

QH-TRIP | Translating Research Into Practice

Implementation Foundations

An Introduction to Implementation
Participant Handbook



Implementation Foundations Learning Module: Participant Handbook

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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.

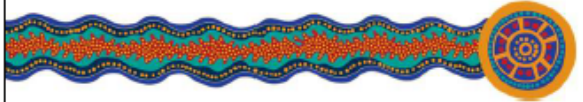
Our aim is that you leave this workshop feeling oriented, reassured, and better equipped to recognise where you are in the implementation journey, and what your next step might be.

Helpful links and resources

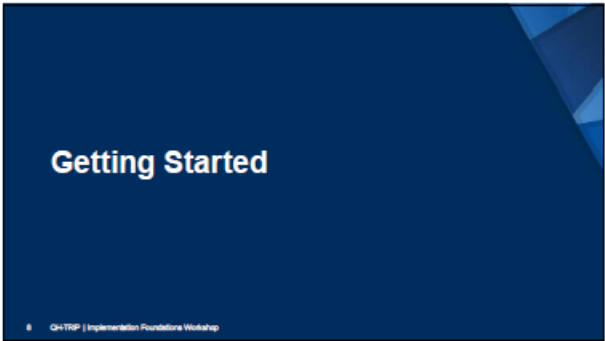
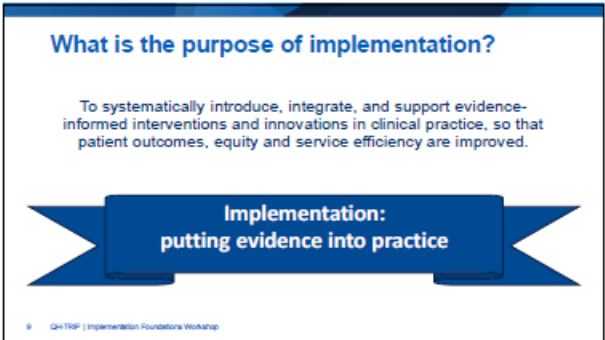
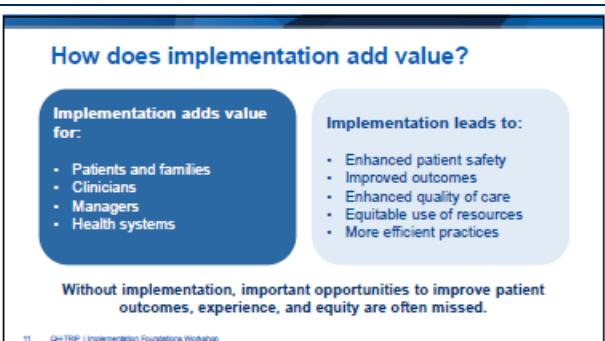
Implementation	
Familiarise yourself with implementation	Implementation science: What is it and why should I care? (Bauer & Kirchner, 2020). An introduction to implementation science for the non-specialist. (Bauer et al., 2015). Implementation science: A critical but undervalued part of the healthcare 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/sXS6iYleGZw?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

Slide	Notes
QH-TRIP Translating Research Into Practice Implementation Foundations Workshop An Introduction to Implementation  0	
 The Queensland Government respectfully acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional and Cultural Custodians of the lands on which we live and work to deliver healthcare to all Queenslanders and recognises the continuation of First Nations peoples' cultures and connection to the lands, waters and communities across Queensland. 1 QH-TRIP Implementation Foundations Workshop 1	
Introduction 2 QH-TRIP Implementation Foundations Workshop 2	
Purpose This Foundation Workshop will help you: • Understand what implementation is and why it matters. • Learn a practical TRIP process for planning implementation. • Build foundations for future learning and application.  3 QH-TRIP Implementation Foundations Workshop 3	

Slide	Notes
Workshop Overview • No expectations of prior implementation experience. • A space to learn, discuss, and explore implementation. • Contribute with curiosity and draw on your own experience. 4 QHTRSP Implementation Foundations Workshop 4	
Learning Objectives - Describe the purpose and practice of implementation. - Identify the key stages of a structured implementation process. - Set a personal learning goal. 5 QHTRSP Implementation Foundations Workshop 5 <u>Reflection – My Personal Learning Goal</u>	
Introductions Introduce yourself and discuss... • Your current role. • Implementation challenges you have encountered or observed. • What you would like to learn about implementation.  6 QHTRSP Implementation Foundations Workshop 6	
Group discussion Please be mindful to... • Listen with curiosity. • Respect confidentiality. • Contribute authentically.  7 QHTRSP Implementation Foundations Workshop 7	

