QH-TRIP | Translating Research Into Practice

Implementation Foundations

An Introduction to Implementation
Participant Handbook

DELIVERING FOR QUEENSLAND
Queensland Government

Implementation Foundations Learning Module: Participant Handbook

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For more information contact:

Office of the Chief Allied Health Officer (OCAHO), Health Workforce Division, Queensland Health, GPO Box 48, Brisbane QLD 4001, email allied_health_advisory@health.qld.gov.au, phone (07) 3328 9928.

Disclaimer

Contents

Prelude

Welcome to the Implementation Foundations workshop.

This workshop is designed to introduce you to the purpose and practice of implementation, and to provide a clear overview of the key stages involved in turning evidence into everyday practice.

Many people are curious about implementation and wonder how to plan for change in our complex health systems. This workshop offers a structured way of thinking about implementation. It will help you make sense of the process, the people involved, and the decisions that shape success over time.

You will be introduced to the sequence and stages of the QH-TRIP implementation process and the reasons why careful planning, attention to context, and engagement with people matter. The focus is on understanding the whole journey, rather than mastering specific theories or tools. You will see how others develop and plan for implementation in a published case study.

You are not expected to identify your own clinical problem. Instead, this workshop provides shared language and a clear mental model that you can carry forward into future learning and practice. You will be encouraged to reflect on some of your own clinical challenges.

For many participants, this workshop is the first step in a longer learning pathway. Those who wish to deepen their understanding will go on to the Implementation Masterclass, where each stage of the process is explored in more detail using a worked case study, practical strategies, and reflective activities.

Our aim is that you leave this workshop feeling oriented, reassured, and better equipped to recognise where you are in the implementation journey, and what your next step might be.

Helpful links and resources

Implementation	
Familiarise yourself with implementation	Implementation science: What is it and why should I care? (Bauer & Kirchner, 2020). An introduction to implementation science for the non-specialist. (Bauer et al., 2015). Implementation science: A critical but undervalued part of the healthcare innovation ecosystem. (Chan et al., 2022).
An interesting paper about language	Concept analysis of health research translation nomenclature. Lizarondo et al., 2025).
Listen to a podcast conversation	An implementation scientist and clinical nurse specialist compare their journeys into using implementation (hosted by the Swiss Learning Health System) https://youtu.be/sXS6iYIeGZw?si=Irbn9awc5uCZkjnt
Read about practice examples of implementation	What Can Implementation Science Do for You? Key Success Stories from the Field. (Kilbourne, Glasgow, & Chambers, 2020).
The Knowledge to Action (KTA) framework	
The KTA framework – the seminal article	Lost in knowledge translation: Time for a map? (Graham et al., 2006).
A recent summary article	Creating system-wide change in medicine: The role of implementation science in achieving scale and adoption. (Barry & Davies, 2025).
Clinical practice guidelines	
What are clinical practice guidelines?	What are clinical practice guidelines? (Queen Margaret University, Edinburgh)
A useful summary of clinical guidelines	Developing and Implementing Clinical Guidelines (Agency for Clinical Innovation NSW Health)
The case study	
Read the case study	Implementing early feeding after liver transplant using implementation frameworks: A multimethod study. (Takefala et al., 2025).
Explanations of Enhanced Recovery after Surgery (ERAS)	
Explanations of Enhanced Recovery after Surgery (ERAS) evidence and practice	Enhanced Recovery After Surgery. (Parks, Routt, & De Villiers, 2018). Revolutionizing surgical care: The power of Enhanced Recovery After Surgery (ERAS). (Mithany et al., 2023).

Guideline Summary	Early oral feeding after colorectal surgery: A mixed methods study of knowledge translation. (Robertson et al., 2018).
Review the ERAS guidelines	Guidelines for perioperative care for liver transplantation: Enhanced Recovery After Surgery (ERAS) recommendations. (Brustia et al., 2022).
COM-B	
Familiarise yourself with the COM-B model	Why Are There Different Versions of the COM-B Model Diagram? - Article (v1). West & Michie, 2023). Susan Michie on Behavioral Change. (Social Science Bites, 2020). The COM-B Website The COM-B Model for Behavior Change (The Decision Lab).
The Theoretical Domains Framework (TDF)	
The TDF – the seminal article	A guide to using the Theoretical Domains Framework of behaviour change to investigate implementation problems. (Atkins et al., 2017).
Revisit and understand the TDF	What is the Theoretical Domains Framework (TDF)? (Moore, 2025).
Organisational Context	
Mapping barriers and enablers to behaviour change	Organizational contextual features that influence the implementation of evidence-based practices across healthcare settings: a systematic integrative review. (Li et al., 2018).
Sustainability	
The five components of sustainability – the seminal paper	Developing a comprehensive definition of sustainability. (Moore et al., 2017).

Presentation slides

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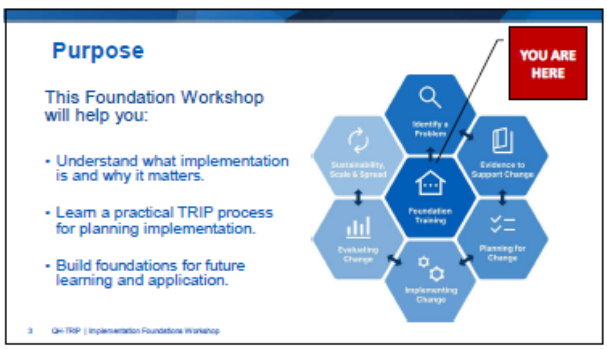 3	

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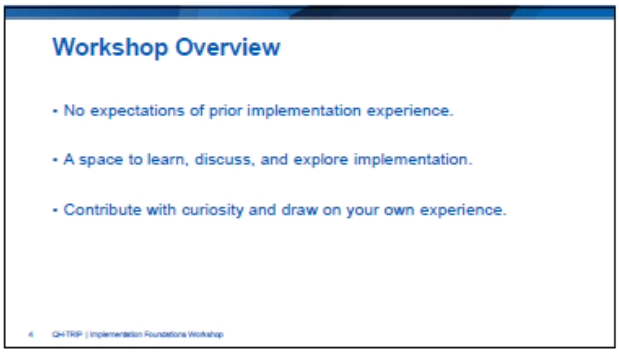
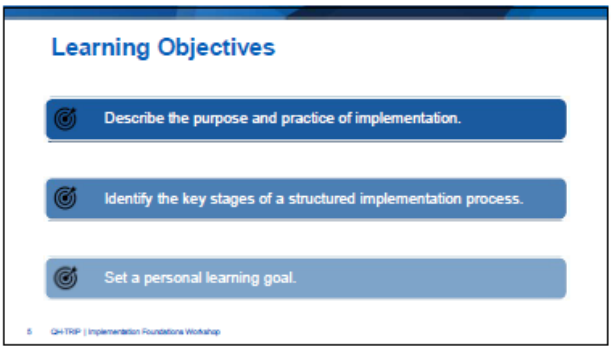
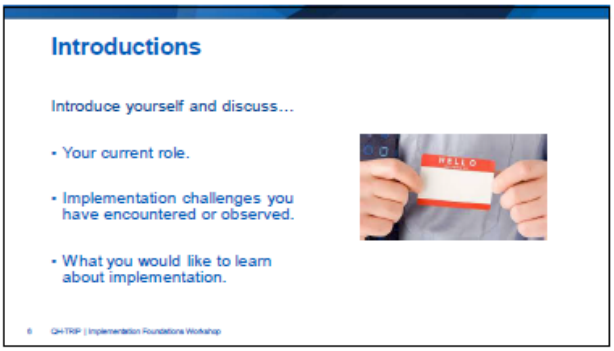
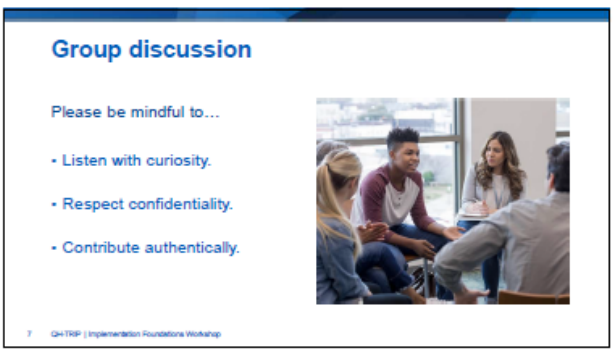
 4	
 5 Reflection – My Personal Learning Goal	
 6	
 7	

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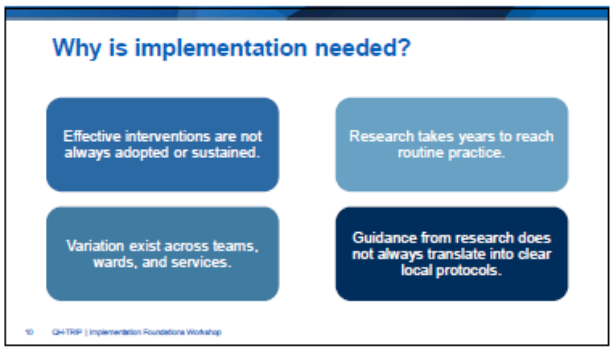
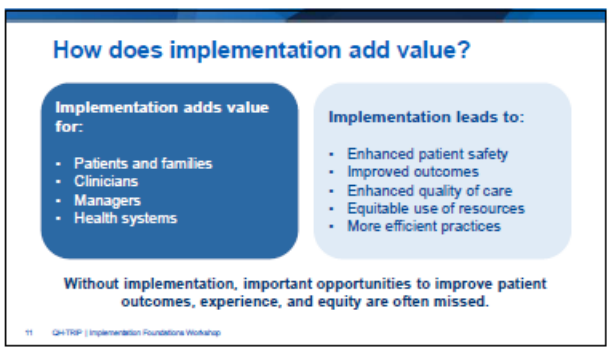
 10	
 11	

