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The Influence of Organisational Readiness on Knowledge Translation and Implementation of Innovation in a Social Hospital: A Case Study

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Abstract

Healthcare organisations recognise the need to deliver higher-quality, evidence-based care. Thus, managers need to improve their practice regarding managing and translating knowledge. Knowledge Translation faces diverse barriers that must be identified and addressed. Therefore, perceptions from 138 nurses at a social hospital were gathered using a pilot European Portuguese version of the Organisational Readiness for Knowledge Translation (OR4KT) instrument, to assess the organisation's readiness to translate knowledge and implement change. Dimensions scores revealed the institution's strengths in dimensions such as Organisational Climate for Change (36.25) and Organisational Support (35.85), but also exposed the need to improve Motivation (32.95) and Change Content (33.13). The overall score settled at 62.72, normalised on a 0 to 100 scale. The variable, "Professional Recognition," was created to account for the high proportion of Specialist Nurses who were not integrated into the professional career structure, revealing that formally recognised specialists reported significantly different perceptions across the organisational culture dimensions. The results indicate that the organisation has a solid foundation for knowledge translation, though its readiness remains below the optimal level.

Keywords: evidence-based practice; knowledge management; knowledge translation; organisational readiness; organisational readiness for knowledge translation; portugal; portuguese healthcare

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1. Introduction

Healthcare institutions face daily challenges that require professionals to adapt their clinical practice to the best available scientific evidence [1]. This need to bridge the gap between professional practice and scientific evidence becomes even more relevant when considering the growing commitment of healthcare professionals to align their interventions with the most recent scientific advancements [2].

Therefore, healthcare professionals need to be integrated in organisations where the Organisational Culture (the shared set of values, beliefs, practices, and norms that guide behaviour and are transmitted to new members [3]) prioritises both the quality of care provided and the resulting health outcomes and benefits.

Organisations such as Magnet Hospitals stand out for fostering an organisational culture that emphasises excellence in nursing care while retaining a higher number of professionals, thereby reducing institutional turnover rates [4,5]. By adopting the Transformational Leadership model, these organisations and their leaders create work environments that encourage continuous professional development and commitment to evidence-based practice, facilitating access to specialised training, supporting career advancement, and enabling the acquisition of new expertise [5–7]. Thus, the ability of a healthcare organisation to effectively and efficiently translate and implement knowledge into practice depends on an internal assessment of its readiness for knowledge translation.

The process of Knowledge Translation may be represented as the bridging element between research findings and their practical implementation [8], which involves converting scientific evidence into effective clinical interventions to integrate them into daily clinical practice, ultimately enhancing health outcomes and benefits for the patients receiving these services [8–10].

In this context, for organisations to ensure the effectiveness of this process, it is crucial to assess their organisational readiness, understood as an organisational climate shaped by the commitment of members to engage in change initiatives and their collective confidence in achieving the intended outcomes of implementation [11]. The lack of awareness or failure to monitor this metric hinders institutions from identifying and understanding the multiple dimensions that may influence the successful implementation of new practices [7].

Aiming to contribute new knowledge to this field of research, the aim of the study was to analyse the influence of the different dimensions and sub-dimensions of the organisational culture of a hospital on knowledge translation and the adoption of new practices in clinical activity.

A team of Canadian researchers [9] developed and validated a transcultural instrument designed to assess the Organisational Readiness for Knowledge Translation level within healthcare settings. The result was a 59-item questionnaire organised into 6 distinct dimensions capable of assessing healthcare organisations' capability to implement evidence-informed change. These dimensions are the determinants of Organisational Culture, and their assessment provides managers and other stakeholders with the opportunity to enhance and perceive the changes needed to promote more efficient, patient-centred, and evidence-based care.

Through an observational, cross-sectional research design, structured as a case study with a descriptive-correlational approach, a Portuguese pilot version of the Canadian instrument was applied, and the study was conducted in a hospital belonging to the social solidarity sector, located in the northern region of Portugal, and allowed for the assessment of nurses' perceptions regarding the six dimensions that constitute organisational readiness for knowledge translation.

With an overall moderately positive score, the results revealed that the organisation presents a good foundation for implementing innovation, although structural and functional constraints remain, which warrant attention.

Contrasting with previous applications of the OR4KT, this study not only applies a pilot version of the instrument within a new national context but also stands among the first efforts to examine organisational readiness for knowledge translation in a Portuguese third-sector healthcare institution. Academically, this research provides a pivotal contribution to the ongoing validation of the OR4KT instrument within the Portuguese context, strengthening the multicentric study, currently under development, which aims to adapt and validate the questionnaire for the Portuguese healthcare settings.

Lastly, from an organisational standpoint, the misalignment between qualification and compensation reflects a structural barrier that undermines motivation, professional identity,

and the commitment to innovation. Literature in the field supports this interpretation, indicating that recognition, both symbolic and financial, is essential to foster a culture of engagement and trust [5,12].

Therefore, when professionals perceive a lack of acknowledgement for their advanced skills, it may lead to demotivation and a passive attitude toward change implementation [12,13], a relationship further supported in this research, which has also identified professional recognition of nurses as a significant institutional determinant, directly influencing organisational readiness for knowledge translation. In this context, lack of professional recognition was defined as the situation in which professionals who, despite possessing the formal education and required certification, had not been integrated into the institution as Specialists nor compensated in accordance with their advanced qualifications.

2. Materials and Methods

In this descriptive and cross-sectional study, the subjects and the objects under analysis are independent. The data collected is factual, and the researcher's moral values are not contemplated, thereby minimising the potential for researcher interference, falling under the scope of the quantitative method.

To drive the investigation, a European Portuguese pilot version of the OR4KT was selected as the main data collection instrument. The instrument comprises 6 distinct dimensions and 24 subdimensions (Table A1), totalling 59 items. Each respondent should rank the items according to a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

The attribute variables correspond to the participants' sociodemographic and professional characteristics, which were also operationalised to facilitate statistical data analysis. Regarding the sociodemographic variables, the following have been identified: gender, age, and academic qualifications. As for professional qualifications, the following were acknowledged: professional title; specialty area; possession of advanced and additional competence in management; professional career classification; management, leadership, or coordination roles; area/context of clinical practice; length of professional practice; length of professional practice within the organisation; length of professional practice in the predominant area of professional activity.