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Slide	Notes										
Perspectives of Implementation Implementation can be viewed as:  A practice area where evidence is integrated into routine clinical practice.  A science that studies theories, models, and strategies.  A process to plan, deliver, and sustain evidence-informed change.  A set of strategies including specific actions that support the process of implementation. 12 QHTRIP Implementation Foundations Workshop 12											
Connecting Science and Practice Implementation Science Provides evidence-informed theories, frameworks, and strategies... ...to support the systematic integration of research evidence into practice... ...improving patient outcomes and service efficiency. Implementation Practice Bridges the gap between what is known to work and what is actually done in clinical settings. It also supports the integration of innovations into everyday clinical practice. 13 QHTRIP Implementation Foundations Workshop 13											
Connecting THE THING When defining implementation science, some very non-scientific language can be helpful... <table border="1"> <tbody> <tr> <td>The Intervention / practice / Innovation is ...</td> <td>... "THE THING".</td> </tr> <tr> <td>Effectiveness research looks at ...</td> <td>... whether THE THING works.</td> </tr> <tr> <td>Implementation research looks at ...</td> <td>... how best to help people / places DO THE THING.</td> </tr> <tr> <td>Implementation strategies are ...</td> <td>... the stuff we do to try to help people / places DO THE THING.</td> </tr> <tr> <td>Main Implementation outcomes are ...</td> <td>... how much and how well they DO THE THING.</td> </tr> </tbody> </table> (Cuman, 2020) 14 QHTRIP Implementation Foundations Workshop 14	The Intervention / practice / Innovation is ...	... "THE THING".	Effectiveness research looks at ...	... whether THE THING works.	Implementation research looks at ...	... how best to help people / places DO THE THING.	Implementation strategies are ...	... the stuff we do to try to help people / places DO THE THING.	Main Implementation outcomes are ...	... how much and how well they DO THE THING.	
The Intervention / practice / Innovation is ...	... "THE THING".										
Effectiveness research looks at ...	... whether THE THING works.										
Implementation research looks at ...	... how best to help people / places DO THE THING.										
Implementation strategies are ...	... the stuff we do to try to help people / places DO THE THING.										
Main Implementation outcomes are ...	... how much and how well they DO THE THING.										
REFLECTION  <i>"What have you noticed in your workplace about why implementation succeeds or stalls?"</i> 15 QHTRIP Implementation Foundations Workshop 15											

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Slide	Notes
Explore challenges in current practice Current Practice Clinical guidelines often exist but are not always used in practice. - Increasing research production. - Rapid digital innovation. - Workforce shortages. - Aging population. - Finite resources. 20 QHTRIP Implementation Foundations Workshop	
Look for an important problem Listen for problems - Out of date practice - Inconsistencies between similar wards or services - Unexplained variations Look for evidence - Clinical guidelines - Passionate colleagues - Journal clubs 21 QHTRIP Implementation Foundations Workshop	
CASE STUDY Implementing early feeding after liver transplant, using implementation frameworks and strategies. https://doi.org/10.1002/ncp.11198 22 QHTRIP Implementation Foundations Workshop Journal: https://doi.org/10.1002/ncp.11198	
CASE STUDY A global change in clinical practice Early Recovery After Surgery (ERAS) protocols have: - Reduced hospital length of stay - Decreased post-operative complications - Improved cost effectiveness of care This holistic approach has led to: - Fewer wound infections - Better pain control - Faster return to daily activities - Higher patient satisfaction 23 QHTRIP Implementation Foundations Workshop	

Slide	Notes
CASE STUDY Implementing early feeding after liver transplant using Implementation Frameworks: A randomised study <i>Current practice</i> <i>"Some colleagues had done a recent project around nutrition on the colorectal ward. As a dietician, I was picking up delays in starting nutrition on the post-liver transplant ward. I was aware of the ERAS literature for other cohorts and evidence-based guidelines for liver transplant patients indicating they should have early nutrition. We have a great research team and support for TRIP projects".</i> 34 Q4-TRIP Implementation Foundations Workshop 24	
A process to understand the problem  • What is the problem you want to address? • Why does this problem exist? • Who is affected by the problem? • Patients, staff • Organisation, team • How significant is the impact? • Patient outcomes • Safety • Cost • Efficiency • What are the consequences of not doing anything? 35 Q4-TRIP Implementation Foundations Workshop 25	
TRIP: Compatible with other frameworks  Central Knowledge Creation Funnel Look for synthesised summaries of research evidence Outer Action Cycle Start at the bottom, move clockwise TRIP starts in a different place 36 Q4-TRIP Implementation Foundations Workshop 26	
TRIP TOOLS • Evidence-Practice Gap Assessment Form • Evidence-Practice Gap Decision Matrix • Interactive Fishbone Tool (Ishikawa Design) 37 Q4-TRIP Implementation Foundations Workshop 27	