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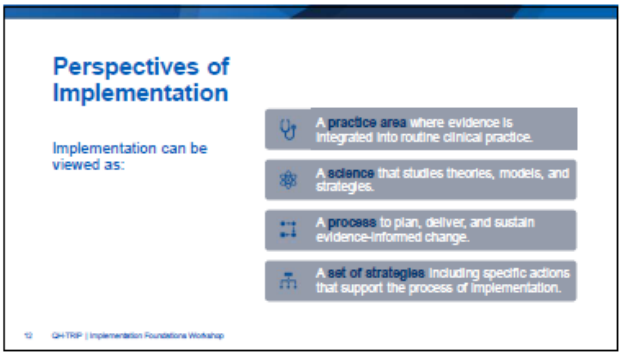
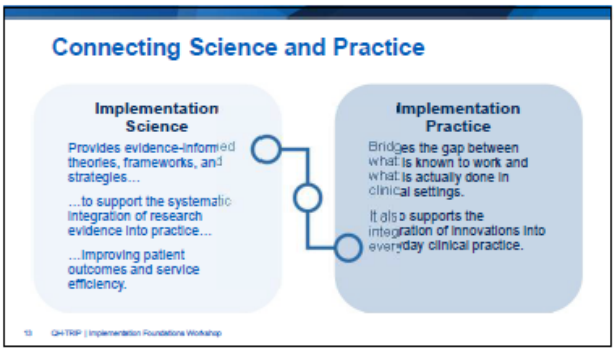
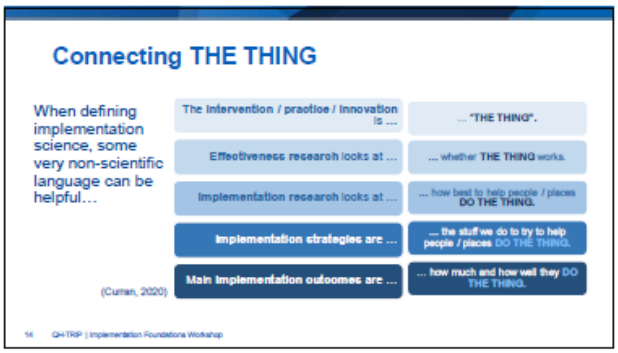
 12	
 13	
 14	
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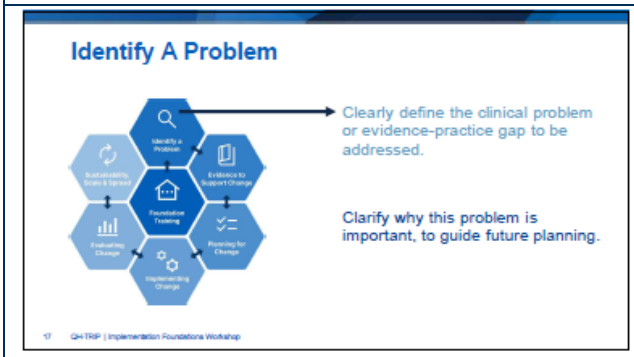 17	
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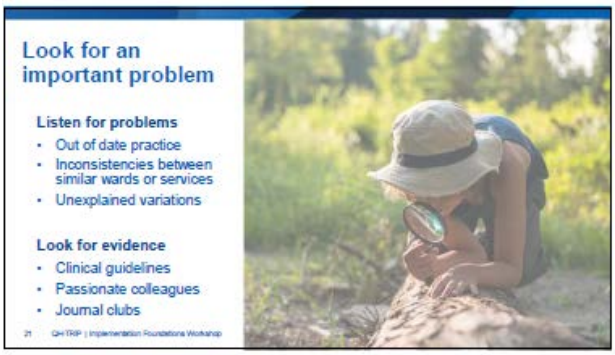 21	
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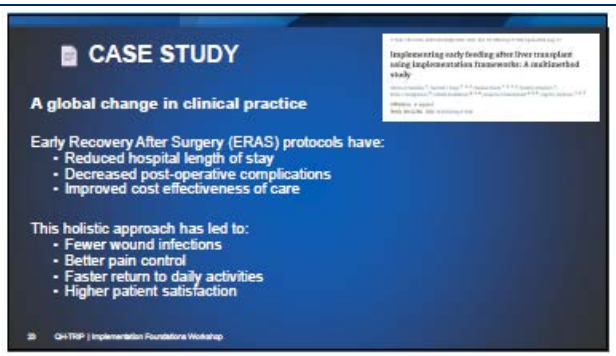 23	

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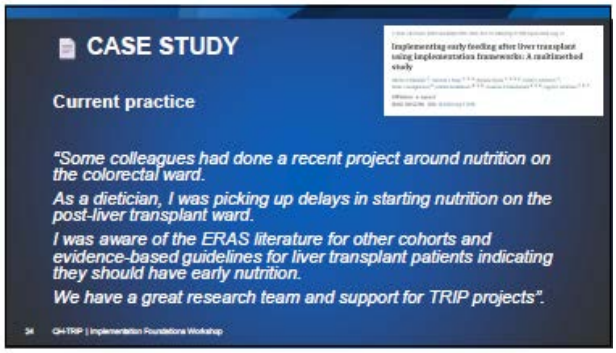
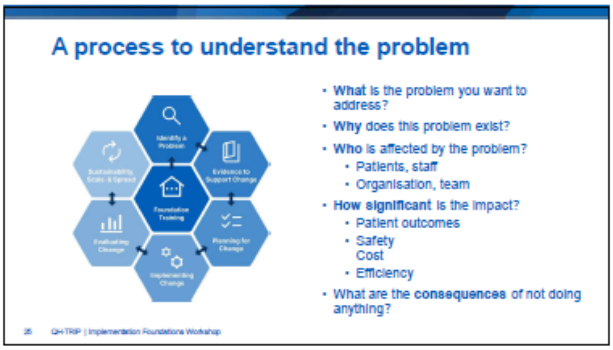
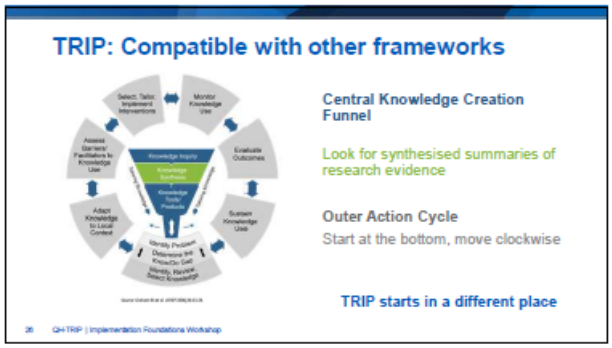
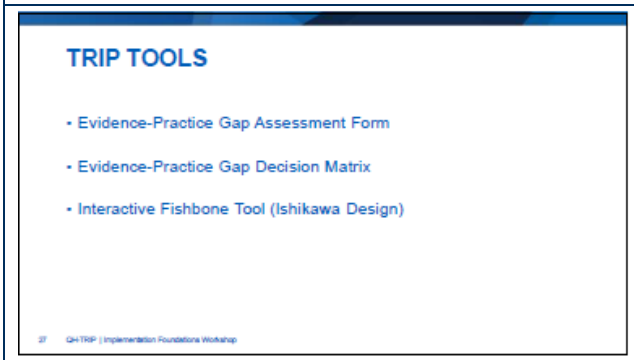
 24	
 25	
 26	
 27	

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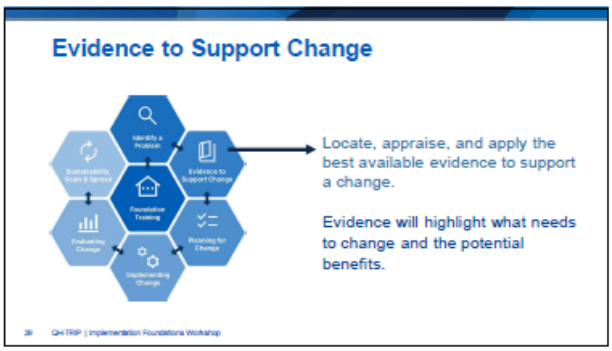 29	
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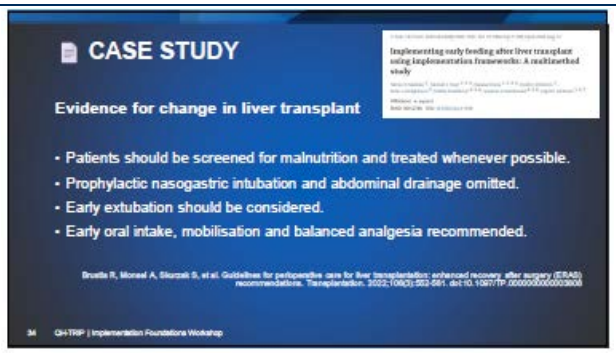
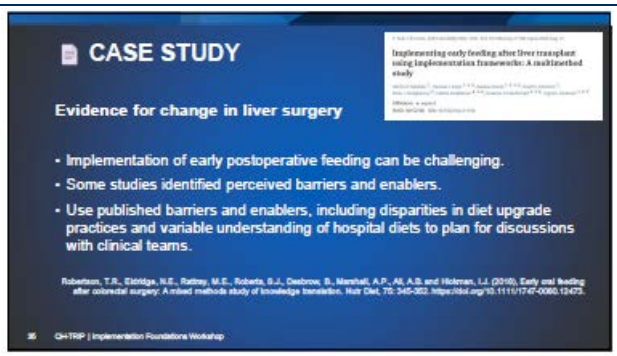
 34 Journal: https://doi.org/10.1002/ncp.11198	
 35	

