view to considering how they influence clinical decision-making.

We subsequently reframed our KT strategies to make them more congruent with the critical knowledges to be translated and with our KT model (Baumbusch et al., 2008). This model embraced the opening up of a dialogic space to invite critical reflection on the assumptions that underpin practice and the *co-construction of knowledge* in context. This approach seemed congruent with fostering critical social justice in the clinic. For example, during dialogue sessions where the investigators and DNSs used case studies to draw out assumptions underpinning practice, concepts such as cultural safety and the influence of practice environments were effective in creating spaces for nurses to engage with critical social justice concepts and reflect on their own "positionalities" in relation to patients. Our engagement in these processes with nurses fostered a deeper awareness of the need for congruence between the kinds of knowledge for translation on the one hand and the methodologies for KT on the other. This understanding is one of the key lessons learned from the KT study.

Approaches to Translating Politically Charged Concepts

A key objective of the project was to translate knowledge to prompt frontline health professionals and administrators to reflect critically on their assumptions about patients using the concept of cultural safety. Specifically, we envisaged that cultural safety might be used to help nurses examine how popularized notions of culture and cultural differences shape assumptions and stereotypes in the context of practice, to examine the interrelated problems of culturalism and racialization, and to see how organizational and structural inequities within health care and in society influence nurses' interpretive perspectives and practices (Browne et al., 2009). Given the complexities inherent in attempting to translate such politically charged concepts, we needed to consider how to engage with nurses in ways that would be relevant to their practice. For example, we were particularly cognizant of the lessons learned from New Zealand, where attempts to directly discuss the issues highlighted by cultural safety (such as the colonization of indigenous peoples and the appropriation of their land and culture — the genesis of poverty and poor health) were met with resistance and defensiveness in many of the nursing and education sectors (Ramdsen, 2002). Equally importantly, KT strategies needed to be relevant to the structure and organization of the practice context in which nurses work.

The current framework of acute-care practice on the units where we conducted the study means that nurses and managers are often oriented towards clinical guidelines, pathways, and assessment tools that support efficient and effective practice in increasingly pressured work environments. In the case of the study, a priority for the manager and physicians on one of the units was the development of a clinical pathway to guide the discharge planning process. The development of this tool emerged as a priority area for "action" and became the fulcrum around which the DNSs and members of the investigative team engaged. The DNSs were able to incorporate questions to prompt nurses to consider patients' social contexts as they engaged in discharge planning. Critical knowledge enhanced the development of such tools and linkages between nurses' everyday activities, management priorities, and the kinds of critically oriented knowledge that could increase effectiveness and thus influence the outcomes of nurses' practice.

The reframing of KT strategies in "windows of opportunity" in the context of everyday practice also creates possibilities for observing their impact over time. For example, critically oriented knowledge that underpins the concept of cultural safety could increase nurses' knowledge about why certain patients are readmitted so soon after discharge. In the process, nurses may be more apt to expand their assessment to explore

the intersecting social, gendered, and personal factors and circumstances that create differential burdens of hardship during the transition from hospital to home. Such assessments, and the nursing interventions they might prompt, could result in fewer complications following hospitalization and in lower readmission rates, eliminating the often "hidden" readmissions. Outcomes from the integration of critical knowledge into nursing practice could thus be observable and measurable, and we encourage further research to this end.

Working the Intersections for Integrated Knowledge

We found that the integration of critical knowledge into a clinical pathway provided a rich opportunity to theorize about the possibilities of paradigm shifts that could move us beyond dichotomous, either/or thinking. This example is helpful in explicating the dialectic between biomedical knowledge and the critical knowledge that illuminates the social context of a patient's life. The treatment of knowledges not as distinct and dichotomous but as intersecting and simultaneous makes it possible to *shift the epistemological and paradigmatic framing of knowledge for nursing practice.* This shift towards intersectionality of knowledges parallels methodological approaches that call for intersections between measurement and critical qualitative inquiry, to provide a comprehensive, integrated understanding of phenomena (e.g., of measurable income disparities, the set of historical relations that position people in particular ways, and the intersections with help-seeking experiences). Critical qualitative inquiry does not supplant measurement, or vice versa; in fact, critical inquiry is constitutive of both quantitative and qualitative methods. In a similar vein, critical knowledge does not supplant biomedical knowledge; rather, it intersects with biomedical, managerial, and clinical knowledge (Anderson et al., 2009) *to produce intersectional, simultaneous knowledge for clinical practice,* thus shifting the vocabulary from "different kinds of knowledge" to "integrated knowledge" for practice. In this conceptualization, no form of knowledge is devalued or privileged; each intersects with the other. This means that *critical knowledge* would be an *integral part* of integrated knowledge for competent, effective, and hence efficient nursing practice and would not be held up as distinct.