A psychometric evaluation of the instrument was also conducted to ensure the present investigation's methodological precision. Reliability was assessed using Cronbach's alpha coefficient, which is intended to measure internal consistency. The following results were obtained for each of the six dimensions of the OR4KT instrument: Organisational Climate for Change ($\alpha = 0.70$), Organisational Contextual Factors ($\alpha = 0.84$), Content of Change ($\alpha = 0.87$), Leadership ($\alpha = 0.9$), Organisational Support ($\alpha = 0.96$), and Motivation ($\alpha = 0.80$). Overall, the instrument demonstrated excellent internal consistency, with a global Cronbach's alpha value of 0.96, indicating a high level of reliability across the instrument's structure. Then, a Principal Component Analysis (PCA) was conducted, constrained to the extraction of six factors, using the Varimax rotation method with Kaiser normalisation. The analysis yielded a Kaiser-Meyer-Olkin (KMO) index value of 0.87, indicating a very good level of sampling adequacy and strong inter-item correlations, ultimately supporting the appropriateness of the data for factor analysis. Therefore, the questionnaire was considered valid and appropriate for use in this context.

A non-probabilistic, convenience sampling method was adopted, justified by the accessibility to the organisational setting and the researcher's proximity to the potential participants. The inclusion criteria were to have at least six months of continuous employment at the healthcare institution under study and to hold an active, open-ended employment contract with the institution.

A total of 163 questionnaires were distributed within the institution, of which 138 valid questionnaires were returned, resulting in a participation rate of 84.66%.

Participation in the study was voluntary, and all participants provided informed consent prior to their involvement, in accordance with ethical research standards.

For the descriptive and inferential analysis, the software Statistical Package for Social Sciences (SPSS)—version 22 was used.

The study was approved by the Ethics Committee for Research in Social and Human Sciences at the University of Minho and received a favourable evaluation for its implementation in December 2024.

3. Results

Given a sample of 138 participants from a total population of 163 nurses, most respondents were female, representing 87.70% of the total sample. The respondents' ages ranged from 22 to 61 years, and the largest group was the individuals between the ages of 41 and 50, representing 30.40% of the sample, and the mean age was 42.09 years.

Regarding academic qualifications, most participants hold a bachelor's degree or equivalent, accounting for 81.20% of the total number of participants. Then, approximately 17.40% of respondents have a master's degree and/or a specialty, while only one individual holds a Doctorate.

Most participants hold the professional title of nurse, representing 80.40% of the sample. Among those identified as specialist nurses, medical-surgical nurses emerged as the most prevalent specialty, accounting for 44% of the specialty group, followed by the rehabilitation nurses with 40%.

3.1. Dimensions and Sub-Dimensions of Organisational Culture for Knowledge Translation

After analysing the questionnaire, the results were organised and interpreted. The Figure 1 presents the OR4KT dimension scores, reflecting nurses' perceptions within the institution.

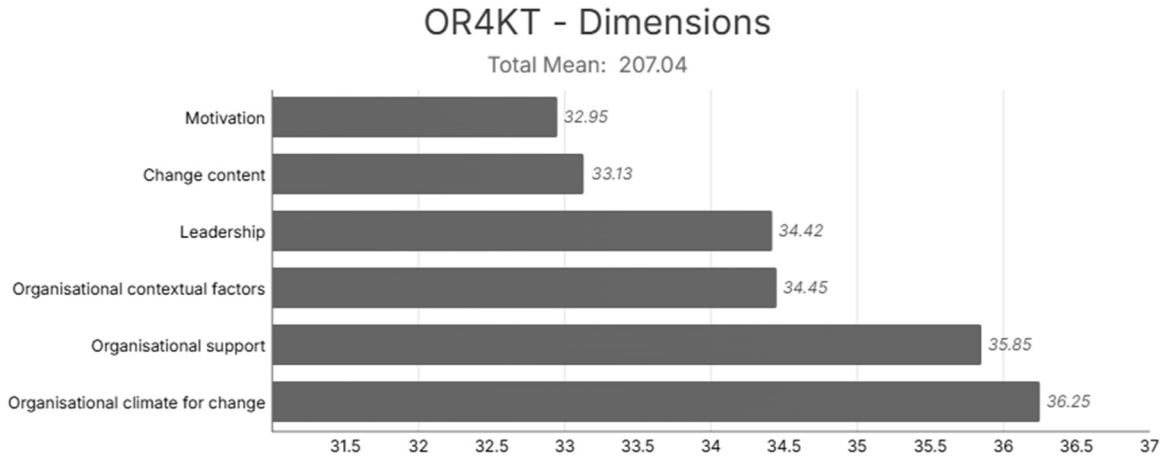

Figure 1. Distribution of the dimensions assessed by the OR4KT instrument, sorted by their corresponding mean rank.

When assessing the *Organisational climate for change* dimension, nurses of the institution have rated all subdimensions positively, agreeing with most of the items. However, regarding the subdimension, "Communication about change", nurses have demonstrated their uncertainty regarding the item, "The formal communication channels work very well", by ranking their perception as neutral. This dimension has achieved a mean score of 36.25, the highest mean score registered throughout the entire questionnaire.

As for the dimension *Organisational Contextual Factors*, nurses provided a divided perception regarding the different subdimensions. The subdimensions "Human resources" and "Material resources" were perceived very neutrally by the respondents, as all items were graded as such. Nevertheless, the subdimension "Organisational Culture" changed the streak of neutrality, as participants have agreed with the items "Staff members have a sense of personal responsibility for improving patient care and outcomes", "Staff members cooperate to maintain and improve effectiveness of patient care", "Staff members are willing to innovate and/or experiment to improve clinical procedures", "Staff members are receptive to change in clinical processes", but remained neutral when scoring the item "Managers solicit opinions of clinical staff regarding decisions about patient care". For this dimension, the mean score registered was 34.45.

