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Guest Editorial

Research, transformational leadership and knowledge translation: a successful formula

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An important role for academics in the caring sciences, and certainly a crucial indicator of their performance, is related to research outputs such as quantitative and qualitative studies and publication of findings in peer-reviewed journals. We recently joined a number of senior academic colleagues for an annual grant writing retreat with the aim of refining applications for external funding for the progression of research proposals. These types of collaborative gatherings represent only a small part of an enormous effort and expenditure of resources in the pursuit of research success in an increasingly competitive environment. However at a more fundamental level, the retreat also revealed a shared passion and commitment to improve practice through research evidence.

Although from a variety of different nursing and midwifery backgrounds, and with a diversity of expertise and experience, the common research goal was to improve the health outcomes of individuals, groups and communities, progress evidence-based clinical practice and advance the delivery of quality services to health clients. Ideas were developed and reflections about the generation and dissemination of knowledge discussed. Dissemination of research findings via publications, presentations and systematic reviews was a theme that generated significant interest among this successful group of academics, particularly in relation to knowledge transfer to clinicians. It became apparent that we had no clear sense that dissemination had a direct and immediate impact on practice. Rather it was acknowledged the translation of knowledge from evidence to practice over the last few years had improved but was still a rather hit-or-miss process, even where there were clear client/patient benefits and significant cost savings. It was apparent that knowledge transfer was therefore not a planned systematic process but a random phenomenon due to the lack of organisational arrangements and/or disengaged health work cultures. Although safety and quality concerns in care settings are paramount and the infrastructure for the implementation of research is often available (particularly for the unidirectional roll-out of policies, procedures, clinical pathways and guidelines), there is often little or no planning to progress the translation of new evidence and knowledge into practice. In addition to this, there is a need for new evidence to 'fit' into and be relevant to complex and unique health contexts and also, and perhaps most importantly, relate to clinicians' existing philosophical, aesthetic, theoretical personal and practice knowledge [1](#).

Where success in knowledge transfer is evident in practice, it has occurred in situations where there has been collaboration between the users of new knowledge including researchers, clinicians, and management [1](#). This collective approach benefits individuals at the grass root and organisational level; however it is the local champions in practice settings that often have the greatest impact on translating new knowledge into practice through positive influence. These champions achieve this by providing the vision and motivation to inspire colleagues to make transformative changes within their clinical settings, characteristics associated with transformational leadership.

Originally developed by American historian and political scientist James Burns, transformational leadership describes how leaders work with others to advance higher levels of morale and performance [2](#). Transformational leadership has since been further articulated into four key elements:

1. *Individualised consideration* – Focus on personal relationships, providing an individual approach, practical assistance and advice;
2. *Intellectual stimulation* – Promotion and celebration of intelligence, creativity and problem-solving;
3. *Inspirational motivation* – Communication of goals and expectation, using understandable language and symbols, and;
4. *Idealised influence* – Creation of a vision and sense of mission, promotion of pride, and role-modelling of respectful and trusting relationships [3](#), [4](#).

Contexts where local champions practice transformational leadership skills and behaviours (as articulated in the elements above), often exhibit a strong team focus where individuals feel supported, empowered and psychologically safe to share their views and participate in decision-making [5](#). Furthermore, there is growing evidence that transformative leadership promotes organisational learning and innovation [6](#), as well as the establishment of positive cycle of leadership development. Perhaps then, transformational leadership skills and behaviours offer a practical and interactive conduit for the effective transference of evidence based research outcomes in local practice settings. It allows new knowledge to be adapted to health settings and individuals, rather than imposed from above according to a homogenised organisational approach.

Equally, from an educational perspective it is vitally important to instil in students in the caring sciences (in our case, nursing and midwifery students), the desire to implement evidence-based findings into practice to ensure quality care practices. This can be achieved through curricula content and processes that promote the translation of research findings into practice for students and graduates. Transformational leadership education should occur in conjunction with studies around research, research findings and evidence-based practice in undergraduate curriculums, to promote participation and collaboration. The sharing of experiences may enable students to make meaning of their own skills and practice and equip them to be more self-aware about their personal values, beliefs and knowledge deficits [7](#) and encourage them to be open to innovation and change in their future careers.

References

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- **1Baumbusch JL, Kirkham SR, Khan KB, McDonald H, Semeniuk P, Tan E, Anderson J. Pursuing common agendas: a collaborative model for knowledge translation between research and practice in clinical settings. *Res Nurs Health* 2008; 31: 130–40.**
- **2Burns J. *Leadership*. 1978, Harper & Row, New York.**
- **3Bass BM, Avolio BJ. Developing transformational leadership: 1992 and beyond. *J Eur Ind Train* 1990; 14: 21–8.**
- **4Robbins SP, Judge TA, Millett B, Jones M. *OB The Essentials*. 2010, Pearson, Frenchs Forest, NSW.**
- **5Nembhard IM, Edmondson AC. Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *J Organ Behav* 2006; 27: 941–66.**

- **6Walker R, Cooke M, Henderson A, Creedy DK. Characteristics of leadership that influence clinical learning: a narrative review. *Nurse Educ Today* 2011; 31: 743–56.**
- **7Honey M, Waterworth S, Baker H, Lenzie-Smith K. Reflection in the disability education of undergraduate nurses: an effective learning tool? *J Nurs Educ* 2006; 45: 449.**