Sustainable Knowledge Translation

This study was based on long-term relationships among administrators, clinicians, and researchers. Yet, as a funded research study, it was conducted within a specific time frame. This meant that the relationships we had established in the practice setting had to come to an end, raising questions about the sustainability of the KT process. While sustainability might be fostered by champions in the practice setting, or by ongoing

collaborative programs of research between the academy and practice, clinical settings are dynamic and the need for KT is continual and evolving; and yet research programs focused on translating evidence-based knowledge inevitably come to an end.

As we have argued elsewhere (Anderson et al., 2009), sustainable KT requires ongoing commitments between the clinical and academic contexts that are not built solely on episodic KT studies. This continuity is all the more important when translating knowledge that requires the questioning of assumptions that are deeply rooted in histories, political processes, and dominant discourses. Such assumptions and discourses do not change overnight, yet questioning them is crucial if we are to provide health care that is both *effective* and *efficient*. For this reason there needs to be ongoing engagement with nurses and practice leaders so that they will see the relevance of integrated knowledge for their work and begin to make the subtle shifts in practice that can occur when one's epistemological and ontological perspectives align with critically oriented knowledge. The sustainability of the KT process and its implementation in relation to nursing practice therefore become more relevant. But nursing practice takes place within the context of organizational structures that can foster or hinder the uptake of critical knowledge.

We therefore need to engage administrative personnel to ensure that KT occurs at all levels of the organization; we also need to examine the structural arrangements between academic and practice settings that might foster KT sustainability. KT processes that have such far-reaching consequences cannot be directed solely at the individual level of nursing practice; they require commitment by those in a position to bring about organizational change. These multilevel approaches call for dialogue and engagement between the academy and practice in ways that will address the structural/contextual issues and knowledge for nursing practice that we have sought to explicate.

Concluding Comments

In this article we have highlighted four lessons learned from our study on translating critical knowledge in the practice context — lessons that can be drawn upon in KT research that focuses on the uptake of critical knowledge in practice. We have highlighted the importance of congruence between research-derived critical knowledges and translation methodologies. We have argued that the reflexive process is key to the integration of critical knowledge into nursing practice, and we have examined the politics and pragmatics that underpin the translation of such knowledge. We have suggested that critical knowledge does not stand on its own but, rather, needs to be integrated, with other knowl-

edges, into the flow of competent nursing practice. Consistent with the epistemological underpinnings of a critical perspective, working the intersections between different kinds of knowledges is key to effective nursing practice. Finally, the translation of critical knowledge into practice cannot occur at the level of individual nursing practice alone. We have concluded that KT must take place at all levels of the organization. It is crucial, therefore, that we re-examine the structural arrangements between academic and practice settings and that we develop new approaches to fostering sustainability in KT.

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Joan Anderson, PhD, RN, is Professor Emerita, School of Nursing, University of British Columbia, Vancouver, Canada. Annette J. Browne, PhD, RN, is Associate Professor, School of Nursing, University of British Columbia. Sheryl Reimer-Kirkham, PhD, RN, is Associate Professor, Nursing, Trinity Western University, Langley, British Columbia. M. Judith Lynam, PhD, RN, is Professor, School of Nursing, University of British Columbia. Paddy Rodney, PhD, RN, is Associate Professor, School of Nursing, University of British Columbia. Colleen Varcoe, PhD, RN, is Associate Professor, School of Nursing, University of British Columbia. Sabrina Wong, PhD, RN, is Associate Professor, School of Nursing, University of British Columbia. Elsie Tan, MSN, RN, is Senior Instructor, School of Nursing, University of British Columbia. Victoria Smye, PhD, RN, is Assistant Professor, School of Nursing, University of British Columbia. Heather McDonald is a PhD candidate in the School of Nursing, University of British Columbia. Jennifer Baumbusch, PhD, RN, is Assistant Professor, School of Nursing, University of British Columbia. Koushambhi Basu Khan is Research Manager, School of Nursing, University of British Columbia. At the time of the study, Joanne Reimer, MN, was Health Science Researcher and Adrienne Peltonen, BSc, and Anureet Brar, MHA, were Research Assistants, School of Nursing, University of British Columbia.