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Article

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 recognize 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. 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. A quantitative, descriptive-exploratory, and cross-sectional study was developed combining descriptive and inferential analyses to identify facilitating and hindering factors of Organisational Culture dimensions. 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 Leadership (34.45). The overall score settled at 62.72, normalised on a 0 to 100 scale. A new variable was computed due to the significant percentage of Specialist Nurses who weren't integrated into the profession's career, and "Professional Recognition" emerged as determinative for Organisational Readiness, with formally recognized Nurse Specialists reporting statistically different perceptions across multiple dimensions of the Organisational Culture. The results revealed that the organisation presents a good foundation for implementing innovation, but hasn't reached optimal readiness.

Keywords: evidence-based practice; knowledge management; knowledge translation; organisational readiness for change; organisational readiness for knowledge translation

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, it is essential for healthcare professionals to be integrated in organisations that prioritize 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 emphasizes excellence in nursing care while retaining a higher number of professionals, thereby reducing institutional turnover rates [3,4]. 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 specialized training, supporting career advancement, and enabling the acquisition of new expertise [4–6]. Thus, the ability

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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.

This process involves converting scientific evidence into effective clinical interventions with the aim of integrating them into daily clinical practice, ultimately enhancing health outcomes and benefits for the patients receiving these services [7,8]. In this context, for organisations to ensure the effectiveness of this process, it is crucial to conduct an assessment that determines their organisational readiness for implementing these changes. 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 with 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 instru-ment designed to assess the Organizational Readiness for Knowledge Translation level within healthcare settings. The result was a 59-item questionnaire organized into 6 dis-tinct dimensions capable of assessing healthcare organizations' capability to implement evidence-informed change. These dimensions are the determinants of Organizational Culture, and their assessment provides managers and other stakeholders 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. From an academic perspective, 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.

2. Materials and Methods

A descriptive and cross-sectional study design has been adopted to analyse and identify the organisational dimensions that either facilitate or challenge the translation of evidence into clinical practice. In this 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 minimizing 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 1), totaling 59 items. Each respondent should rank the items recurring to a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The completion of the instrument allowed to assess the primary variable of interest, the "Organisational Readiness for Knowledge Translation".

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Table 1. OR4KT tool: Dimensions and Subdimensions.

	OR4KT					
Dimensions	**Climate**	**Context**	**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

The attribute variables, correspond to the participants' sociodemographic and professional characteristics, which were also operationalized to facilitate statistical data analysis. Regarding the sociodemographic variables, the following have been identified: gender, age, and academic qualifications. As for professional qualifications, it was acknowledge: 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 (α = 0.702), Organisational Contextual Factors (α = 0.837), Content of Change (α = 0.869), Leadership (α= 0.897), Organisational Support (α = 0.954), and Motivation (α= 0.797). Overall, the instrument demonstrated excellent internal consistency, with a global Cronbach's alpha value of 0.960, 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 normalization. The analysis yielded a Kaiser-Meyer-Olkin (KMO) index value of 0.869, 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.

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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, the majority of respondents were female, representing 87.7% 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 30.4% 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 81.2% of the total number of participants. Then, approximately 17.4% 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 80.4% 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 Table 2 presents the OR4KT dimension scores, reflecting nurses' perceptions within the institution.

When assessing the *Organisational climate for change* dimension, nurses of the institution have rated all subdimensions positively, agreeing with the majority 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 as achieved a mean score of 36.246, 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 34.449.

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, 57.2% of respondents perceived "External stakeholders are involved in the planning process" as neutral, while 43.5% 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 39.1% 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.

Lastly, the *Motivation* dimension perceptions uncovered 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

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pressures to make changes", however felt neutral in the 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 206.15 and a standard deviation of 29.07, indicating a moderate dispersion in overall readiness perceptions among participants.

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 [9], 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 [9] 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.

Table 2. OR4KT Dimensions Mean and Standard Deviation.

OR4KT Instrument	Mean	SD
Organisational climate for change	36.246	4.792
Organisational contextual factors	34.449	5.495
Change content	33.130	4.872
Leadership	34.420	6.593
Organisational support	35.848	7.300
Motivation	32.949	5.381
Total	207.044	28.285

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

Through the use of inferential analysis, it was determined whether the sociodemographic and professional characteristics of the participants influenced their perception on 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 the Table 3.

Table 3. Associations Between Professional Characteristics and OR4KT Dimensions.