Proceeding with the dimension *Change content*, most participants agreed with all items of the subdimensions, therefore, perceiving positively the dimension itself. The mean score registered was 33.13.

The *Leadership* dimension received a rating similar to the previous dimension. However, some items reflected a neutral stance among participants. For example, 57.20% of respondents perceived "External stakeholders are involved in the planning process" as neutral, while 43.50% expressed neutrality regarding "Administrative and clerical staff are involved in the change process". Being the mean rank score, registered for this dimension, 34.42.

As for the *Organisational support*, most of the participants revealed, once again, a positive perception, agreeing with all items of the subdimensions, being the least voted item "There is formal mechanism established for obtaining feedback related to the proposed change" with 39.10% of respondents agreeing with it, and the highest voted the "Team members provide practical support for new ideas and their application". The mean for this dimension settled at 35.85.

The *Motivation* dimension presented a divided view over the different subdimensions. As for the "Pressure for Change" subdimension, most of respondents agreed with two items, "Pressures to make changes come from staff members" and "Senior leaders make pressures to make changes"; however felt neutral in all other items of the subdimension. Then, for the "Training and educational needs" subdimension, participants perceived this subdimension neutrally. Additionally, when assessing the "Adequate knowledge and skills" subdimension, nurses also felt neutral when ranking their perception. Next, the "Commitment" subdimension was perceived positively, with both items being ranked as agree. Lastly, the mean rank of the whole dimension was set at 32.95.

Finally, the OR4KT instrument allowed for the assessment of the institution's organisational readiness for knowledge translation, which, after analysis, total scores fluctuated from 132.00 to 283.00, with a mean of 207.04 and a standard deviation of 28.285, indicating a moderate dispersion in overall readiness perceptions among participants. The Figure 1 is an illustration of the six dimensions of the OR4KT instrument, arranged in ascending order by their respective mean score, which facilitates comparison efforts between the dimensions assessed by the instrument.

To enhance interpretability and the ease of understanding, the scale was normalised in accordance with the procedure proposed by the team responsible for the instrument's validation [14], thereby converting the original scale of 59–295 into a standardised 0–100 scale. When normalised, scores of the questionnaire ranged from 30.93 to 94.92, with a mean of 62.72. When comparing those values to the ones proposed by the previous author [14] in their study, it shows that, besides being very close to the optimal cut-off point proposed by them (64.48), the institution still doesn't have an optimal organisational readiness for knowledge translation.

3.2. The Effect of the Sample's Sociodemographic and Professional Characteristics on Organisational Readiness for Knowledge Translation

Recurring to inferential analysis, it was determined whether the sociodemographic and professional characteristics of the participants influenced their perception of organisational readiness for knowledge translation, by assessing potential associations between variables such as age, gender, academic qualifications, professional role, and years of experience, and the six dimensions of the organisational culture assessed by the OR4KT instrument. To assess and establish these associations, the statistical significance was set at $p < 0.05$.

Based on the results of non-parametric statistical tests, no significant effects were observed for any of the sociodemographic variables examined (gender, age and academic qualifications).

Specific professional characteristics demonstrated statistically significant effects in some of the OR4KT dimensions, identified in Table 1.

Table 1. Statistical associations between professional characteristics and the dimensions assessed using the OR4KT instrument.

OR4KT	Professional Title	Professional Category	Management Roles	Care Context	Professional Experience
	p	*p*	*p*	*p*	*p*
Organisational climate for change	**0.008**	**<0.001**	0.057	**0.012**	0.572
Organisational contextual factors	0.694	**0.017**	0.066	0.253	0.268
Change content	0.532	0.244	**0.020**	0.130	**0.038**
Leadership	0.373	0.012	**0.033**	0.451	0.884
Organisational Support	0.658	0.176	**0.038**	0.712	0.527
Motivation	0.725	0.626	**0.013**	0.103	0.411
Total	0.604	0.028	**0.018**	0.147	0.391

3.3. Recognition of Professional Qualification and Its Influence in the Perception over the Institution

During the characterisation of the sample, a considerable proportion of professionals were identified as holding the necessary qualifications to be classified as Nurse Specialists, yet these were not formally recognised as such within their professional career category. Considering these findings and aiming to better understand the potential impact of this lack of recognition, particularly in terms of its influence over the organisation's readiness to translate knowledge, it was relevant to examine its effects more closely. To conduct the subsequent analysis, a new variable was computed to reflect this discrepancy. A Mann-Whitney U test was conducted to assess whether professional recognition through professional integration into the specialist career influences the distribution of OR4KT dimensions, Table 2. The results revealed statistically significant differences.

Table 2. Statistical Influence of Professional Recognition on the OR4KT Dimensions.

OR4KT	*p*
Organisational climate for change	**<0.001**
Organisational contextual factors	**0.009**
Change content	0.143
Leadership	**0.005**
Organisational support	0.098
Motivation	0.389
Total	**0.014**

4. Discussion

The *Organisational Climate for Change* dimension aims to assess the extent to which the organisational culture is perceived as a facilitator to change. As such, peer collaboration emerged as a main strength in the dimension, with most professionals describing strong teamwork and mutual support among colleagues. Nonetheless, high levels of stress were also reported, with many respondents acknowledging frequent frustration and noting that heavy workloads often reduce the effectiveness of their interventions. These constraints align with the literature describing heavy workloads and burnout as barriers to Knowledge Translation (KT) [15,16].

Perceptions of trust and openness within the organisation were mixed. While many professionals recognised mutual trust among colleagues, 47.10%, a substantial proportion expressed uncertainty, 33.30%, suggesting that confidence and transparency are not yet consistent across teams. Similarly, several respondents reported feeling hesitant to ask questions or share opinions openly, reflecting limited communication fluidity. Regarding leadership, only a portion of staff felt their ideas were genuinely considered, indicating that managerial support for innovation may be perceived more as symbolic than as an established organisational practice.

These findings highlight the importance of leadership and communication, as literature emphasises that effective KT requires transparent communication and participative decision-making [17–19]. The hospital presents a solid peer foundation, but stress, operational overload, and limited managerial inclusiveness constrain its full transformative potential.