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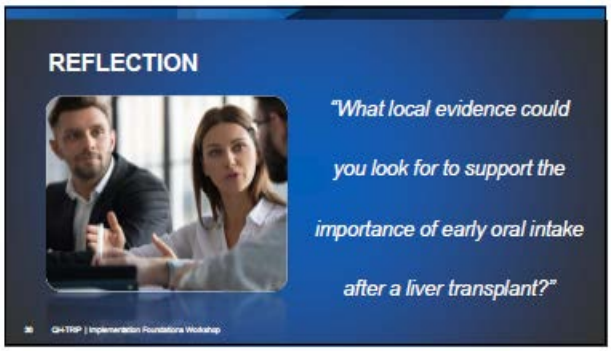
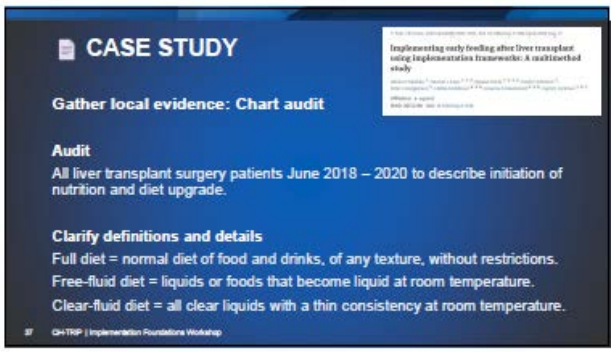
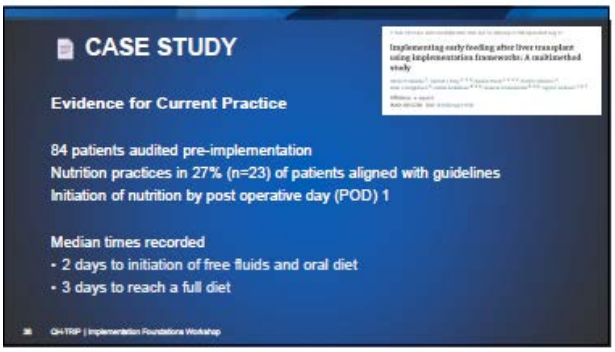
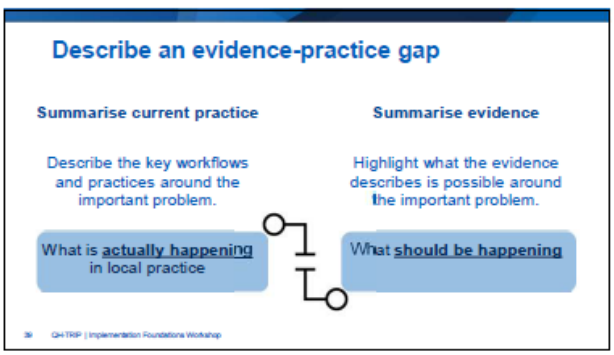
 36 Case study: Describe the evidence-practice gap	
 37	
 38	
 39	

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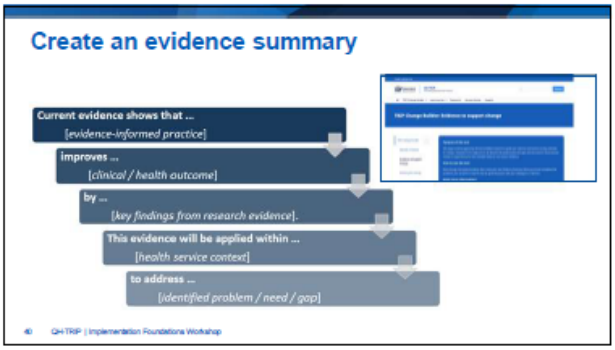
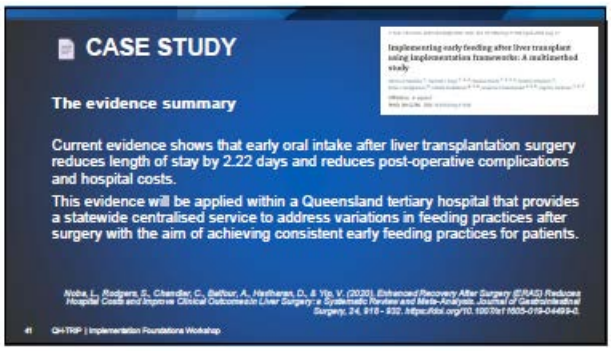
 40	
 41	
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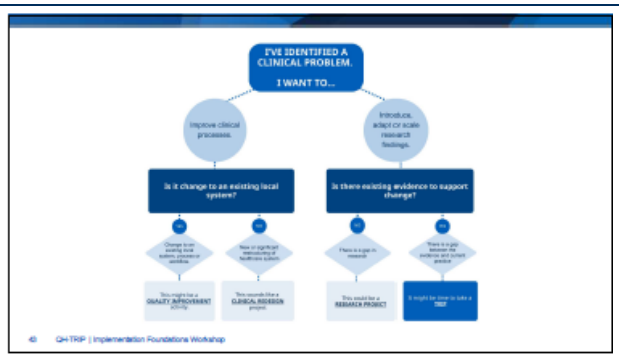 43	

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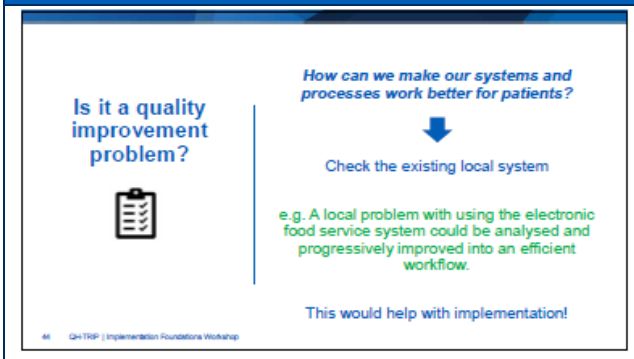
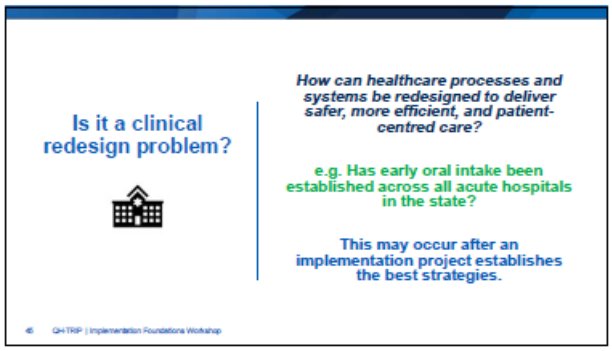
 44	
 45	
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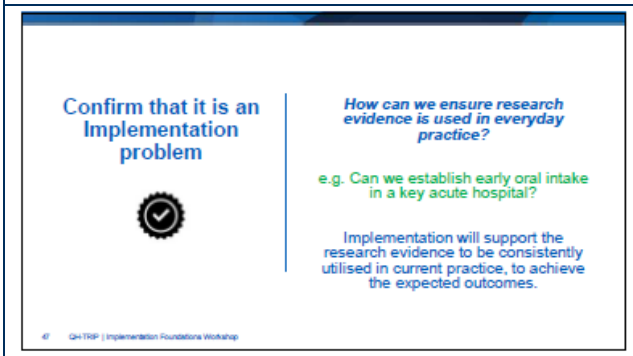 47	

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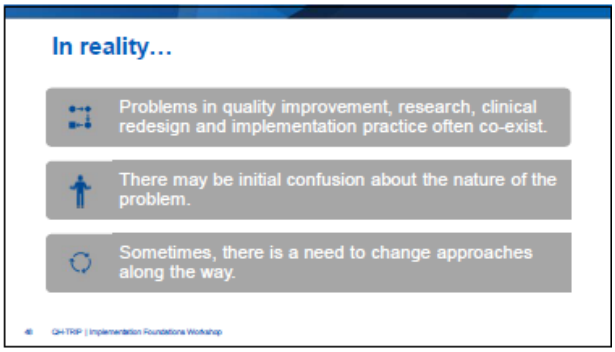 48	
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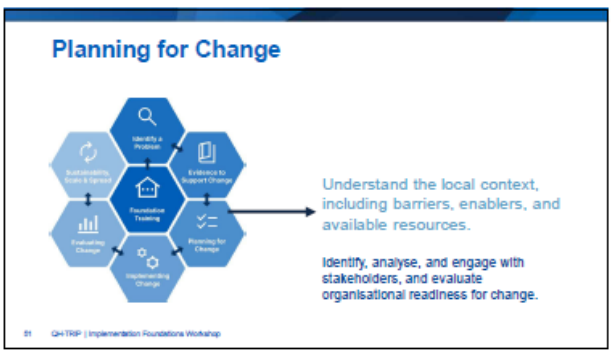 51	