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

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Total	0.604	0.028	0.018	0.147	0.391

A statistically significant effect of professional title was identified in the dimension "Organisational Climate for Change" (p = 0.008). Then, the Professional Category significantly influenced multiple dimensions of the OR4KT, namely the "Organisational Climate for Change" (p < 0.001), the "Organisational Contextual Factors" (p = 0.017), and the "Leadership" (p = 0.012), as well as the overall OR4KT score (p = 0.028). The variable "Management Roles" also demonstrated significant associations with several dimensions, including "Change Content" (p = 0.020), "Leadership" (p = 0.033), "Organisational Support" (p = 0.038), and "Motivation" (p = 0.013), and with the total OR4KT score (p = 0.018). Regarding "Care Context", a statistically significant difference was observed only in the "Organisational Climate for Change" dimension (p = 0.012). Among the three variables examined linked to professional experience, "Years of Professional Experience", "Years in the Institution", and "Years in the Current Context", only "Professional Years" revealed a significant association, within the "Change Content" dimension (p = 0.038).

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

During the characterization 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 recognized as such within their professional career category. In light of this 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 implement change, it was deemed relevant to examine its effects more closely. To conduct the subsequent analysis, a new variable was computed to reflect this discrepancy. Therefore, the newly computed variable was classified as ordinal, with the following categories: Nurse Specialists who are not integrated into the corresponding professional category; Nurse Specialists or Nurse Managers who are formally integrated into the appropriate professional category. This classification was selected on the basis that Nurse Managers need to be recognized as Nurse Specialists by the Portuguese Nursing Order, and be professionally integrated in the career, of at least the position of Specialist Nurses. A Mann-Whitney U test was conducted to assess whether professional recognition through integration into the specialist career influences the distribution of OR4KT dimensions, Table 4. The results revealed statistically significant differences in three dimensions: Organisational climate for change, p < 0.001, Organisational contextual factors with p = 0.009 and Leadership with p = 0.005. Cumulatively, also the whole instrument has shown statistical differences, with p = 0.014 for the OR4KT total score.

Table 4. Influence of Professional Recognition on 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 strength in which 78.3% of respondents agreed that staff work as a team, and 74% confirmed mutual support; however, high levels of stress were reported with 63.8% of respondents acknowledging frequent frustration, and 75.3% affirming that the heavy workload reduced intervention

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effectiveness. These constraints align with the literature describing heavy workloads and burnout as barriers to Knowledge Translation (KT) [10,11].

Trust and openness showed mixed perceptions, while 47.1% agreed that mutual trust was strong, still 33.3% remained neutral. Similarly, only 34.8% felt free to ask questions, while another 30.4% remained neutral. Regarding managerial openness, 34.1% felt their ideas were considered by their leaders, but 28.3% disagreed. However, even though 52.9% agreed that managers encourage innovation, the neutrality registered on other items suggests that this support may be more symbolic rather than systematic.

These findings highlight the importance of leadership and communication, as literature emphasizes that effective KT requires transparent communication and participative decision-making [12–14]. The hospital presents a solid peer foundation, but stress, operational overload, and limited managerial inclusiveness constrain its full transformative potential. Consolidating active listening, transparent communication, and professional participation in decision-making are instrumental to sustaining readiness for change over time [4,15].

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

Role definition appeared ambiguous, with only 41.3% of respondents agreeing that responsibilities for change are clearly defined, while 50.7% remained neutral, indicating weak accountability structures [16,17]. Financial support was one of the most critical weaknesses, for only 15.2% perceived adequate budget allocation, whereas 44.9% disagreed and nearly 40% had a neutral stance, reinforcing the importance of financial capacity as a barrier to change [18]. Training support showed similar gaps, as only 36.9% felt it was adequate, 26.8% disagreed, and 36.2% were neutral, suggesting unequal access to continuous education, despite its recognized importance for KT [19,20]. Facilities and equipment were also insufficient, with 28.9% agreeing they had the necessary tools, while 47.8% were neutral and 23.1% disagreed, echoing the importance of the JBI FAME model's emphasis on practical feasibility [21]. Staffing was another limitation, with only 29.7% perceiving adequate resources, 41.3% felt neutral, and 29% disagreeing with the statement, consistent with documented concerns about HR shortages [12,22].

However, a strong professional culture emerged, with 76.8% of the personnel feeling personally responsible for improving patient care, and 83.4% reporting cooperation to maintain care quality. Innovation willingness was also high, with 76.1% of participants revealing to be open to new procedures and 72.5% receptive to clinical changes, aligning with the readiness dimensions [11].

Nonetheless, leadership participation in clinical decisions remained limited, with 45.6% of respondents feeling that managers sought their opinions, 36.2% were neutral, and 18.1% disagreed, reflecting a distant, non-participatory leadership style, which should be replaced by a more transformative approach to better align "bedside" staff with the institutional strategy [13,14].