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Evidence to Support Change 28 QHTRIP Implementation Foundations Workshop 28	
Evidence to Support Change  Locate, appraise, and apply the best available evidence to support a change. Evidence will highlight what needs to change and the potential benefits. 29 QHTRIP Implementation Foundations Workshop 29	
Identify the research evidence Research evidence = core of implementation. Use the best quality research available to influence and improve practice.  30 QHTRIP Implementation Foundations Workshop 30	
Look for clinical and practice guidelines  Developed by groups of experts to summarise research evidence. Interpret research for practical application. Usually recommend practical clinical pathways. 31 QHTRIP Implementation Foundations Workshop 31	

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Check for other evidence If guidelines are not available, look for: • Systematic and scoping reviews. • High-quality primary research studies. • Common work practices.  32 QHTRIP Implementation Foundations Workshop 32	
Look for organisational evidence Is the problem important in... • Policies. • Benchmarking studies. • Operational and performance data. • Audit results, incident reports. • Staff experiences. • Patient feedback and complaints. 33 QHTRIP Implementation Foundations Workshop 33	
CASE STUDY Evidence for change in liver transplant • Patients should be screened for malnutrition and treated whenever possible. • Prophylactic nasogastric intubation and abdominal drainage omitted. • Early extubation should be considered. • Early oral intake, mobilisation and balanced analgesia recommended. Brudie R, Monard A, Storz S, et al. Guidelines for postoperative care for liver transplant recipients: enhanced recovery after surgery (ERAS) recommendations. <i>Transplantation</i>. 2022;106(2):552-561. doi:10.1097/TP.0000000000003608 34 QHTRIP Implementation Foundations Workshop 34 Journal: https://doi.org/10.1002/ncp.11198	
CASE STUDY Evidence for change in liver surgery • Implementation of early postoperative feeding can be challenging. • Some studies identified perceived barriers and enablers. • Use published barriers and enablers, including disparities in diet upgrade practices and variable understanding of hospital diets to plan for discussions with clinical teams. Robertson, T.R., Elstige, N.E., Ratney, M.E., Roberts, S.J., Desbrow, B., Marshall, A.P., Al, A.B. and Holmes, L.J. (2016), Early oral feeding after colorectal surgery: A mixed methods study of knowledge translation. <i>Health Care</i>, 75, 345-353. https://doi.org/10.1111/hc.12473. 35 QHTRIP Implementation Foundations Workshop 35	

Slide	Notes
REFLECTION  <i>"What local evidence could you look for to support the importance of early oral intake after a liver transplant?"</i> Q4 TRIP Implementation Foundations Workshop 36 Case study: Describe the evidence-practice gap	
CASE STUDY Gather local evidence: Chart audit Audit All liver transplant surgery patients June 2018 – 2020 to describe initiation of nutrition and diet upgrade. Clarify definitions and details Full diet = normal diet of food and drinks, of any texture, without restrictions. Free-fluid diet = liquids or foods that become liquid at room temperature. Clear-fluid diet = all clear liquids with a thin consistency at room temperature. Q4 TRIP Implementation Foundations Workshop 37	
CASE STUDY Evidence for Current Practice 84 patients audited pre-implementation Nutrition practices in 27% (n=23) of patients aligned with guidelines Initiation of nutrition by post operative day (POD) 1 Median times recorded - 2 days to initiation of free fluids and oral diet - 3 days to reach a full diet Q4 TRIP Implementation Foundations Workshop 38	
Describe an evidence-practice gap Summarise current practice Describe the key workflows and practices around the important problem. What is <u>actually happening</u> in local practice Summarise evidence Highlight what the evidence describes is possible around the important problem. What <u>should be happening</u> Q4 TRIP Implementation Foundations Workshop 39	

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Create an evidence summary 40 QHTRIP Implementation Foundations Workshop 40	
CASE STUDY The evidence summary Current evidence shows that early oral intake after liver transplantation surgery reduces length of stay by 2.22 days and reduces post-operative complications and hospital costs. This evidence will be applied within a Queensland tertiary hospital that provides a statewide centralised service to address variations in feeding practices after surgery with the aim of achieving consistent early feeding practices for patients. Nishi L, Rodgers S, Cheshire C, Bellor A, Neilson D, & Wo Y. (2021). Enhanced Recovery After Surgery (ERAS) Reduces Hospital Costs and Improves Clinical Outcomes After Surgery: a Systematic Review and Meta-Analysis. <i>Journal of Gastrointestinal Surgery</i>, 24, 918 - 932. https://doi.org/10.1007/s10053-019-04494-0 41 QHTRIP Implementation Foundations Workshop 41	
42 QHTRIP Implementation Foundations Workshop 42	
43 QHTRIP Implementation Foundations Workshop 43	

