Getting research closer to practice: using a research capacity building framework to design a clinician researcher role in occupational therapy.

Kylie Bower
Princess Alexandra Hospital and The Hopkins Centre

Background

A 12 month pilot CR role in the Brain Injury Rehabilitation Service (BIRS) was created as a joint initiative of the Princess Alexandra Hospital Occupational Therapy (OT) Department (funding 3 days of clinical work) and The Hopkins Centre (funding 2 days of research work), commencing in November 2018. Design and evaluation of the role was based on Cooke’s framework for RCB1 (figure 1). Unlike traditional methods of evaluating RCB (like publications, grant awards), the model presents a more holistic framework including six evidence-based principles of RCB which can be demonstrated across four organisational levels.

The framework informed a 12 month workplan, and an evolving table of evidence where achievements in various domains were recorded. Outcomes were evaluated by key stakeholders to indicate levels of progress, as represented in figure 1. The enablers and challenges to achieving these outcomes, and future recommendations are described below.

![Figure 1](image.png)

**Enablers**

1. **Strong vision and detailed workplan**
   - Provided agreed, discrete objectives that helped manage the scope of activity & gave weight to both research and clinical tasks.

2. **Established research culture and resources**
   - Provided strong foundation for - and value in - research skill development.

3. **‘Protected’ research time**
   - Reduced ‘tension’ between research and clinical demands.2

4. **Presence in both clinical and research roles**
   - Helped integrate evidence and research into clinical practice through team meetings activities, formal supervision, and informal conversations.

5. **Clear mentorship / support structure**
   - Facilitated skill development and role validation.

**Challenges**

1. **Influencing team members’ skills**
   - 6-monthly staff rotations, and their competing clinical priorities have perhaps limited this.

2. **Maintaining ‘protected’ research time**
   - Clinical and administrative tasks encroached more on research time than in reverse.

3. **Informal research support**
   - Was limited by location of the CR in the OT office as opposed to the Hopkins office.

4. **Funding future research / sustainability**
   - Grant applications were a time consuming task, with no guarantee of success.

5. **Unclear economic impact**
   - Was not evaluated in this project, and is cited as a challenge to RCB evaluation.1

6. **Ambiguity of evaluation**
   - Few parameters exist for evaluating items in the model, leading to very subjective ratings.

**Examples of outcomes**

1. **The CR obtained skills and confidence in:**
   - Basic project management, writing research plans, applying for ethics and grants, participating in basic quantitative and qualitative methodologies and writing for publication.

2. **Teams’ participation in research was kept close to practice:**
   - A consumer was engaged in a multidisciplinary (MD) research team regarding fatigue after traumatic brain injury, the CR assisted in finalising a knowledge translation project to engage patients with stroke in managing arm recovery, CR facilitated commencement of a QI project for mood assessment in stroke, helped engage a team in proposing a critically appraised topic.

3. **Collaborations were developed modestly across organisations:**
   - Members of the Hopkins Centre, University of Queensland, Griffith University, BIRU MD team and BIRU OT team were engaged in a research proposal.

4. **Dissemination is planned at a supra-organisational level:**
   - Presenting outcomes of the CR position to the Hopkins Symposium, to the statewide Occupational Therapy Rehabilitation Collaboration and in a journal publication. A clinical tool developed in a knowledge translation project will be shared across the Health District.

5. **Sustainability, infrastructures and skill development were not significantly addressed at a supra-organisational level.**

**Recommendations**

1. **Longer project timeframe** — perhaps 2 years
   - This may enable more influence at a supra-organisational level.

2. **Selectively align clinical supervision**
   - Align relationships between CR and junior staff with research skill development goals.3

3. **Split location of CR role**
   - Between clinical and research office spaces to balance informal research support in both directions, and help ‘protect’ research time.

4. **Plan clinically-integrated methodologies**
   - To minimise dependence on external funding sources, and time spent applying for this.

5. **Further refinement of Cooke’s model**
   - To facilitate more objective measurement of success across domains, and address economic impact.

**Literature Cited**