To strengthen the organisational climate for change, managers must address workload pressures that drive stress and burnout, while institutionalising clear mechanisms for staff participation, open communication, and innovation support. By consolidating active listening, transparent communication, and professional participation, leaders may be able to convert existing teamwork strengths into sustainable organisational capacity for knowledge translation.

As for the *Organisational Contextual Factors* dimension, it evaluates the structural, administrative, and resource-based support for sustaining evidence-informed change.

Role definition within the organisation appeared ambiguous, with 41.30% of respondents perceiving responsibilities for change as clearly defined, but more than half remained neutral, suggesting limited clarity and weak accountability structures [11,20].

Financial support emerged as one of the dimension's most critical weaknesses, with only 15.20% of respondents perceiving adequate budget allocation and more than 80% expressing disagreement or neutrality. This pattern reinforces the notion that limited financial capacity hinders change efforts [21].

Training support showed similar gaps, as only 36.90% felt it was adequate, 26.80% disagreed, and 36.20% were neutral, suggesting unequal access to continuous education, despite its recognised importance for knowledge translation [22,23].

Facilities and equipment were also perceived as insufficient, as just 28.90% of professionals felt they had the necessary tools to support change initiatives. This limitation reinforces the JBI FAME model's emphasis on practical feasibility [24].

Staffing has also emerged as a limitation, with only 29.70% of professionals perceiving human resources as adequate, while the remainder expressed uncertainty or disagreement. This finding aligns with evidence that highlights workforce shortages as a persistent constraint in healthcare settings [17,25].

However, a strong professional culture emerged, with most staff describing a shared sense of responsibility for improving patient care and a cooperative commitment to maintaining quality standards. There was also a clear openness to innovation, with professionals

expressing receptiveness to new procedures and clinical changes, reflecting an overall positive alignment with the readiness dimensions [16].

Nonetheless, leadership participation in clinical decision-making remained limited. Less than half of respondents felt that managers actively sought their input, while 54.30% remained neutral or disagreed, suggesting a leadership approach perceived as distant and insufficiently participatory.

Efforts to enhance this dimension will require clearer role definition, adequate financial support, and continuous training, with a stronger investment in resources and staffing. While professionals depict high responsibility and openness to innovation, these strengths can only translate into effective change if supported by a structured, equitable access to education and sufficient infrastructure. Managers should also adopt a more participatory leadership style, ensuring frontline staff are actively involved in decision-making to align institutional strategies with clinical practice [18,19].

Regarding the dimension, *Change Content*, it assesses how professionals perceive the clarity, benefits, feasibility, and patient alignment of proposed changes.

Respondents reported a high willingness to adjust, with 62.30% agreeing or strongly agreeing, consistent with the previously noted high change commitment, and their practical benefits for a constantly evolving, patient-centred provision of care [11].

Similarly, 63.00% perceived an ability to exchange ideas and influence patient care decisions, aligning with the KTA model on feedback and adaptation mechanisms [8]. Flexibility to deal with change was affirmed by 56.50% of participants, resonating with the literature on adaptability as an implementation enabler [17].

Then, the ability to adjust routines was endorsed by 60.90% of nurses, reflecting the concept of "sensemaking" [26] which emphasises how professionals continuously interpret and respond to an evolving demand, and need to develop an openness to routine modification. Likewise, 65.90% of participants agreed to hold the ability to adapt to new standards, further supporting adaptability as a predictor of success, particularly in healthcare, where regulatory updates must be rapidly integrated [16].

Patient-related items showed moderately positive but less decisive results. Even though acceptance of changes was endorsed by 57.30%, neutrality remained high, suggesting the presence of variations in feedback communication [27].

Patient needs and preferences were recognised by most professionals, consistent with the JBI Evidence-Based Practice model assumption that the patient needs and beliefs are a fundamental pillar in designing respectful, meaningful, effective, and patient-centred care interventions [24,28]. However, neutrality persisted, with 34.10% of neutral responses.

Similarly, most of the respondents also agreed that changes had more advantages than disadvantages, indicating some uncertainty about expected health outcomes, endorsing the JBI FAME model's emphasis on communication of benefits, which promotes the alignment of expectations, treatment engagement, and sustainability [24,28].

The strongest endorsement of the present dimension concerned science-based changes, as 74.60% affirmed that changes were based on current knowledge, with less than 2% of individuals disagreeing, which highlights a high institutional confidence in evidence-based practices [8].

Overall, findings confirm that professionals perceive proposed changes as evidence-based, adaptable, and meaningful, supporting the view of content and context as foundational to organisational readiness and knowledge translation initiatives [11]. The high adaptability scores suggest that changes are integrated rather than disruptive, reinforcing that compatibility with routines and a clear rationale boosts the professionals' confidence [15,21].

Lastly, professionals interpret the change content as clear, adaptable, and science-based, which strengthens confidence in its integration into practice. To capitalise on this, managers should ensure that communication about patient-related benefits is consistent and transparent, reducing neutrality and uncertainty among staff. Maintaining structured feedback channels, aligning changes with patient needs, and continuously monitoring outcomes will reinforce adaptability and sustain professionals' trust in the value of new practices [29].

Concerning the *Leadership* dimension, it evaluates how nurse managers and institutional decision-makers drive and sustain change.

Accountability was strongly affirmed, with more than three-quarters of respondents perceiving that managers hold staff accountable, a practice consistent with Weiner's concept of change efficacy [11].

Likewise, more than two-thirds of respondents recognised leadership involvement and presence in continuous improvement of care, resonating with Kaplan's findings that strong, visible leadership is critical for sustaining evidence-based practice [15], and 60.90% acknowledged feedback provision, a key promoter of knowledge translation [8,22].

Managerial presence was strongly perceived, with more than 80% of participants acknowledging active managerial engagement. Clinician involvement was likewise viewed positively, as approximately two-thirds of respondents agreed that clinical staff play an active role in improvement initiatives.