Slide	Notes
Is it a quality improvement problem?  <i>How can we make our systems and processes work better for patients?</i> ↓ Check the existing local system e.g. A local problem with using the electronic food service system could be analysed and progressively improved into an efficient workflow. This would help with implementation! 44 QH-TSP Implementation Foundations Workshop 44	
Is it a clinical redesign problem?  <i>How can healthcare processes and systems be redesigned to deliver safer, more efficient, and patient-centred care?</i> e.g. Has early oral intake been established across all acute hospitals in the state? This may occur after an implementation project establishes the best strategies. 45 QH-TSP Implementation Foundations Workshop 45	
Is it a research problem?  <i>What is the impact of a specific intervention, factor, or phenomenon on defined outcomes?</i> No, we have sufficient evidence to guide practice. Research evidence usually underpins clinical guidelines. 46 QH-TSP Implementation Foundations Workshop 46	
Confirm that it is an Implementation problem  <i>How can we ensure research evidence is used in everyday practice?</i> e.g. Can we establish early oral intake in a key acute hospital? Implementation will support the research evidence to be consistently utilised in current practice, to achieve the expected outcomes. 47 QH-TSP Implementation Foundations Workshop 47	

In reality...



Problems in quality improvement, research, clinical redesign and implementation practice often co-exist.



There may be initial confusion about the nature of the problem.



Sometimes, there is a need to change approaches along the way.

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Comparing Quality Improvement, Research Projects, Clinical Redesign, and Implementation

Summary	Guiding Question	Purpose	Scope	Goal	Methods	How They Work Together
Quality Improvement (QI) Focused on improving patient care and safety through systematic changes to practice.	How can we make our practice more effective and efficient?	Improve patient care and safety through systematic changes to practice.	Local or regional, often limited to a specific practice or department.	To improve patient care and safety through systematic changes to practice.	Plan, Do, Check, Act (PDCA) cycle, Root Cause Analysis (RCA), Failure Mode and Effects Analysis (FMEA).	QI projects often focus on specific, measurable outcomes and are typically implemented in a single practice or department.
Research projects Designed to generate new knowledge and understanding of patient care and safety.	What is the impact of a specific intervention on patient care and safety?	Generate new knowledge and understanding of patient care and safety.	Local or regional, often limited to a specific practice or department.	To generate new knowledge and understanding of patient care and safety.	Randomized controlled trials, Cohort studies, Case-control studies, Cross-sectional studies.	Research projects often focus on understanding the underlying mechanisms of patient care and safety and are typically implemented in a single practice or department.
Clinical redesign Focused on redesigning patient care and safety through systematic changes to practice.	How can we redesign our practice to improve patient care and safety?	Redesign patient care and safety through systematic changes to practice.	Local or regional, often limited to a specific practice or department.	To redesign patient care and safety through systematic changes to practice.	Plan, Do, Check, Act (PDCA) cycle, Root Cause Analysis (RCA), Failure Mode and Effects Analysis (FMEA).	Clinical redesign projects often focus on redesigning the entire patient care and safety process and are typically implemented in a single practice or department.
Implementation Focused on implementing new knowledge and understanding of patient care and safety.	How can we implement new knowledge and understanding of patient care and safety?	Implement new knowledge and understanding of patient care and safety.	Local or regional, often limited to a specific practice or department.	To implement new knowledge and understanding of patient care and safety.	Plan, Do, Check, Act (PDCA) cycle, Root Cause Analysis (RCA), Failure Mode and Effects Analysis (FMEA).	Implementation projects often focus on implementing new knowledge and understanding of patient care and safety and are typically implemented in a single practice or department.

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Planning for Change

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Planning for Change



Understand the local context, including barriers, enablers, and available resources.

Identify, analyse, and engage with stakeholders, and evaluate organisational readiness for change.

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Identify people around the important problem

Stakeholders are:

- People who are impacted by change
- Those who can influence change

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Value of Stakeholders

Stakeholders:

- Build a shared understanding of the problem
- Enhance the relevance and need for change

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Brainstorm to identify stakeholders

Consider what is important about the change for key stakeholders:

Health professionals

Administrators

Finance and IT staff

Managers

Patients, Consumers

Families

Community members

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TRIP Stakeholder Mapping

Map your Stakeholders

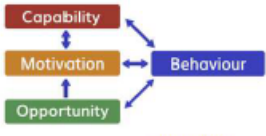
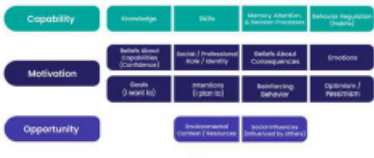
	1	2	3	4	5
Stakeholder					
Name					
Organization					
Perspectives & Objectives (What is important to them related to your project?)					
Role (What role will they have in your project?)					
Support & Opposition (Only level of support for your project or how they would best be engaged?)					
Level of engagement (Continuum)					
Methods of engagement (Strategies you could use to engage them)					

