

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

The Hopkins Centre

Research for Rehabilitation and Resilience



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.

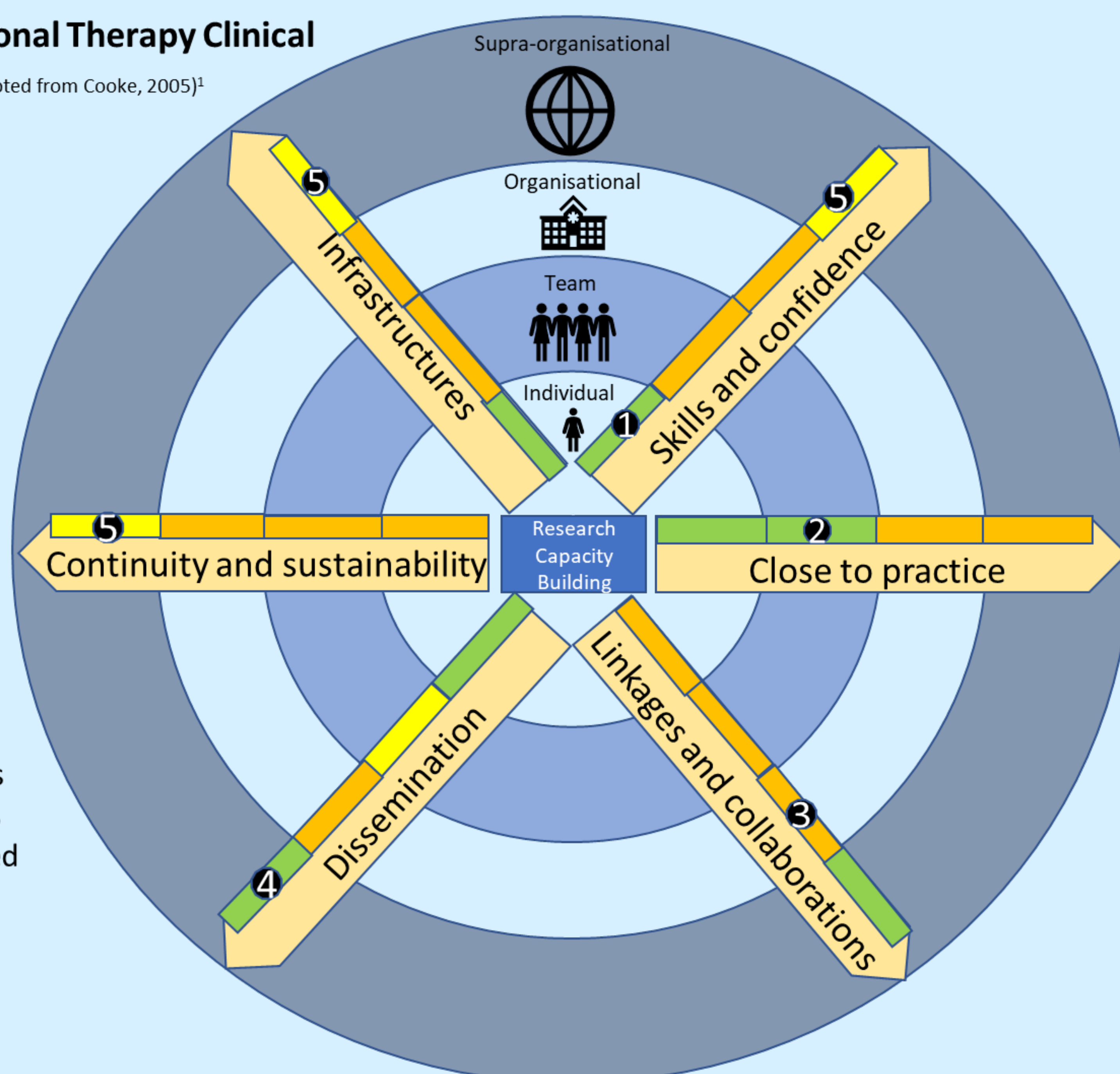
Introduction

Clinician researcher (CR) roles are considered to be an effective strategy for research capacity building (RCB). This poster describes how a CR role was designed and evaluated using an explicit RCB framework.

Figure 1

Evaluation of Occupational Therapy Clinical Researcher Position (adapted from Cooke, 2005)¹

Progress is represented across 4 organisational levels (concentric circles), and six principles ('arms') for effective research capacity building.



Key:
 Strong outcomes
 Modest outcomes
 Limited outcomes
 1 Examples are described adjacent.

Examples of outcomes

- 1** The CR obtained **skills and confidence** in: basic project management, writing research plans, finding funding opportunities, 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** eg 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 by 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.

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 tasks, 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.

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.

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