Conversely, participation of administrative staff was limited, with only 29.70% of nurses agreeing with the item, despite evidence that inclusive engagement strengthens change implementation [17]. Decision-making was perceived as "top-down," reaching only 30.10% of agreement on staff inclusion, contrasting with recommendations for participatory governance [18,30,31]. External stakeholder involvement was also scarce, being perceived by only about one-quarter of respondents.

Overall, leadership was recognised as a facilitator of change, with strong managerial presence, accountability, and feedback provision supporting the dimension. However, limited involvement of administrative staff, scarce participation of external stakeholders, and reliance on top-down decision-making processes constrain broader engagement and involvement. To strengthen this dimension, managers should adopt a more participatory and transformational leadership approach, ensuring inclusive governance, shared decision-making, and psychological safety that empower staff and sustain innovation [29].

As for the *Organisational Support* dimension, it evaluates the availability of resources, institutional mechanisms, and monitoring practices that sustain evidence-informed change.

In this study, a supportive team culture was evident, as the majority (68.10%) of respondents agreed that colleagues provide practical support for new ideas, consistent with collective efficacy and social facilitation for organisational readiness [11]. Cooperation in developing and applying ideas was also positively perceived, with over 60% of agreement, reinforcing teamwork as a known enabler of knowledge translation [32].

However, assistance in developing new ideas, with 47.80% of agreement, and resource sharing, with 57.90%, were less consistent, with high levels of neutrality, generating concerns about reliance on informal rather than institutionalised processes, a liability documented in the literature [21].

Monitoring and evaluation mechanisms were acknowledged, with 55% of respondents affirming that progress is continuously measured and 57.30% confirming that outcomes are regularly assessed, reflecting an institutional alignment on the importance of transparent monitoring for sustaining improvement [8,15,22]. Yet, neutrality remained high, suggesting a possible weak visibility of the existing systems. Then, the dissemination of performance measures was endorsed by 57.30% of respondents, though communication

appeared inconsistent, a gap highlighted in the research field [16,20]. Leadership review of results had a good perception provided by over 60% of participants, reinforcing the institutional commitment and accountability [19]. Nonetheless, only about half of the participants agreed that formal feedback mechanisms were in place, suggesting an underuse of these mechanisms or a limited awareness, despite their role as key adaptive elements of knowledge translation [33].

Therefore, the Organisational support dimension was perceived as a relative strength, with teamwork and monitoring mechanisms contributing to readiness for change. However, reliance on informal processes and inconsistent visibility of feedback and communication systems weakens its sustainability. To address this, managers should formalise support structures, strengthen the visibility of monitoring outcomes, and institutionalise consistent feedback and dissemination mechanisms across their departments to ensure equitable and transparent support for innovation and knowledge translation.

The *Motivation* dimension evaluates the extent to which internal and external factors, such as institutional pressure, leadership behaviour, and prior experience with change initiatives, influence healthcare professionals to promote and monitor evidence-based change.

The item "Patients make pressures to make changes" revealed a modest external motivation from service users, with only 35.50% of participants agreeing with this item. Yet, 39.90% remained neutral and 24.60% actively disagreed. This limited patient-driven pressure aligns with the notion that although patient engagement is central to person-centred care, its influence on organisational innovation is often indirect or overlooked [27].

In contrast, the item "Pressures to make changes come from staff members" received a higher confirmation, has over 60% of nurses' consent with the item, and only 5.00% disagree. In turn, this reflects a strong staff motivation, which reinforces the perceived relevance and urgency of change efforts [8,24]. Similarly, "Senior leaders make pressures to make changes" was endorsed by 59.40% of participants, although 10.10% disagreed.

In terms of governance, the connection between strategic leadership and operational teams appeared limited. Few professionals perceived change pressures as originating from board members or oversight bodies, suggesting that governance engagement in driving improvement is relatively weak. This gap highlights the need for stronger alignment between strategic vision and the practical realities of implementation [11,34].

External drivers were likewise perceived as weak. Fewer than one-third of respondents felt that funding organisations exert pressure for change, while many expressed neutrality or disagreement. This suggests that funders remain an underutilised catalyst for improvement, despite evidence that resource-based incentives can effectively stimulate change, particularly in under-resourced settings [21].

Institutional learning also appeared underdeveloped, since the item "There is implementation change experience gained from projects or pilot programs and their evaluation" was only positively rated by about a third of respondents. Therefore, suggesting a limited consolidation of institutional learning, despite evidence that experience is a powerful enabler of Knowledge Translation efforts and that failure to consolidate instruction may lead to repeated errors [17]. Similarly, only 45% of nurses agreed that managers are knowledgeable about innovation based on past experience, which may indicate a moderate confidence in leadership expertise, but also signals that innovation knowledge may not be systematically developed or shared across management levels, as empirically advised [22].

Benchmarking practices were also perceived as weak. Thus, only 31.10% of respondents agreed that knowledge is available about how similar innovations are used by other organisations, suggesting limited external comparison and, consequently, reduced ability to adapt concept-proven strategies. Leadership behaviour showed mixed results, for 44.90% agreed that senior managers promote change by behaving consistently with it, but 25.00%

disagreed, and 30.40% were neutral. This reflects partial role modelling, a critical factor for translating strategy into organisational culture [19]. Finally, the statement "Senior managers define the course of change" received a stronger agreement, with more than half of respondents endorsing it, possibly indicating that managers play a defined strategic role but could strengthen their influence to reach more professionals.

The literature reinforces that motivation depends not only on internal beliefs in the value of change but also on leadership visibility, role modelling, and institutional recognition. Professionals in Magnet Hospitals report higher motivation when engaged nurse leaders, clinical autonomy, and growth opportunities are present [5], factors partially identified in this study but still requiring reinforcement. Likewise, motivation in healthcare is shaped by the organisational climate, leadership trust, and personal investment in institutional goals [15,29]. The present findings are consistent with this perspective, as motivation appears to be internally driven, with greater influence from staff and leaders than from external players such as funders or regulators.

Nevertheless, the recurrent neutrality across items highlights the need to expand and improve accessibility to knowledge on successful external practices and to institutionalise recognition mechanisms that strengthen intrinsic motivation. By doing so, the organisation could progress from a baseline of moderately positive motivation to a more active and engaged culture of change.