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 62.3% agreeing or strongly agreeing, consistent with the notion of change commitment [16]. Similarly, 63.0% perceived an ability to exchange ideas and influence patient care decisions, aligning with the KTA model on feedback and adaptation [8]. Flexibility to deal with change was affirmed by 56.5% of participants, resonating with literature on adaptability as an implementation enabler [12].

Then, the ability to adjust routines was endorsed by 60.9% of nurses, reflecting the concept of "sensemaking" [23] which emphasizes how professionals continuously interpret and respond to an evolving demand, and need to develop an openness to routine modification. Likewise, 65.9% of participants agreed on 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 [11].

Patient-related items showed moderately positive but less decisive results. Even though, acceptance of changes was endorsed by 57.3%, neutrality remained high, with 36.2% of respondents

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feeling neutral, suggesting the presence of differences in feedback communication [24]. Patient needs and preferences were recognized by 57.2% of professionals, consistent with the JBI Model assumption that the patient needs and beliefs are a fundamental pillar in designing respectful, meaningful, effective, and patient-centred care interventions [21,25], yet neutrality persisted, with 34.1% neutral responses. Similarly, 57.2% 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 [21,25].

The strongest endorsement of the present dimension concerned science-based changes, as 74.6% affirmed that changes were based on current knowledge, with only 1.4% of individuals disagreeing, highlighting 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 readiness [16]. The high adaptability scores suggest that changes are integrated rather than disruptive, reinforcing that compatibility with routines and a clear rationale boost confidence [10,18]. Sustaining such alignment requires continuous monitoring and adaptation [26].

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

According to the questionnaire results, accountability was strongly affirmed, with 75.4% of respondents perceiving that managers hold staff accountable, a practice consistent with Weiner's concept of change efficacy [16]. Likewise, 66.7% recognized leadership involvement and presence in continuous improvement of care, resonating with Kaplan's findings [10], while 60.9% acknowledged feedback provision, promoting factors of KT [8,19]. Managerial presence was also highly reported, with 80.5% of participants feeling their engagement, and clinician involvement was also positively rated with 67.4% of participants having some agreement level regarding this item. Conversely, participation of administrative staff was limited , with only 29.7% of nurses agreeing with the item, despite evidence that inclusive engagement strengthens change implementation [12]. Decision-making was perceived as "top-down," reaching only 30.1% of agreement on staff inclusion, contrasting with recommendations for participatory governance [13,27,28]. External stakeholder involvement was also scarce, being only perceived by 25.3% of respondents

Overall, leadership was perceived as a facilitator of change, but greater inclusiveness and transformational approaches are needed to inspire, empower, and ensure psychological safety [26].

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 68.1% of respondents agreed that colleagues provide practical support for new ideas, consistent with collective efficacy and social facilitation for organisational readiness [16]. Cooperation in developing and applying ideas was also positively perceived, with 60.9% of agreement, reinforcing teamwork as a known enabler of knowledge translation [29]. However, assistance in developing new ideas, with 47.8% of agreement, and resource sharing with 57.9% were less consistent, with high neutrality, generating concerns about reliance on informal rather than institutionalized processes, a liability documented in the literature [18].

Monitoring and evaluation mechanisms were acknowledged, with 55% of respondents affirming that progress is continuously measured and 57.3% confirming that outcomes are regularly assessed, reflecting an institutional alignment on the importance of transparent monitoring for sustaining improvement [8,10,19]. Yet, neutrality remained high, suggesting a possible weak visibility of the existing systems. Then, the dissemination of performance measures was endorsed by 57.3% of respondents, though communication appeared inconsistent, a gap highlighted in the research field [11,17]. Leadership review of results, had a good perception provided by 61.6% of participants, reinforcing the institutional commitment and accountability [14]. Nonetheless, only 50.7% agreed

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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 KT [30].

Overall, organisational support emerges as a relative strength of the institution, with evidence of available resources, teamwork, and monitoring mechanisms. However, neutrality across several items revealed opportunities to improve accessibility, formalization, and communication of existing tools, ensuring that assistance, feedback, and dissemination practices are consistently integrated across all departments.

The *Motivation* dimension evaluates the extent to which internal and external factors, such as institutional pressure, leadership behavior, 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 35.5% of participants agreeing with this item. Yet, 39.9% remained neutral and 24.6% actively disagreed. This limited patient-driven pressure aligns with the notion that although patient engagement is central to person-centered care, its influence on organisational innovation is often indirect or overlooked [24]. In contrast, the item "Pressures to make changes come from staff members" received a higher confirmation, has 60.9% of nurses consent with the item, and only 5.0% disagree. In turn, this reflects a strong staff motivation, which reinforces the perceived relevance and urgency of change efforts [8,21]. Similarly, "Senior leaders make pressures to make changes" was endorsed by 59.4% of participants, although 10.1% disagreed.