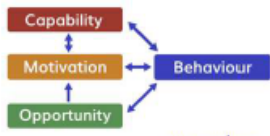
Create your TRIP Stakeholder Matrix

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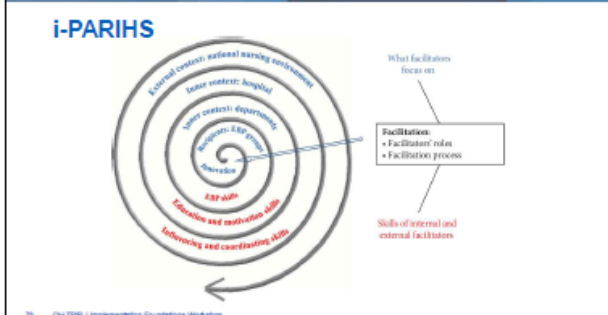
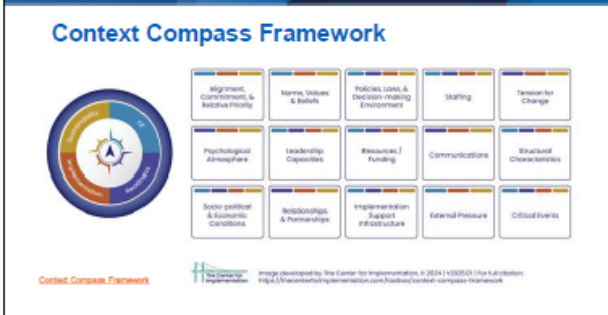
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Clarify the Change Describe the evidence-informed intervention i.e. THE THING to be introduced • What do key people need to do differently... • To achieve a specific benefit (outcome)... • That will address the original clinical problem. 56 QH-TSP Implementation Foundations Workshop 56	
Change workplace behaviours Implementation aims to change behaviours for some people to reach a specific outcome. 57 QH-TSP Implementation Foundations Workshop 57	
REFLECTION  <i>"Who are potential stakeholders in this case example?"</i> <i>How could you explore their interests in adopting early nutrition guidelines?"</i> 58 QH-TSP Implementation Foundations Workshop 58	
CASE STUDY Stakeholders • Transplant surgeons • Surgical fellows, registrars, residents • Transplant hepatologists • Transplant nurses • Nurse Unit Manager • Intensivists • Intensive care nurses NB. Lead investigator who conducted the interviews was the only clinician working in the transplant service. 59 QH-TSP Implementation Foundations Workshop Implementing early feeding after liver transplant using implementation frameworks: A multi method study Journal Pre-proof 59	

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CASE STUDY Engaging with local stakeholders Semi-structured interviews to understand perspectives of: • Current practice • Proposed changes of nutrition and diet upgrade after liver transplant Data analysis to: • Identify barriers and enablers 60 Q4TRIP Implementation Foundations Workshop 60	
A sequence of behavioural analysis 1. Clarify what people need to do differently. 2. Identify perceived barriers and enablers to proposed change from those who need to change. 3. Map individual barriers and enablers to behaviour change using behavioural models (COM-B and/or TDF). 4. Identify implementation strategies that fit the organisation. 5. Co-design practical implementation strategies. To be continued... 61 Q4TRIP Implementation Foundations Workshop 61	
COM-B Model of Behaviour Change People need to have: • The ability to 'do' something. • The desire to 'do' it more than other things. • The time, resources, and social support to 'do' it.  www.com-b.org 62 Q4TRIP Implementation Foundations Workshop 62	
Theoretical Domains Framework (TDF) Consistent with COM-B Analyses behaviour determinants deeply  www.com-b.org 63 Q4TRIP Implementation Foundations Workshop 63	

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Map individual barriers and enablers Discuss change with people who 'need to change'. Ask whether they have: • The knowledge and skills to change • Intention and habits to make the change • Time, resources, and social support to change  www.com-b.org 64	
CASE STUDY Map Individual Barriers and Enablers <i>"... if they're malnourished and you're not feeding them, then you risk having postoperative complications... You should feed your patient pretty quickly."</i> – Transplant registrar <i>"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..."</i> – Transplant fellow <i>"... here lies some conservatism because... you do not want to push someone orally, if they're not ready. So, um, fear of aspiration... which you're thinking about the safety of your patient is, is a major consideration."</i> – Transplant surgeon  www.com-b.org 65	
CASE STUDY Deeper analysis of behaviour  66	
REFLECTION  <i>"How can you identify and map perceived barriers and enablers to early oral nutrition?"</i> <i>Review Table 3 – focus on theme "Early nutrition in a complex patient group."</i> 67 <u>Case study: Mapping behaviour (Table 3)</u>	