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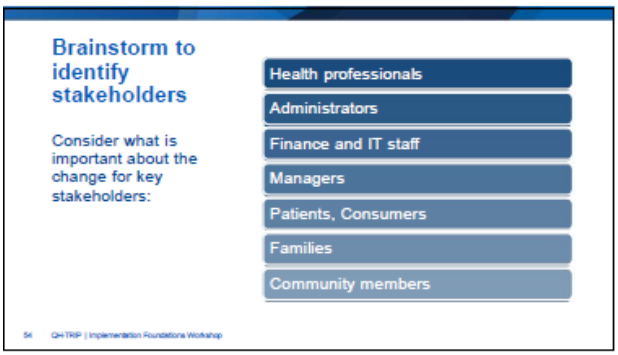
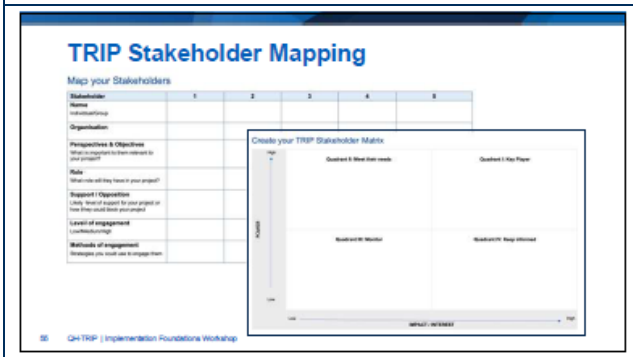
 54	
 55	

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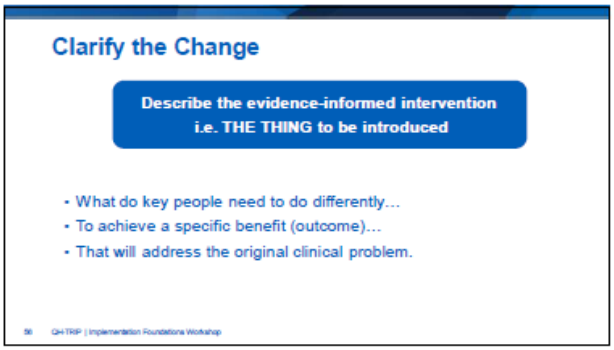
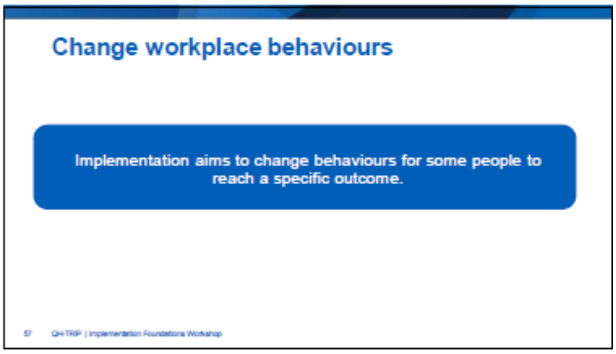
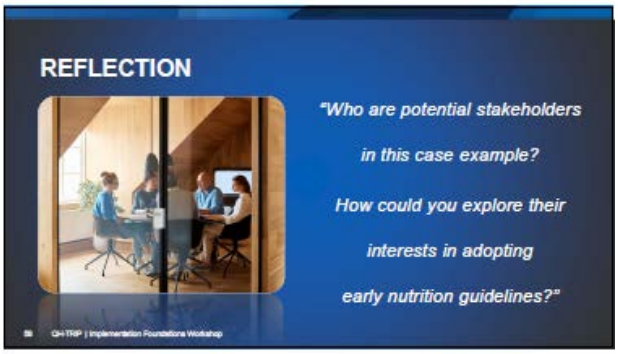
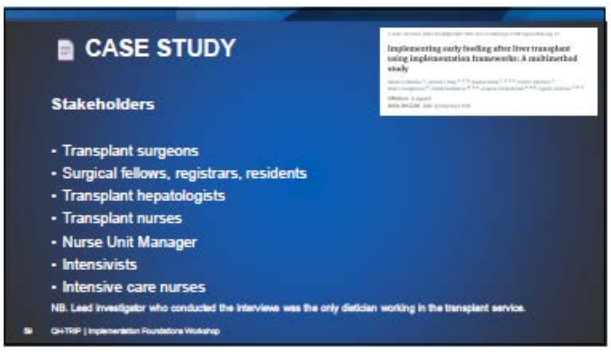
 56	
 57	
 58	
 59	

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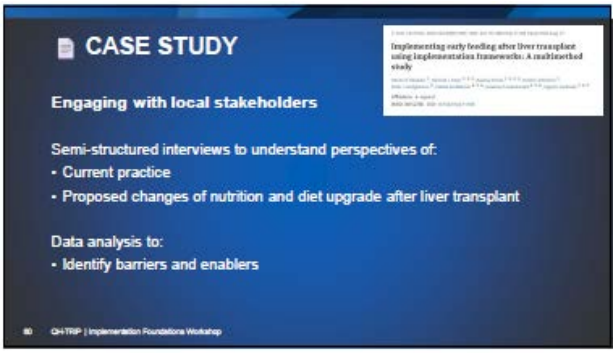
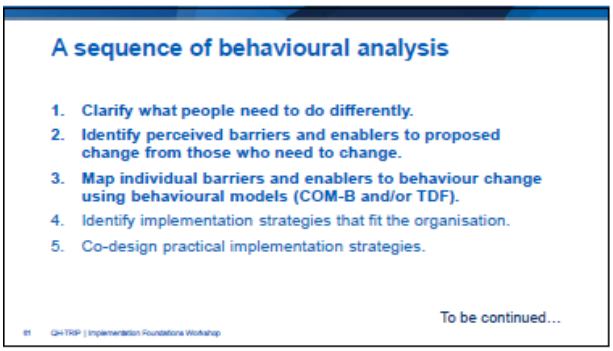
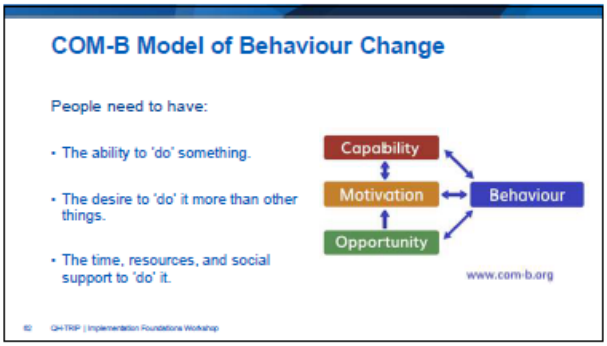
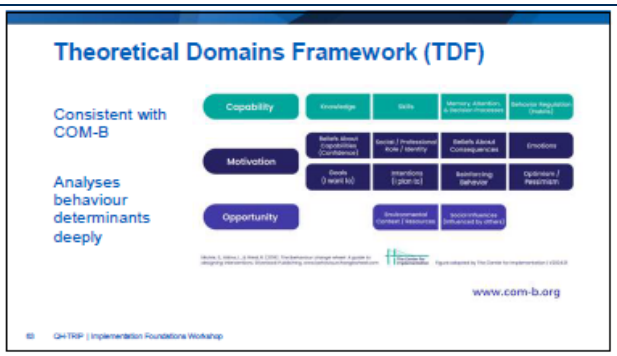
 60	
 61	
 62	
 63	

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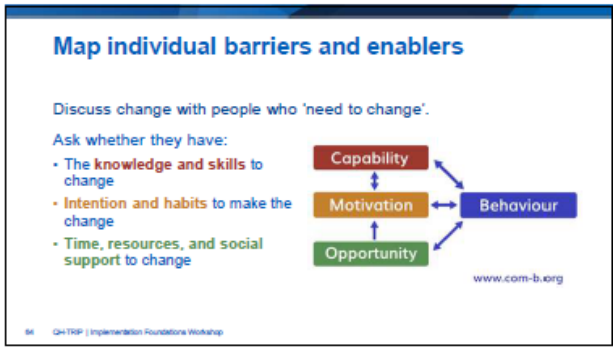
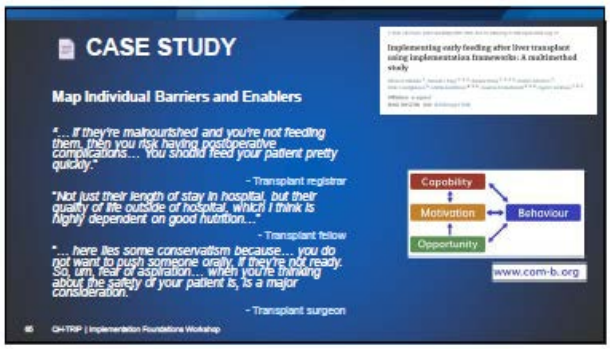
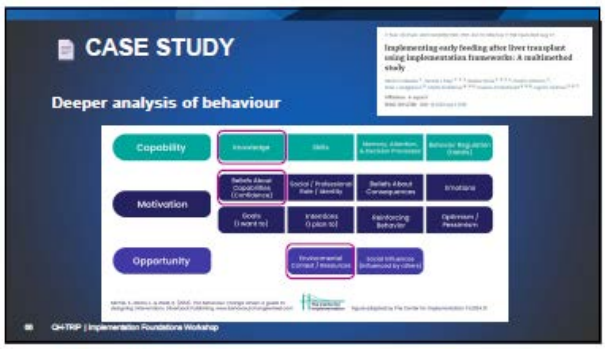
 64	
 65	
 66	
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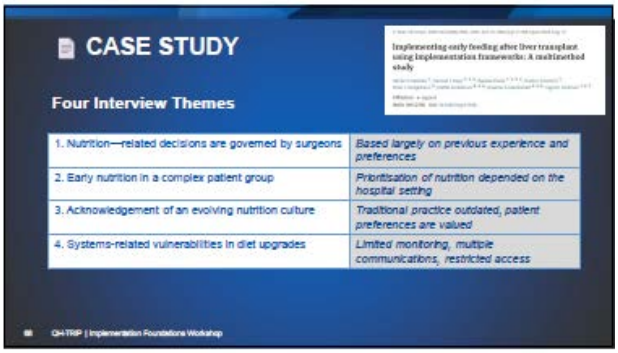 68	
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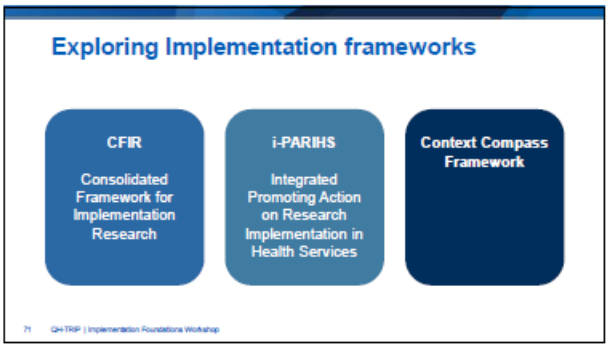 71	