Regarding governance, "Pressures to make changes come from board members or overseers" received only 4.8% of agreement, with 17.4% of disagreement and 39.9% of neutrality. These results show a weaker connection between governance bodies and operational teams, underscoring the importance of governance engagement in aligning strategic vision with operational implementation [16,31]. Similarly, external drivers were perceived as limited, once only 28.0% of respondents agreed that funding organisations create pressure for change, while 24.6% disagreed and 46.4% remained neutral. This might suggest that funders are a potentially underused driver, despite resource-based incentives being shown to encourage adoption of change, particularly in under-resourced contexts [18].

Institutional learning also appeared underdeveloped, since the item "There is implementation change experience gained from projects or pilot programs and their evaluation" was positively rated by 34.0% of respondents, while 21.0% disagreed and 44.9% were neutral. Therefore, suggesting a limited consolidation of institutional learning, despite evidence that experience is a powerful enabler of KT readiness and that failure to consolidate lessons may lead to repeated errors [12]. Similarly, only 45.0% of nurses agreed that managers are knowledgeable about innovation based on past experience, while 14.5% disagreed and 43.5% remained neutral, 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 [19].

Benchmarking practices were also perceived as weak. Thus, only 31.1% of respondents agreed that knowledge is available about how similar innovations are used by other organisations, while 20.2% disagreed and 48.6% remained neutral, suggesting limited external comparison and, consequently, reduced ability to adapt concept-proven strategies. Leadership behavior showed mixed results, for 44.9% agreed that senior managers promote change by behaving consistently with it, but 25.0% disagreed and 30.4% were neutral. This reflects partial role modelling, a critical factor for translating strategy into organisational culture [14]. Finally, "Senior managers define the course of change" was more positively rated, with 52.9% of agreement, though 36.2% remained neutral and 13.8% disagreed, 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 [4], factors partially identified in this study but still requiring

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reinforcement. Likewise, motivation in healthcare is shaped by organisational climate, leadership trust, and personal investment in institutional goals [10,26]. 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 institutionalize 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.

4.2. Influence of Respondents Characteristics over 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. Which suggests that perceptions of organisational culture and readiness for change 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 [31]. 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 positioning within the institutional hierarchy.

The Professional Category, which differentiates nurses as nurses, specialist nurses, and nurse managers, emerged statistically significant associations, observing them in the Organisational Climate for Change ($p < 0.001$), Organisational Contextual Factors ($p = 0.038$), and Leadership ($p = 0.012$), as well as in the overall OR4KT score ($p = 0.041$). These results align with the literature, which highlights that individuals in leadership or formally recognized 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 [3,16,26,32].

Similarly, Management Roles, categorized in formal, informal or none, were also significantly associated with more positive perceptions across multiple dimensions, including Change Content ($p=0.020$), Leadership ($p=0.033$), Organisational Support ($p=0.038$), and Motivation ($p=0.013$), as well as with the total OR4KT score ($p= 0.018$). The relationship between leadership engagement and positive readiness for change is documented [12], 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 ($p = 0.011$), suggesting that the nature of daily clinical activities may condition how professionals perceive teamwork, communication, and trust [11].

Interestingly, years of professional experience were not significantly associated with any of the OR4KT dimensions, except for Change Content ($p = 0.044$), 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.

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4.3. Recognition and Compensation of Speacialists: 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, 94.1% of the specialist nurses included in the sample had not been formally recognized or compensated in accordance with their title, exposing a discrepancy between professional credentialing and institutional career integration.

In light of 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 institution's readiness to implement evidence-based change, 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 the career recognition.

From an organisational standpoint, this 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, are essential to foster a culture of engagement and trust [4,15].

When professionals perceive a lack of acknowledgment for their advanced skills, it may lead to demotivation and a passive attitude toward change implementation [15,32].

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, as revealed by the Mann-Whitney U test, where the mean rank for integrated professionals was 106.75, compared to 66.11 for those not formally recognized, 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 [11]. When skilled professionals do not feel valued or integrated into the institution, the risk of disengagement and resistance to change increases [33].

Moreover, when analyzing the Organisational Contextual Factors these were also perceived more negatively by non-recognized 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 [34].

However, no significant differences were observed in the Motivation or Change Content dimensions. This may indicate that even though specialists are non-recognized 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

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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.

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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)

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