Finally, managers should prioritise strengthening institutional learning, systematically sharing innovative knowledge across leadership levels, and adopting benchmarking practices to bring in proven strategies from other organisations. At the same time, formal recognition mechanisms and visible role modelling are essential to convert staff motivation into a more active, organisation-wide culture of change.

4.1. Influence of Respondents' Characteristics on Organisational Culture Dimensions

Understanding how sociodemographic and professional variables influence perceptions of organisational readiness for knowledge translation (OR4KT) allows for the identification of internal asymmetries that may hinder or facilitate the implementation of innovation. In this research, a multidimensional analysis was conducted using non-parametric inferential tests to explore whether such characteristics significantly shaped responses to the six dimensions of the OR4KT instrument.

When assessing the possible correlations/influences of the characteristics, none of the sociodemographic variables, such as gender, age, or academic qualification, were found to be statistically associated with any of the OR4KT dimensions. This suggests that perceptions of organisational culture and organisational readiness for knowledge translation are relatively homogeneous across sociodemographic groups. Falling under the principles that contextual and structural aspects of organisations tend to influence professionals' engagement with change more than intrinsic demographic traits [34]. Aligning the absence of significant differences with the notion that interventions to improve readiness should be systemic rather than targeted by demographic segmentation.

In contrast, several professional variables were significantly associated with one or more OR4KT dimensions, indicating that perceptions of organisational culture and readiness may vary according to role, recognition, or position within the institutional hierarchy.

The Professional Category, which differentiates nurses as nurses, specialist nurses, and nurse managers, emerged with statistically significant associations. These results align with the literature, which highlights that individuals in leadership or formally recognised positions often experience greater autonomy, inclusion in decision-making processes, and access to institutional resources, thereby developing more favourable perceptions of the organisation's capability for change [4,11,13,29].

Similarly, Management Roles, categorised in formal, informal or none, were also significantly associated with more positive perceptions across multiple dimensions. The relationship between leadership engagement and positive readiness for change is documented [17], and these findings confirm that those more involved in strategic and managerial functions tend to have a broader, more optimistic view of the organisation's change potential.

Another noteworthy association was observed between the professional context (direct care, management, or other) and the Organisational Climate for Change, suggesting that the nature of daily clinical activities may condition how professionals perceive teamwork, communication, and trust [16].

Interestingly, years of professional experience were not significantly associated with any of the OR4KT dimensions, except for Change Content, which may reflect a greater ability among more experienced professionals to critically evaluate the feasibility and value of proposed changes based on clinical reality. However, no significant associations were found within years of service in the institution or in the specific care context.

4.2. Recognition and Compensation of Specialists: Perceived Impact on Institutional Functioning

During this study, it became evident that a significant number of the nurses had completed the academic and professional training required to obtain the title of Specialist Nurse, officially recognizable by the Portuguese Nursing Council. Despite holding this qualification, the vast majority weren't integrated into the corresponding specialist career, nor were they compensated as such in the institution. In fact, 94.10% of the specialist nurses included in the sample were not formally recognised or compensated in accordance with their title, exposing a discrepancy between professional credentialing and institutional career integration.

Considering this disjunction, it was pertinent to examine how such a condition might influence the institution's capacity to translate knowledge into practice.

This discrepancy had a significant impact on how professionals perceived the organisational readiness for knowledge translation, particularly in the dimensions of Organisational Climate for Change, Organisational Contextual Factors, and Leadership, which, according to the non-parametric test of Mann-Whitney U, revealed statistically significant differences depending on career recognition.

The Leadership dimension was significantly influenced by the recognition variable, in which specialist nurses, who were formally integrated into the career, reported more positive perceptions of leadership involvement and institutional support in change processes. This difference was statistically significant, indicating a tendency for more favourable perceptions of leadership among those whose specialist status was institutionally acknowledged.

Therefore, it seems that formal recognition may reinforce professionals' confidence in the institution's strategic direction and enhance their perceived inclusion in organisational decision-making. These dynamics are particularly relevant in the context of change processes, where professional engagement and alignment with institutional goals are essential to sustain knowledge translation efforts.

The lack of formal career progression also appears to affect perceptions of Organisational Climate for Change. Specialists without formal recognition expressed lower agreement with statements related to collaboration, mutual support, and openness to innovation. These elements are central to creating a psychologically safe environment, which is a prerequisite for implementing change [16]. When skilled professionals do not feel valued or integrated into the institution, the risk of disengagement and resistance to change increases [35].

Moreover, when analysing the Organisational Contextual Factors, these were also perceived more negatively by non-recognised specialists, which may be attributed to a sense of organisational injustice or misalignment between effort and reward, that, according to the Equity Theory, can significantly undermine performance and satisfaction [36].

However, no significant differences were observed in the Motivation or Change Content dimensions. This may indicate that even though specialists are non-recognised by their differentiation, they may maintain a high intrinsic motivation and a positive view of the importance and relevance of the process of change itself. Further reinforcing the notion that motivated individuals may still be constrained by demotivating organisational structures, particularly when those structures fail to formally acknowledge their contributions.

These findings have direct implications for health unit management challenges, since the healthcare system should ensure that the career structure aligns with professional qualifications and is not merely a matter of compliance. As proved by the results of this research, this gap between professional qualification and recognition directly affects the institution's capacity to evolve, adapt, and implement innovation. As such, any strategic effort to improve organisational readiness for knowledge translation must consider the formal integration and fair compensation of Nurse Specialists.

In summary, career recognition is not a mere administrative concern, but rather a strategic determinant of organisational performance. The effective implementation of innovation in healthcare settings is intrinsically linked to the way institutions value and reward their human capital, particularly those with advanced competencies, who might even be valuable leaders, and who will sustain these transformative processes.

5. Conclusions

This research contributes to the ongoing validation of the OR4KT instrument within the Portuguese context, as part of a broader multicentric study being conducted in Portugal to adapt and validate the questionnaire for the Portuguese healthcare settings.

As with any research effort, this study also presents methodological limitations that need to be acknowledged. These limitations do not compromise the validity of the findings, but rather define the scope within which they should be considered.

