Evidence-Based Knowledge Translation: Why Traditional Mandatory Training Fails (and What Actually Works)

Are you still sitting staff through hours of mandatory training and not seeing any results? **You're** not alone and the evidence is very clear on why this isn't working and what to do instead.

The problem: Time in seats does not result in behaviour change

Most organisations still equate "training completed" with "risk managed". Staff are booked into annual mandatory sessions, they sign the attendance sheet, complete an online quiz, and then go back to doing exactly what they did before. Sound familiar?

Systematic reviews of training for health professionals show that traditional, didactic education alone tends to produce only small improvements in practice, often around 6% compliance change at best, and these gains are hard to sustain. Staff leave the training and may *"feel"* informed, but day-to-day behaviour and outcomes hardly shift.

What the evidence says works

Across multiple reviews of behaviour change and knowledge translation interventions in healthcare, some common features consistently show better results.

The evidence points to:

- Active learning, not passive listening
  Analysis of teaching methods show that when learners participate (discussion, problem-solving, application tasks), learning outcomes improve compared with traditional lectures. Even in workplace settings, shifting from "presentation mode" to active engagement can increase learning outcomes by more than 50% compared with passive formats.

- Short, focused, skills-based sessions
  A short 2-hour, theoretically informed workshop have been shown to lead to significant increases in knowledge, perceived control, and intention to use behaviour change techniques, without needing full-day training blocks.

- Blend of education plus practice

  Training programs that combine educational content with practical application, role-play, rehearsal, real-world practice and monitoring, are more likely to improve both delivery quality for participants and real practice behaviour changes than education alone.

- Action and monitoring, not just information

  Interventions with action and monitoring components, such as audit and feedback, reminders, and educational coaching are more successful than information-only approaches. These strategies support staff to embed changes in everyday work, not just understand them in theory.

- Tailored feedback using real data

  Audit and feedback, where clinicians receive regular, structured data on their own practice, has repeatedly been linked with behaviour change. An audit-with-feedback intervention can result in an 80% increase in improved staff practice, demonstrating how targeted data can shift behaviour and safety culture.

What does this mean for your mandatory training program?

If your current approach is “everyone sits through the same annual slide deck”, the evidence suggests you are investing in time, not outcomes. To translate knowledge into safer, higher-quality care, mandatory training needs to look and feel different.

Evidence-aligned knowledge translation training will:

- Start with the real gaps in practice, using your own incident, audit, and quality indicator data to focus the learning.
- Use short, focused modules that mix core evidence with practical application, rehearsal, and practice reflection, not just PowerPoint and a quiz.
- Build in behaviour change techniques such as goal setting, prompts, peer discussion, and commitment statements, which have been shown to influence clinicians’ intentions and norms.
- Include ongoing audit and feedback cycles so staff can see their progress and adjust behaviour over time, rather than waiting for the next quarterly report.
- Provide facilitation and coaching support, where a skilled facilitator helps teams apply evidence to their local context and workflows.

A practical model you can implement

An evidence-based knowledge translation program for mandatory topics such as, falls, medication safety, infection prevention, and documentation might look like this:

1. Define the practice problem using your data
   Use existing audits, incidents and quality indicators to identify where practice is inconsistent or outcomes are off track. Translate that into 1–3 specific behaviours you need staff to change, rather than a long list of "things to remember".

2. Replace long day training sessions with short, active modules
   Design 60–120-minute sessions that combine: a summary of the best-practice evidence; interactive case discussions using your real scenarios; and practice of the desired behaviors.

3. Embed audit, feedback, and reminders
   Build a simple chart or graph so teams can see how their practice is changing over time, and provide brief, regular feedback to staff at huddles or team meetings. Reinforce key behaviours with prompts, checklists or electronic reminders in the workflow, not just at training.

4. Support local problem-solving
   Use a facilitator or local champion model to help teams remove barriers, adapt tools, and test small changes in their own settings. This kind of "educational outreach" has been associated with more successful behaviour change than generic training alone.

If your organisation is still equating "hours of training completed" with "quality and safety assured", it is time to rethink the model. The evidence is clear: shorter, active, data-driven, and feedback-rich approaches are more likely to change behaviour and improve outcomes than traditional mandatory sessions. I work with services to design evidence-based knowledge translation programs that align training with real practice change, using your data, your risks and your context. If you want your training to genuinely shift indicators rather than simply meet compliance, let's connect and explore what this could look like for your organisation.