Slide	Notes								
CASE STUDY Four Interview Themes <table border="1"> <tbody> <tr> <td>1. Nutrition-related decisions are governed by surgeons</td><td>Based largely on previous experience and preferences</td></tr> <tr> <td>2. Early nutrition in a complex patient group</td><td>Prioritisation of nutrition depended on the hospital setting</td></tr> <tr> <td>3. Acknowledgement of an evolving nutrition culture</td><td>Traditional practice outdated, patient preferences are valued</td></tr> <tr> <td>4. Systems-related vulnerabilities in diet upgrades</td><td>Limited monitoring, multiple communications, restricted access</td></tr> </tbody> </table> GH TRIP Implementation Foundations Workshop	1. Nutrition-related decisions are governed by surgeons	Based largely on previous experience and preferences	2. Early nutrition in a complex patient group	Prioritisation of nutrition depended on the hospital setting	3. Acknowledgement of an evolving nutrition culture	Traditional practice outdated, patient preferences are valued	4. Systems-related vulnerabilities in diet upgrades	Limited monitoring, multiple communications, restricted access	
1. Nutrition-related decisions are governed by surgeons	Based largely on previous experience and preferences								
2. Early nutrition in a complex patient group	Prioritisation of nutrition depended on the hospital setting								
3. Acknowledgement of an evolving nutrition culture	Traditional practice outdated, patient preferences are valued								
4. Systems-related vulnerabilities in diet upgrades	Limited monitoring, multiple communications, restricted access								
Organisational context influences the problem Organisational context = internal and external factors that influence how an organisation functions.  GH TRIP Implementation Foundations Workshop									
Exploring organisational context Many implementation models, frameworks and theories. Use with support from mentors and/or researchers. Understand whether the organisation is ready to support change.  GH TRIP Implementation Foundations Workshop									
Exploring Implementation frameworks CFIR Consolidated Framework for Implementation Research i-PARIHS Integrated Promoting Action on Research Implementation in Health Services Context Compass Framework GH TRIP Implementation Foundations Workshop									

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CFIR 2.0  72 QHTRIP Implementation Foundations Workshop 72 Link: https://cfirguide.org/	
i-PARIHS  73 QHTRIP Implementation Foundations Workshop 73	
Context Compass Framework  74 QHTRIP Implementation Foundations Workshop 74	
Summary: Organisational Context Factors Implementation Frameworks describe: • Proposed change (innovation) – THE THING • Inner organisational setting – immediate team, service or organisation • Outer setting – broader healthcare environment • Implementation process – strategies supporting change 75 QHTRIP Implementation Foundations Workshop 75	

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CASE STUDY Implementing only feeding after liver transplant using Implementation Frameworks: A real-world study Descriptions of the system vulnerabilities Process to monitor diet code changes are lacking <i>"The resident documents on iEMR and then the rest is magic" - Transplant surgeon</i> Multiple avenues for communication <i>"If it's been written, hopefully the next in charge reviewing notes can pick it up but if it's not noted... then it will get missed and at best the next day" - Transplant nurse</i> Nurses action changes but are restricted by access to diet systems <i>"The truth is that access to that program is a bit frustrating ... you need your password, not all nurses on the floor get one" - Transplant NUR</i> 76 QH-TSP Implementation Foundations Workshop 76	
CASE STUDY Implementing only feeding after liver transplant using Implementation Frameworks: A real-world study Summarise organisational changes Monitoring of diet code changes <i>Surgeons make pragmatic decisions, junior doctors enact, unaware how diet codes get actioned and changed.</i> Multiple avenues for communication <i>Verbal orders AND documentation in medical chart.</i> Nurses' action restricted by access to diet systems <i>Nurses accept responsibility to change diet codes BUT access is inconsistent AND competing priorities.</i> 77 QH-TSP Implementation Foundations Workshop 77 Case study: Mapping behaviour (Table 3)	
Summarise organisational readiness 1 Highlight organisational strengths and contextual factors to create a 'picture' of how to support change. 2 Identify organisational issues likely to hinder change. 3 A logic model can explain how the change will deliver the outcomes. 78 QH-TSP Implementation Foundations Workshop 78	
What is a logic model? Logic models describe: - The pathway from project initiation to impact. - A clear process from what is invested, to what is delivered, to the outcomes achieved. Inputs → Activities → Outputs → Outcomes 79 QH-TSP Implementation Foundations Workshop 79	