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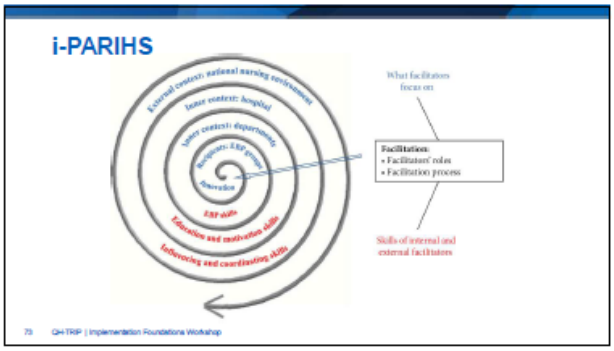
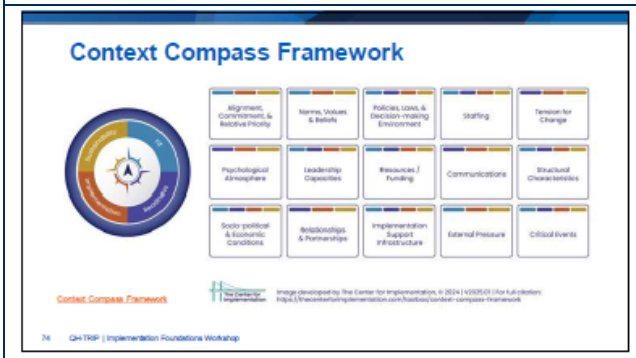
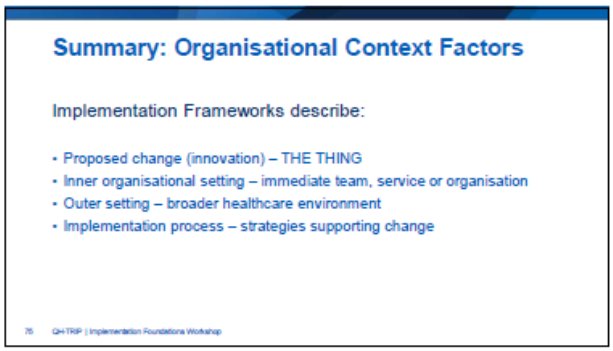
 73	
 74	
 75	

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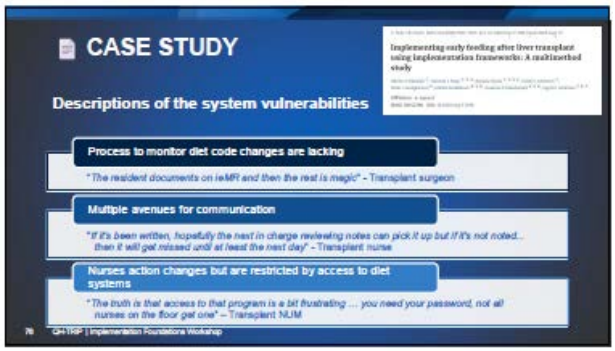
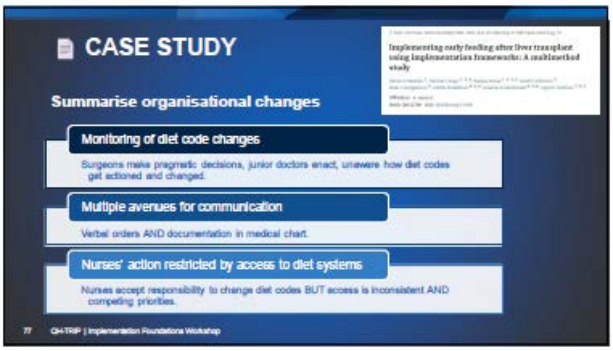
 76	
 77 Case study: Mapping behaviour (Table 3)	
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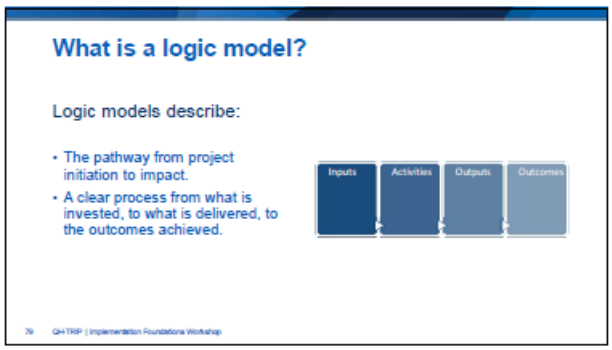 79	

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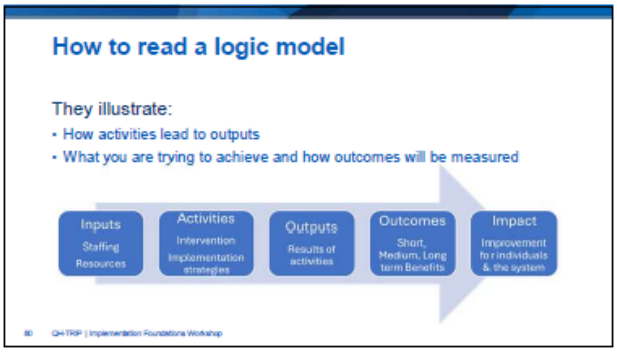
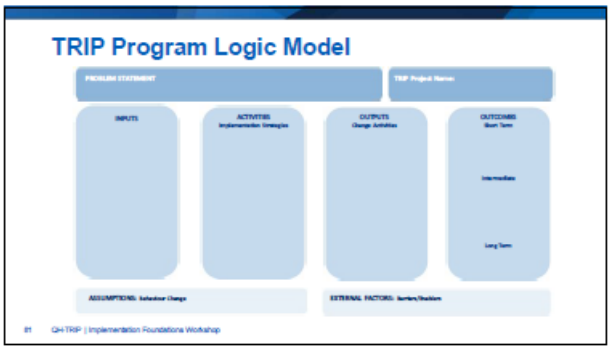
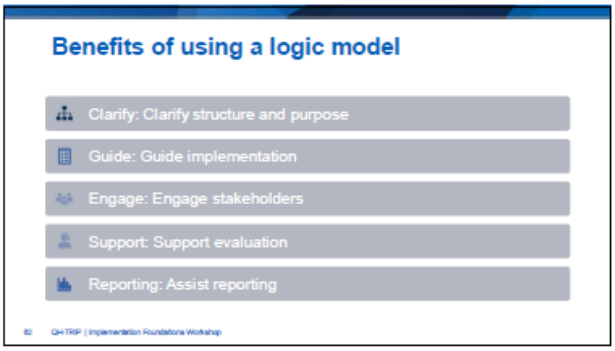
 80	
 81	
 82	
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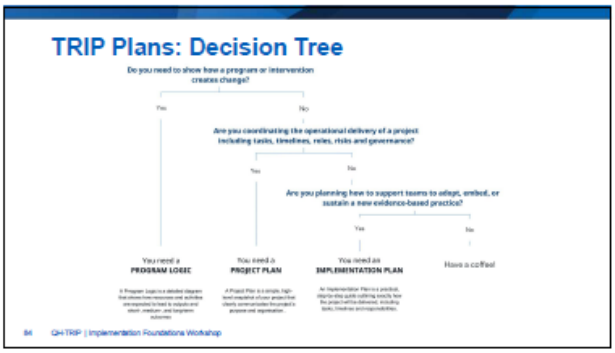 84	
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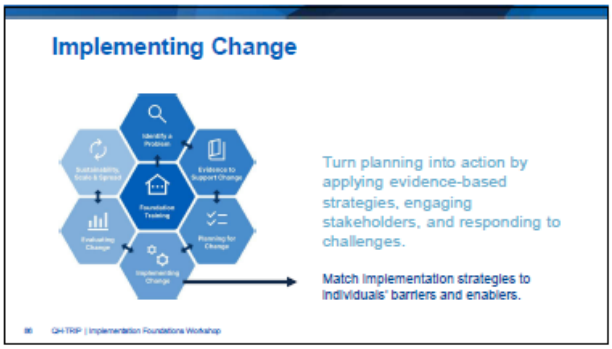
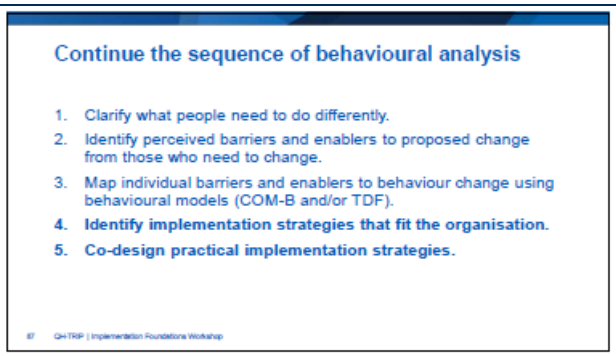
 86	
 87	