First, the study was purposely conducted in a single healthcare institution and included only nursing professionals. Consequently, this use of a non-probabilistic convenience sample limits the generalizability of the findings to other healthcare settings, professional groups, or healthcare sectors.

Next, the cross-sectional design of the study acquired participants' responses at a single point in time, while appropriate for exploring associations and identifying patterns, this type of design does not allow for analysis of change efforts in organisational readiness over time or in response to specific interventions, but rather serve the purpose of assessing the current situation regarding organisational readiness at a given moment in time.

Then, the study's sample represented 84.66% of the eligible population, as it was not possible to recover the responses from 25 participants.

Future research may seek to expand the population under study by including multiple healthcare institutions from different sectors (public, private, and the third sector), allowing for a comparative analysis across organisational contexts and contributing to a more in-depth research of the organisational readiness for the knowledge translation theme. Additionally, the adoption of alternative research designs, such as longitudinal studies, would create the opportunity for the assessment of how organisational readiness evolves over time and in response to specific interventions aimed at strengthening the various dimensions of organisational culture that support knowledge translation.

Lastly, our results highlight the need for further research into how the fair compensation of Specialist Nurses might influence organisations and affect their direct capacity to implement innovation and translate knowledge into practice, compromising the quality of care provided.

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Abbreviations

The following abbreviations are used in this manuscript:

DOI	Digital Object Identifier
HR	Human Resources
ISO	International Organization for Standardization
JBI	Joanna Briggs Institute
KMO	Kaiser-Meyer-Olkin Analysis
KT	Knowledge Translation
KTA	Knowledge to Action Cycle
OR4KT	Organisational Readiness for Knowledge Translation instrument
PCA	Principal Component Analysis
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences (v.22)

Appendix A. OR4KT Instrument: Dimensions and Subdimensions

Table A1. Full OR4KT instrument structure with dimensions and subdimensions for assessing organisational readiness for knowledge translation.

	OR4KT					
Dimensions	**Organisational Climate for Change**	**Organisational Contextual Factors**	**Change Content**	**Leadership**	**Organisational Support**	**Motivation**
Subdimensions	Staff Cohesion	Human Resources	Attributes of Change	Leadership champion	Support Climate	Pressure for Change
	Staff work related stress	Material Resources	Perceived Complexity	Strategic Planning Process	Monitoring	Training and educational needs
	Communication about change	Organisational Culture	Patient Experiences	Decision making process	Evaluation process	Adequate Knowledge and Skills
	Manager's Openness to change		Research evidence	Adequate level of involvement	Feedback	Commitment

References

1. Teixeira, L.O.; Pinto, C.B.; Carvalho, A.L.; Teixeira, A.I.C.; Augusto, M.C.B. Supervisão no indicador de prática clínica: A prática baseada na evidência no contexto do paciente cirúrgico. *RevSALUS—Rev. Científica Int. Rede Académica Das Ciências Saúde Lusofonia* **2022**, *3*, 13–25. [CrossRef]
2. Silva, V.M.D. I Consenso SOBEP de aspiração de crianças com tubo endotraqueal: A busca pela aproximação da ciência e da prática. *Rev. Soc. Bras. Enferm. Pediatras* **2019**, *18*, 60–61. [CrossRef]
3. da Costa, G.C.; Araújo, L.M.G.; Ferreira, L.M.G. Cultura organizacional: Conceitos e tipologias. *Bol. Conjunt. BOCA* **2021**, *6*, 20–27. [CrossRef]
4. Hoffman, M. Magnet Hospitals: Attraction and Retention of Professional Nurses. *AORN J.* **1983**, *38*, 456. [CrossRef]
5. Upenieks, V.V. What Constitutes Effective Leadership?: Perceptions of Magnet and Nonmagnet Nurse Leaders. *JONA J. Nurs. Adm.* **2003**, *33*, 456–467. [CrossRef] [PubMed]
6. Haller, K.; Berends, W.; Skillin, P. Organizational Culture and Nursing Practice: The Magnet Recognition Program® as a Framework for Positive Change. *Rev. Médica Clínica Las Condes* **2018**, *29*, 328–335. [CrossRef]
7. Turkel, M.C.; Reidinger, G.; Ferket, K.; Reno, K. An Essential Component of the Magnet Journey. *Nurs. Adm. Q.* **2005**, *29*, 254–262. [CrossRef]
8. Graham, I.D.; Logan, J.; Harrison, M.B.; Straus, S.E.; Tetroe, J.; Caswell, W.; Robinson, N. Lost in Knowledge Translation: Time for a Map? *J. Contin. Educ. Health Prof.* **2006**, *26*, 13. [CrossRef]
9. Pereira, R.P.G. Enfermagem Baseada Na Evidência: Atitudes, Barreiras E Práticas. Ph.D Thesis, Universidade do Porto, Porto, Portugal, 2016.
10. WHO Regional Office for Europe. *Rapid Response: Knowledge Translation Mechanisms to Translate Evidence into Public Health Policy in Emergencies*; WHO Regional Office for Europe: Copenhagen, Denmark, 2021.
11. Weiner, B.J. A Theory of Organizational Readiness for Change. *Implement. Sci.* **2009**, *4*, 67. [CrossRef] [PubMed]
12. Shirey, M.R. Authentic Leaders Creating Healthy Work Environments for Nursing Practice. *Am. J. Crit. Care* **2006**, *15*, 256–267. [CrossRef]
13. Kramer, M.; Schmalenberg, C.E. Best Quality Patient Care: A Historical Perspective on Magnet Hospitals. *Nurs. Adm. Q.* **2005**, *29*, 275–287. [CrossRef]
14. Grandes, G.; Bully, P.; Martinez, C.; Gagnon, M.-P. Validity and Reliability of the Spanish Version of the Organizational Readiness for Knowledge Translation (OR4KT) Questionnaire. *Implement. Sci.* **2017**, *12*, 128. [CrossRef]
15. Kaplan, L.; Zeller, E.; Damitio, D.; Culbert, S.; Bayley, K.B. Improving the Culture of Evidence-Based Practice at a Magnet® Hospital. *J. Nurses Prof. Dev.* **2014**, *30*, 274–280. [CrossRef]
16. Nilsen, P.; Schildmeijer, K.; Ericsson, C.; Seing, I.; Birken, S. Implementation of Change in Health Care in Sweden: A Qualitative Study of Professionals' Change Responses. *Implement. Sci.* **2019**, *14*, 51. [CrossRef]
17. Lau, R.; Stevenson, F.; Ong, B.N.; Dziedzic, K.; Treweek, S.; Eldridge, S.; Everitt, H.; Kennedy, A.; Qureshi, N.; Rogers, A.; et al. Achieving Change in Primary Care—Causes of the Evidence to Practice Gap: Systematic Reviews of Reviews. *Implement. Sci.* **2016**, *11*, 40. [CrossRef]
18. Caetano, A.; das Neves, J.G.; Ferreira, J.M.C. *Psicossociologia das Organizações*; Edições Sílabo: Lisbon, Portugal, 2020; ISBN 978-989-561-129-4.
19. Huston, C.J.; Marquis, B.L. *Leadership Roles and Management Functions in Nursing: Theory and Application*, 11th ed.; Wolters Kluwer: Philadelphia, PA, USA, 2024; ISBN 978-1-9751-9306-5.
20. Gagnon, M.-P.; Attieh, R.; Dunn, S.; Grandes, G.; Bully, P.; Estabrooks, C.A.; Légaré, F.; Roch, G.; Ouimet, M. Development and Content Validation of a Transcultural Instrument to Assess Organizational Readiness for Knowledge Translation in Healthcare Organizations: The OR4KT. *Int. J. Health Policy Manag.* **2018**, *7*, 791–797. [CrossRef] [PubMed]
21. Shafaghat, T.; Imani Nasab, M.H.; Bahrami, M.A.; Kavosi, Z.; Roozrokh Arshadi Montazer, M.; Rahimi Zarchi, M.K.; Bastani, P. A Mapping of Facilitators and Barriers to Evidence-Based Management in Health Systems: A Scoping Review Study. *Syst. Rev.* **2021**, *10*, 42. [CrossRef] [PubMed]
22. *ISO 30401:2018*; Knowledge Management Systems. International Organization for Standardization: Geneva, Switzerland, 2018.
23. Pittman, J.; Cohee, A.; Storey, S.; LaMothe, J.; Gilbert, J.; Bakoyannis, G.; Ofner, S.; Newhouse, R. A Multisite Health System Survey to Assess Organizational Context to Support Evidence-Based Practice. *Worldviews Evid. Based Nurs.* **2019**, *16*, 271–280. [CrossRef]
24. Jordan, Z.; Lockwood, C.; Munn, Z.; Aromataris, E. Redeveloping the JBI Model of Evidence Based Healthcare. *Int. J. Evid. Based Healthc.* **2018**, *16*, 227–241. [CrossRef] [PubMed]
25. Moreno-Monsivais, M.G. Practice Based on Scientific Evidence as the Foundation of Clinical Practice. *Aquichan* **2019**, *19*, 1–4. [CrossRef]
26. Weick, K.E. Sensemaking in Organizations. *Thousand Oaks* **1995**, *13*, 113–116. [CrossRef]