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How to read a logic model They illustrate: • How activities lead to outputs • What you are trying to achieve and how outcomes will be measured 80 QH-TRIP Implementation Foundations Workshop 80	
TRIP Program Logic Model 81 QH-TRIP Implementation Foundations Workshop 81	
Benefits of using a logic model - Clarify: Clarify structure and purpose - Guide: Guide implementation - Engage: Engage stakeholders - Support: Support evaluation - Reporting: Assist reporting 82 QH-TRIP Implementation Foundations Workshop 82	
TRIP TOOLS & RESOURCES 83 QH-TRIP Implementation Foundations Workshop 83	

Slide	Notes
TRIP Plans: Decision Tree Do you need to show how a program or intervention creates change? <pre> graph TD Q1{Do you need to show how a program or intervention creates change?} Q1 -- No --> A[You need a PROGRAM LOGIC] Q1 -- Yes --> Q2{Are you coordinating the operational delivery of a project including tasks, timelines, roles, risks and governance?} Q2 -- No --> B[You need a PROJECT PLAN] Q2 -- Yes --> Q3{Are you planning how to support teams to adopt, embed, or sustain a new evidence-based practice?} Q3 -- No --> C[Have a conflict] Q3 -- Yes --> D[You need an IMPLEMENTATION PLAN] </pre> You need a PROGRAM LOGIC A Program Logic is a series of steps that show how an intervention is expected to create change. It includes a logic model and a theory of change. You need a PROJECT PLAN A Project Plan is a single high-level overview of your project. It includes a timeline, roles, risks, and governance. You need an IMPLEMENTATION PLAN An Implementation Plan is a detailed plan that shows how you will support teams to adopt, embed, or sustain a new evidence-based practice. It includes a timeline, roles, risks, and governance. 84 Q4-TRIP Implementation Foundations Workshop 84	
Implementing Change 85 Q4-TRIP Implementation Foundations Workshop 85	
Implementing Change  Turn planning into action by applying evidence-based strategies, engaging stakeholders, and responding to challenges. Match implementation strategies to individuals' barriers and enablers. 86 Q4-TRIP Implementation Foundations Workshop 86	
Continue the sequence of behavioural analysis 1. Clarify what people need to do differently. 2. Identify perceived barriers and enablers to proposed change from those who need to change. 3. Map individual barriers and enablers to behaviour change using behavioural models (COM-B and/or TDF). 4. Identify implementation strategies that fit the organisation. 5. Co-design practical implementation strategies. 87 Q4-TRIP Implementation Foundations Workshop 87	

Slide	Notes
What are implementation strategies? Specific and practical actions that address barriers and leverage enablers to support implementation, for example: - Educational meetings - Workshops, simulations - Printed, digital guides - Facilitation support - Audit and feedback - Reminders - Clinical Champions 88 QH-TROP Implementation Foundations Workshop	
Step 4: Identify implementation strategies that fit the organisation Highlight which behavioural components reflect most barriers and enablers to change. Brainstorm strategies to support the routine implementation of the change intervention ... i.e. implementation strategies.  89 QH-TROP Implementation Foundations Workshop	
Step 5: Co-design practical implementation strategies Identify implementation strategies to match barriers and enablers. Discuss with stakeholders to identify the most feasible and practical strategies.  90 QH-TROP Implementation Foundations Workshop	
CASE STUDY Descriptions of perceived barriers Mutual belief in benefits despite variable knowledge "Getting the nutrition level up to where it should be, is going to assist with their function, it's going to give them more energy, help with wound healing" – Transplant NLM History of malnutrition before transplant "We know that they're malnourished, if we don't get on top of that early in some way, we will prolong that, and their recovery will be longer" – Transplant Fellow Prioritisation of nutrition with contemplation of risks vs. benefits "You do not want to push someone orally, if they're not ready ... fear of aspiration ... the safety of your patient is a major consideration" – Transplant surgeon 91 QH-TROP Implementation Foundations Workshop	

CASE STUDY

Implementing early feeding after liver transplant using Implementation Framework: A multistaged study

Revisit behavioural analysis

Potential barriers to the acceptance of early nutrition:

- Mutual belief in benefits
- History of malnutrition before transplant
- Prioritisation of nutrition with contemplation of risks vs. benefits

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Case study: Applying the COM-B

CASE STUDY

Implementing early feeding after liver transplant using Implementation Framework: A multistaged study

Key barrier: Accept early nutrition

Capability

- Knowledge
- Memory, attention, decision processes

Motivation

- Belief about consequences

Opportunity

- Environmental context/resources

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CASE STUDY

Implementing early feeding after liver transplant using Implementation Framework: A multistaged study

Identify suitable implementation strategies

Feed list of barriers into CFIR-ERIC tool (accessible here: <https://cfirguide.org/cfir-tools-templates>)

Look at suggested strategies for enablers

Document and discuss with stakeholders

Tailoring to Context

- Which strategies best address specific barriers as aligned with constructs from the CFIR?