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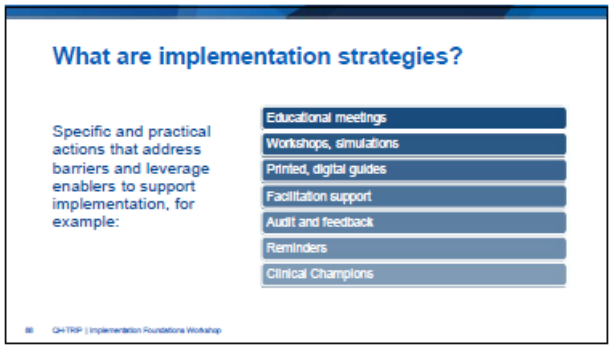 88	
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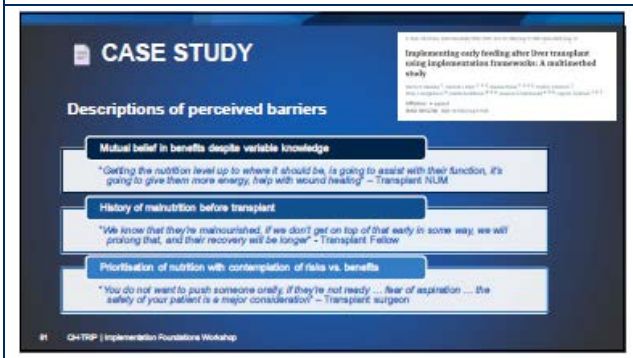 91	

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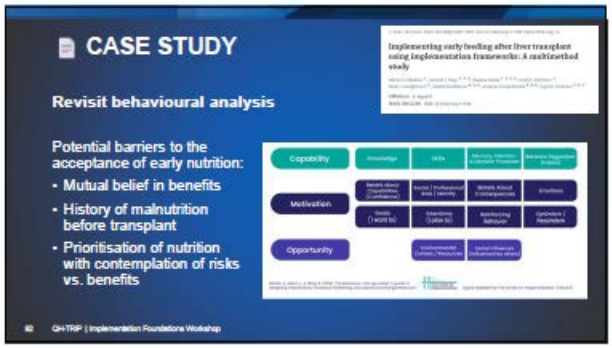
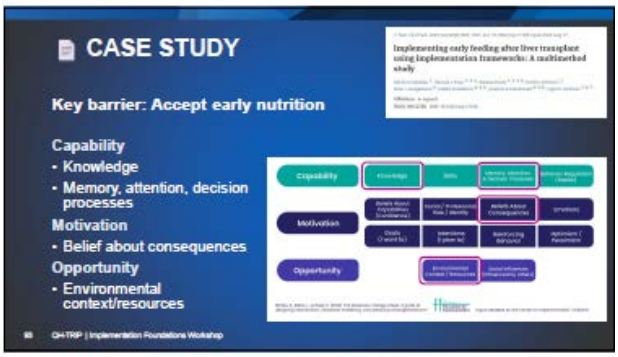
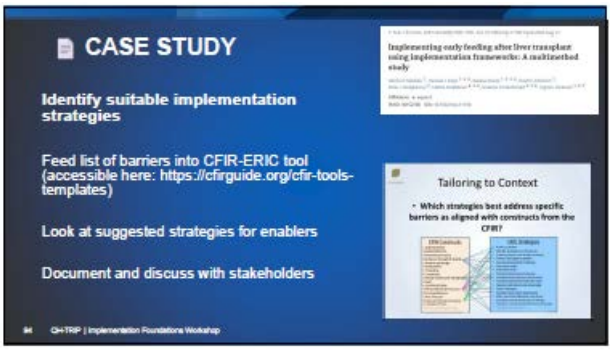
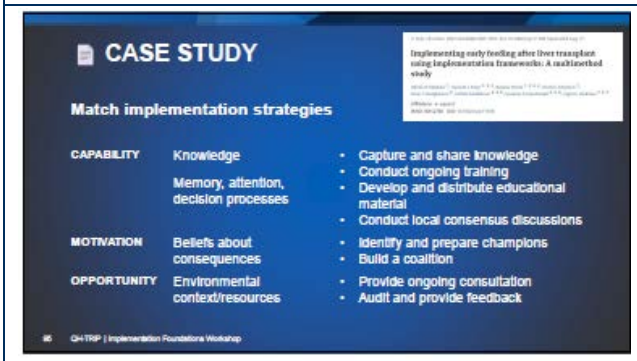
 92 Case study: Applying the COM-B	
 93	
 94 Link: https://cfirguide.org/cfir-tools-templates	
 95	

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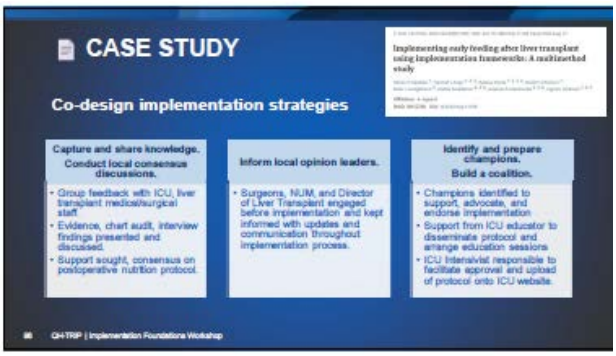 98	
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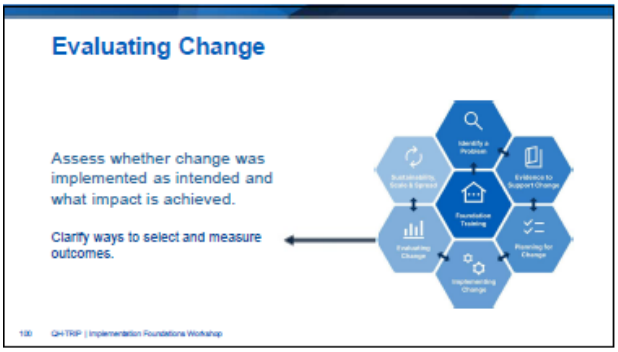
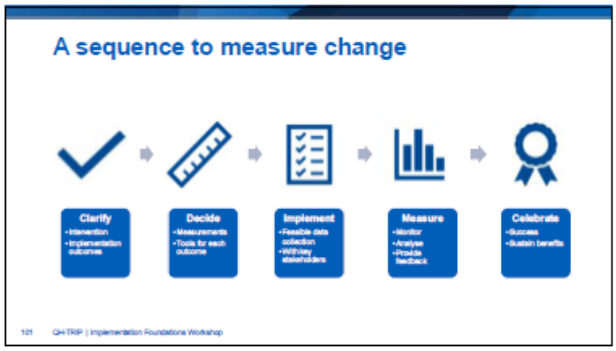
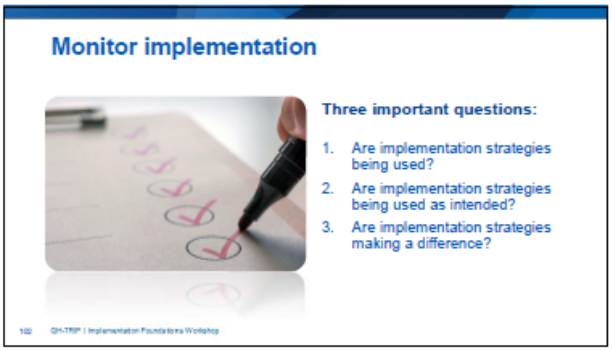
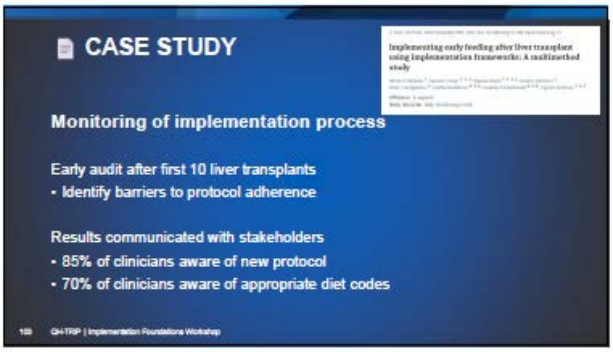
 100	
 101	
 102	
 103	

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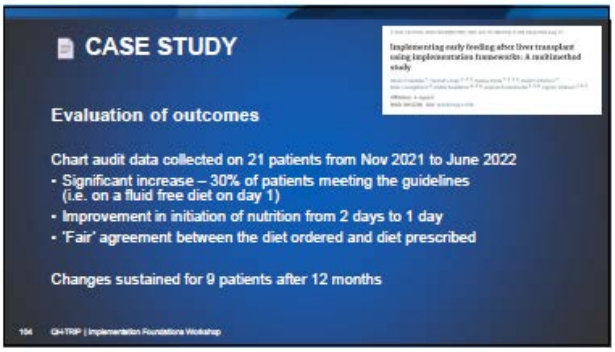
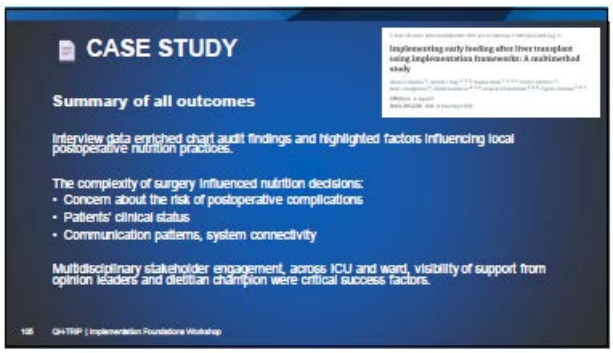
 104	
 105	
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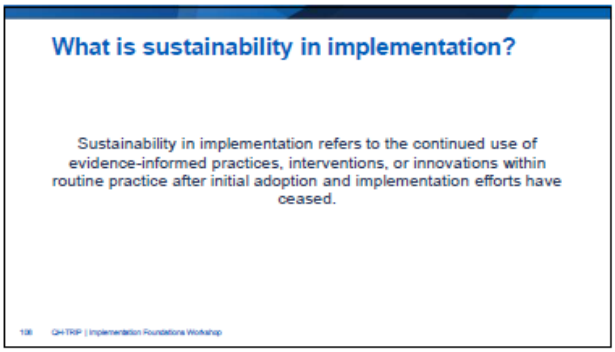 108	
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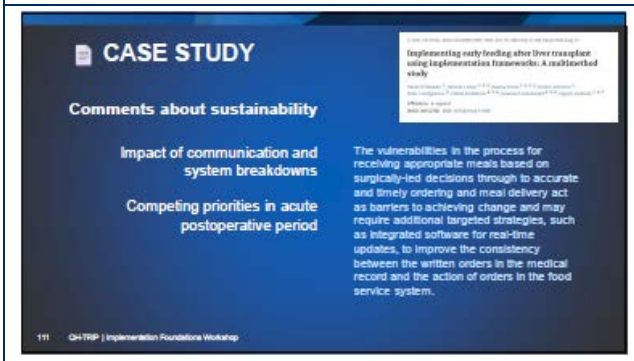 111	