27. Gagliardi, A.R.; Berta, W.; Kothari, A.; Boyko, J.; Urquhart, R. Integrated Knowledge Translation (IKT) in Health Care: A Scoping Review. *Implement. Sci.* **2016**, *11*, 38. [CrossRef]
28. Pearson, A.; Wiechula, R.; Court, A.; Lockwood, C. The JBI Model of Evidence-Based Healthcare. *Int. J. Evid. Based Healthc.* **2005**, *3*, 207–215. [CrossRef] [PubMed]
29. Pereira, R.; Martins, M.M.; Rodrigues, F. Prática baseada na evidência, translação do conhecimento e cultura organizacional. In *Um Olhar Para A SAÚDE Com Ciência E Educação*; Escola Superior de Enfermagem de Coimbra (ESEnfC): Coimbra, Portugal, 2024; pp. 145–163. ISBN 978-989-35570-3-7.
30. Oborn, E.; Barrett, M.; Prince, K.; Racko, G. Balancing Exploration and Exploitation in Transferring Research into Practice: A Comparison of Five Knowledge Translation Entity Archetypes. *Implement. Sci.* **2013**, *8*, 104. [CrossRef] [PubMed]
31. Rego, A.; Pina e Cunha, M.; Gomes, J.F.S.; Campos e Cunha, R.; Cabral Cardoso, C.; Marques, C.A. *Manual de Gestão de Pessoas e do Capital Humano*, 3rd ed.; Edições Sílabo: Lisbon, Portugal, 2015; ISBN 978-972-618-813-1.
32. Attieh, R.; Gagnon, M.-P.; Estabrooks, C.A.; Légaré, F.; Ouimet, M.; Vazquez, P.; Nuño, R. Organizational Readiness for Knowledge Translation in Chronic Care: A Delphi Study. *BMC Health Serv. Res.* **2014**, *14*, 534. [CrossRef]
33. Martin, V.; Henderson, E.S.; Charlesworth, J. *Managing in Health and Social Care*, 2nd ed.; Routledge: New York, NY, USA, 2010; ISBN 978-0-415-49388-8.
34. Gagnon, M.-P.; Attieh, R.; Ghandour, E.K.; Légaré, F.; Ouimet, M.; Estabrooks, C.A.; Grimshaw, J. A Systematic Review of Instruments to Assess Organizational Readiness for Knowledge Translation in Health Care. *PLoS ONE* **2014**, *9*, e114338. [CrossRef]
35. Tummers, L. Explaining the Willingness of Public Professionals to Implement New Policies: A Policy Alienation Framework. *Int. Rev. Adm. Sci.* **2011**, *77*, 555–581. [CrossRef]
36. Adams, J.S. Inequity In Social Exchange. In *Advances in Experimental Social Psychology*; Berkowitz, L., Ed.; Academic Press: Cambridge, MA, USA, 1965; Volume 2, pp. 267–299.

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