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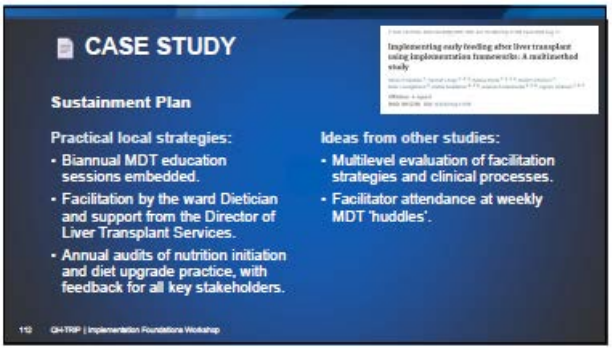 112	
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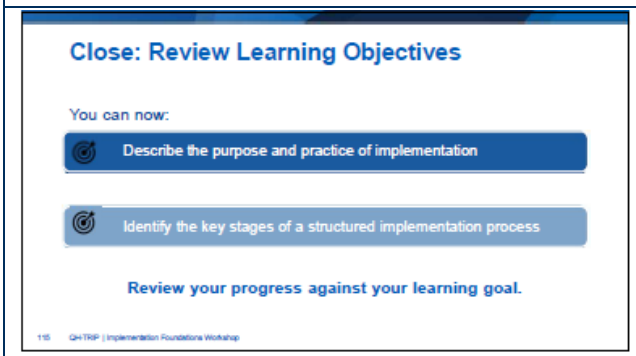 115 Reflection: Foundation Module Review	

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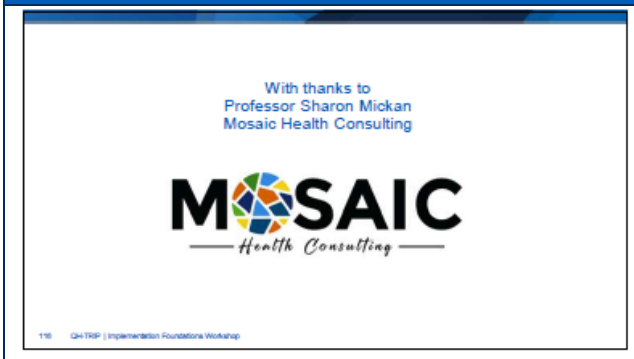 With thanks to Professor Sharon Mickan Mosaic Health Consulting MOSAIC Health Consulting	

Appendices

1. **Reflection**: My Personal Learning Goal
2. **Case study**: Describe the evidence-practice gap
3. **Case study**: Mapping behaviour
4. **Case study**: Applying the COM-B
5. **Case Study**: Implementation Strategies
6. **Reflection**: Foundation Module Review
7. **Template**: Describe a Local Problem
8. **Template**: Discuss the importance of the problem
9. **Template**: Summarise the evidence-practice gap
10. **Template**: Using the COM-B to explore behaviour change
11. **Template**: Stakeholder mapping
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13. **Template**: QH-TRIP Program Logic Model
14. **Guide**: QH-TRIP Program Logic Model
15. **Guide**: Comparing Quality Improvement, Research Projects, Clinical Redesign, and Implementation

A.1 Reflection – My Personal Learning Goal

My Personal Learning Goal	Date:

A.2 Case study: Describe the evidence-practice gap

Describe the Problem	
Summarise the research evidence	
Describe current practice	
Summarise the Evidence-Practice Gap	
Current evidence shows that ….	*evidence-informed practice*
improves ….	*clinical/health outcome*
by ….	*benefit described in research evidence*
This evidence will be applied within ….	*specific health service*
to address ……	*important problem*
with the aim of achieving…..	*intended improvement*

A.3 Case study: Mapping behaviour (Table 3)

TABLE 3 Selected quotations from 19 semistructured individual interviews of clinicians involved in the first 30 days of liver transplant care.

Theme/subtheme	TDF	Selected quotes
Nutrition-related decisions are governed by surgeons		
Surgeons are decision-makers for nutrition initiation and diet upgrades	• Social/professional role and identity • Social influences	"...we try and get patients on nutrition, but the final decision is left with the surgeon who did the operation and the surgical team working with him or her" – Transplant hepatologist "For this type of operation, yes. So anything, um, where... has been intra-abdominal access for surgical procedure, we would routinely defer, uh, decision making for, uh, enteral or oral feeds to the surgical team" – ICU consultant
Acceptance of individual variability	• Environmental context and resources • Beliefs about capabilities	"I do defer to the surgeons because individual surgeons have different, um, thresholds for when doing, uh, begin nutrition" – Transplant hepatologist "I think the overall message is it varies amongst different consultants. Everyone's got a bit of a different thing that they like done" – Transplant registrar
Influence of experience, patient tolerance, and input from the clinical team	• Skills • Memory, attention, and decision processes • Social/professional role and identity	"So, I think it's divided into two – it's surgeon preference and it's patient factors. So, surgeon preference might be someone that's used to doing something that they're regimented in their training...So that's one side of it. The other side of it is patient factors. So can they tolerate a diet yet?..." – Transplant fellow
Early nutrition in a complex patient group		
Mutual belief in benefits despite variable knowledge	• Knowledge • Beliefs about consequences • Environmental context and resources	"... if they're malnourished and you're not feeding them, then you risk having postoperative complications, so anastomotic leaks, wound breakdowns, your big concerns from a selfish, surgical perspective. But I think you generally want to have better patient outcomes. You should feed your patient pretty quickly" – Transplant registrar "Not just their length of stay in hospital, but their quality of life outside of hospital, which I think is highly dependent on good nutrition, you know, getting their fatigue, sorted out, getting their stamina back, everything like wounds, healing up, etc. Nutrition is like the foundation stone to this. So, if you don't put it in early, you're going to be a few steps back..." – Transplant fellow "I think that it could delay everything. It could delay the whole healing process. I mean, getting the nutrition level up to where it should be, is going to, um, assist with, you know, maybe their function, it's going to give them more energy, um, help with wound healing" – Transplant NUM
History of malnutrition before transplant	• Knowledge • Beliefs about consequence	"And I think in liver transplant patients, those of who are quite sick, and we know that they're malnourished, if we don't get on top of that early in some way, shape or form, we will prolong that, and their recovery will be longer" – Transplant fellow
Prioritization of nutrition with contemplation of risks vs benefits	• Beliefs about consequences • Memory attention and decision processes	"Um, so, um, and there lies some conservatism because, um, um, you do not want to push someone orally, if they're not ready. So, um, fear of aspiration, um, when you're thinking about the safety of your patient is, is a major consideration." – Transplant surgeon

(Continues)

TABLE 3 (Continued)

Theme/subtheme	TDF	Selected quotes
An evolving nutrition culture		
A fading legacy of awaiting physical signs of gut function to commence nutrition	• Knowledge • Beliefs about consequences	"I mean, I think historically people, you know, waited for flatus, and you know, bowel movements, and as far as I'm concerned, that's, that's what I referred to previously as surgical dogma. If the patient is not nauseated, then they should be able to drink" – Transplant surgeon
Increased acceptance for early nutrition	• Beliefs about consequences • Environmental context and resources	"I think overall the surgical culture with nutrition is shifting. I think the whole, you know, starve the patient for three days and then slowly feed them and that is, is shifting out because people are becoming aware of how important nutrition is in patients" – Transplant registrar
Patient preferences are valued in decision making	• Beliefs about consequences • Goals	"...patients will determine when they're ready to eat.... just let them choose what they want and that they will either eat or they won't eat... I don't think we should restrict them particularly" – Transplant surgeon
System-related vulnerabilities in diet upgrades		
Processes to monitor diet code changes are lacking	• Environmental context and resources • Memory, attention, and decision processes	"The resident documents on iEMR and then the rest is magic" – Transplant surgeon "...if you were on the round as the in charge, they've, you've had a verbal order from the doctor. Um, and just because they forgot to write it in the notes, I would, would say to the nurse still upgrade it, and you might just go back to that doctor and just go, "Hey, can you just document that?" – Transplant nurse (04)
Multiple avenues for communication	• Environmental context and resources • Memory, attention, and decision process	"...documentation in the chart with diet communication —verbal and written. Yeah. That's what I think, I think, I think, you know, the written communication is as important as the verbal communication. It's one of the major aspects to assess in the postoperative setting...so therefore to record in the chart" – Transplant surgeon "If it's been written, hopefully the next in charge reviewing notes can pick it up and then that's an opportunity for a mistake to be missed, but if it's not noted and it's not been done off a verbal order by the first in charge, then it will get missed until at least the next day. Um, um, so that's quite a lot of barriers and a lot of sort of turns with, is we need to remember to, to do these upgrades" – Transplant nurse
Nurses action changes but are restricted by access to diet systems	• Environmental context and resources • Professional role	"Uh, well obviously we also have nursing on the ward round who action it usually" – Transplant surgeon "The truth is that access to that program is a bit frustrating, to be honest, the HBCIS, because to upgrade a diet we use the patient flow program, and that is one of the most frustrating programs. So, you need your HBCIS password, not all nurses on the floor get one" – Transplant NUM

Abbreviations: HBCIS, hospital based corporate information system; ICU, intensive care unit; iEMR, integrated electronic medical records; NUM, nurse unit manager; TDF, Theoretical Domains Framework.

A.4 Case study: Applying the COM-B

Identify the Stakeholders	
Identify Stakeholders	
How did they engage with them?	
Identify Barriers & Enablers	
Analyse Barriers & Enablers: Use COM- B Model	
The capability to 'do' something	
The desire to 'do' it more than other things	
Time, resources and social support to 'do' it	
Describe the Organisational Context	

A.5 Case Study: Implementation Strategies

Identify implementation strategies	
Monitor and Evaluate Outcomes	
Monitor Implementation Process	
Evaluate Intervention Outcome	
Evaluate Implementation Outcomes	
Summarise sustainability	

A.6 Reflection: Foundation Module Review

Review my Personal Learning Goal
Which stage of the implementation process feels most relevant right now?
Notes: Future Plans

A.7 Template: Describe a Local Problem

1. Where is the problem?	
2. What do you want to change?	
3. What is the evidence for change?	
4. Who is involved?	

A.8 Template: Discuss the importance of the problem

Parameters	Describe the local problem
Does the problem compromise patient safety?	
Does the problem contribute to inequity, risk or inefficiencies?	
Where do people experience frustration most acutely?	
Where is the biggest gap between evidence and practice?	
Are there people with time & resources to address this problem?	
Are the conditions favourable right now?	

A.9 Template: Summarise the evidence-practice gap

Current evidence shows that ….	*evidence-informed practice*
improves ….	*clinical/health outcome*
by ….	*benefit described in research evidence*
This evidence will be applied within ….	*specific health service*
to address ……	*important problem*
with the aim of achieving…..	*intended improvement*

A.10 Template: Stakeholder mapping

Stakeholder	1	2	3	4	5
Name Individual/Group					
Organisation					
Perspectives & Objectives What is important to them relevant to your project?					
Role What role will they have in your project?					
Support / Opposition Likely level of support for your project or how they could block your project					
Level of engagement Low/Medium/High					
Methods of engagement Strategies you could use to engage them					

A.11 Template: TRIP Stakeholder Matrix

Communication strategy: **Actively monitor and consult** Invite input early, communicate regularly *Local stakeholders:*	**HIGH POWER HIGH INTEREST**	**LOW POWER HIGH INTEREST**	Communication strategy: **Empower, involve, inform** Update regularly and invite to contribute to working groups *Local stakeholders:*
Communication strategy: **Keep satisfied and informed** Provide summary updates aligned with strategic priorities *Local stakeholders:*	**HIGH POWER LOW INTEREST**	**LOW POWER LOW INTEREST**	Communication strategy: **Monitor with minimal effort** Keep informed with general summaries and updates *Local stakeholders:*

A.12 Template: Using the COM-B to explore behaviour change

COM-B	Sample questions	Local questions
Capability	Do you have the physical skills required?	
	What do you need to learn more about?	
	Do you understand the reason for change?	
Motivation	Do you believe you can do this well?	
	Will it make a difference, for you, your patients?	
	Will this change fit in with existing habits, processes?	
Opportunity	Is there sufficient time, resources & space for change?	
	Is there a new tool/template?	
	Does everyone think it is a good idea?	

A.13 Template: QH-TRIP Program Logic Model

<table>
<tr><td colspan="3">PROBLEM STATEMENT:</td><td>TRIP PROJECT NAME:</td></tr>
<tr><td rowspan="3">INPUTS</td><td rowspan="3">ACTIVITIES
Implementation Strategies</td><td rowspan="3">OUTPUTS
Change Activities</td><td>OUTCOMES
Short Term</td></tr>
<tr><td>Intermediate</td></tr>
<tr><td>Long Term</td></tr>
<tr><td colspan="2">ASSUMPTIONS: Behaviour Change</td><td colspan="2">EXTERNAL FACTORS: Barriers/Enablers</td></tr>
</table>

A.14 Guide: QH-TRIP Program Logic Model

<table>
<tr><td colspan="3">PROBLEM STATEMENT
Describe the evidence-practice gap this project seeks to address.
Identify why the project is needed, drawing on research evidence, local data, and stakeholder perspectives.</td><td>TRIP PROJECT NAME
What is the ‘thing’ you are implementing?</td></tr>
<tr><td>INPUTS
The things you invest in to make the project possible.

Stakeholders
e.g. patients, staff, project team, leaders, external partners.

Internal Factors/Organisational Context
e.g. culture and readiness, leadership support, infrastructure, resources, policies and procedures.

Implementation process
e.g. strategies, structures and mechanisms to facilitate the ‘thing’.

Innovation Characteristics
e.g. evidence strength and quality, advantages/disadvantages, adaptability, complexity, compatibility.

System-Level Factors
e.g. policy directives, professional guidelines, financing, performance targets, strategic alignment, partnerships.</td><td>ACTIVITIES
Implementation Strategies
The actions, strategies, or interventions you will carry out to implement the evidence into practice.
e.g. staff training, workflow redesign, stakeholder engagement, audit and feedback.</td><td>OUTPUTS
Change Activities
The specific activities you will undertake, guided by your chosen implementation strategies.
e.g. staff training sessions, handouts</td><td>OUTCOMES
Short Term
Immediate changes in knowledge, skills or awareness.

Intermediate
Changes in behaviour, policy, or service delivery.

Long Term
Ultimate impacts such as improved patient outcomes, system efficiency, or sustainability of evidence use.</td></tr>
<tr><td colspan="2">ASSUMPTIONS: Behaviour Change
Conditions that must hold true for activities to lead to outcomes.
e.g. Training staff will increase their confidence to use the guidelines.</td><td colspan="2">EXTERNAL FACTORS: Barriers/Enablers
Conditions outside the project’s control that may influence success.
e.g. organizational culture, leadership support, policy change, workforce pressures.</td></tr>
</table>

Note! Movement between activities, outputs, and outcomes is dynamic, with feedback loops created through adaptation, learning, and monitoring.

A.15 Guide: Comparing Quality Improvement, Research Projects, Clinical Redesign, and Implementation

	Summary	Guiding Question	Focus	Scope	Goal	Methods	How They Work Together
Quality Improvement (QI)	Localised, practical approach to improving specific care delivery processes.	*How can we make our systems and processes work better for patients?*	Incremental changes to local healthcare processes to improve efficiency, effectiveness, patient safety and other desired results.	Context-specific, targeting performance within a particular setting.	To improve local processes, performance, and outcomes in a defined healthcare context.	Continuous cycle of improvement, focusing on processes and metrics, using structured, systematic approaches like the PDSA cycle.	QI provides structured methods to test and refine changes.
Research projects	Designed to generate new knowledge, test hypotheses or validate existing theories, as a foundation for scientific advancement.	*What is the impact of a specific intervention, factor or phenomenon on defined outcomes?*	Advancing knowledge through systematic inquiry, including hypothesis testing, or exploring new methodologies.	Broad or specific, depending on the study design – can examine populations, interventions, systems or experiences with the aim of producing evidence that extends beyond the local setting.	To expand the scientific evidence base and generate insights that inform practice, policy or further research.	Rigorous scientific designs – experimental, quasi-experimental, observational, qualitative, or mixed methods approaches. *Note: Implementation research is a type of study design used in research projects.*	Research provides the evidence base that implementation projects adapt and apply.
Clinical redesign	Structured approach to reshaping healthcare processes and systems to improve efficiency, safety, and patient-centred outcomes.	*How can healthcare processes and systems, be redesigned to deliver safer, more efficient, and patient-centred care?*	Improving patient outcomes, care quality, safety and efficiency through streamlined processes and reduced inefficiencies.	Applicable across all healthcare settings and specialties, from system-wide reforms to focused service improvements, and can address both clinical and administrative workflows.	To transform systems and processes to strengthen healthcare quality, system efficiency and sustainability.	Systematic methodologies (e.g. PDSA cycle, Lean methodology, Six Sigma); process mapping; technology integration; benchmarking and data analysis.	Clinical redesign embeds policy, processes and innovations into workflows and clinical care delivery.
	Implementation theories and frameworks can be used to inform all the approaches above.						
Implementation	Systematic process to ensure research is used in practice to improve health outcomes.	*How can we ensure research evidence is used in everyday practice?*	Applying and adapting research evidence across the continuum – from knowledge creation to implementation and evaluation – to improve health outcomes.	Broad, system-level activity involving various stakeholders including clinicians, policymakers and patients.	To ensure research evidence informs practice to achieve better health outcomes.	Iterative process using strategies for developing, synthesising, disseminating, and implementing research evidence.	Implementation ensures changes are grounded in the best available evidence.