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Link: <https://cfirguide.org/cfir-tools-templates>

CASE STUDY

Implementing early feeding after liver transplant using Implementation Framework: A multistaged study

Match implementation strategies

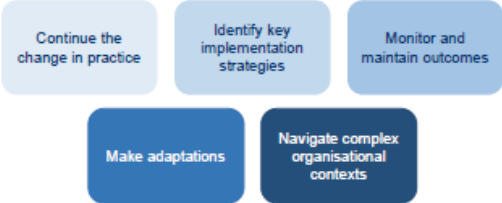
Domain	Constructs	Strategies
CAPABILITY	Knowledge Memory, attention, decision processes	• Capture and share knowledge • Conduct ongoing training • Develop and distribute educational material • Conduct local consensus discussions
MOTIVATION	Beliefs about consequences	• Identify and prepare champions • Build a coalition
OPPORTUNITY	Environmental context/resources	• Provide ongoing consultation • Audit and provide feedback

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Slide	Notes			
REFLECTION  <i>"How would you discuss with stakeholders to determine the most feasible implementation strategies?"</i> Q4-TRIP Implementation Foundations Workshop 96 Case Study: Implementation Strategies				
CASE STUDY Discuss with stakeholders • Share evidence for early oral feeding after liver transplant • Summarise individual barriers and matching implementation strategies • Stakeholders agreed on a consensus feeding protocol • Champions identified to facilitate implementation of protocol Q4-TRIP Implementation Foundations Workshop 97				
CASE STUDY Co-design implementation strategies <table><tr><td> Capture and share knowledge. Conduct local consensus discussions. • Group feedback with ICU, liver transplant medical/surgical staff • Evidence, chart audit, interview findings presented and discussed. • Support sought, consensus on postoperative nutrition protocol. </td><td> Inform local opinion leaders. • Surgeons, NUM, and Director of Liver Transplant engaged before implementation and kept informed with updates and communication throughout implementation process. </td><td> Identify and prepare champions. Build a coalition. • Champions identified to support, advocate, and endorse implementation • Support from ICU educator to disseminate protocol and arrange education sessions • ICU intensivist responsible to facilitate approval and upload of protocol onto ICU website. </td></tr></table> Q4-TRIP Implementation Foundations Workshop 98	Capture and share knowledge. Conduct local consensus discussions. • Group feedback with ICU, liver transplant medical/surgical staff • Evidence, chart audit, interview findings presented and discussed. • Support sought, consensus on postoperative nutrition protocol.	Inform local opinion leaders. • Surgeons, NUM, and Director of Liver Transplant engaged before implementation and kept informed with updates and communication throughout implementation process.	Identify and prepare champions. Build a coalition. • Champions identified to support, advocate, and endorse implementation • Support from ICU educator to disseminate protocol and arrange education sessions • ICU intensivist responsible to facilitate approval and upload of protocol onto ICU website.	
Capture and share knowledge. Conduct local consensus discussions. • Group feedback with ICU, liver transplant medical/surgical staff • Evidence, chart audit, interview findings presented and discussed. • Support sought, consensus on postoperative nutrition protocol.	Inform local opinion leaders. • Surgeons, NUM, and Director of Liver Transplant engaged before implementation and kept informed with updates and communication throughout implementation process.	Identify and prepare champions. Build a coalition. • Champions identified to support, advocate, and endorse implementation • Support from ICU educator to disseminate protocol and arrange education sessions • ICU intensivist responsible to facilitate approval and upload of protocol onto ICU website.		
Evaluating Change Q4-TRIP Implementation Foundations Workshop 99				

Slide	Notes
Evaluating Change Assess whether change was implemented as intended and what impact is achieved. Clarify ways to select and measure outcomes. 100 QH-Trip Implementation Foundations Workshop	
A sequence to measure change Clarify • Elements • Implementation outcomes Decide • Measurements • Tools for each outcome Implement • Possible data collection strategies • Stakeholders Measure • Monitor • Analyse • Provide feedback Celebrate • Success • Sustain benefits 101 QH-Trip Implementation Foundations Workshop	
Monitor implementation Three important questions: 1. Are implementation strategies being used? 2. Are implementation strategies being used as intended? 3. Are implementation strategies making a difference? 102 QH-Trip Implementation Foundations Workshop	
CASE STUDY Monitoring of implementation process Early audit after first 10 liver transplants • Identify barriers to protocol adherence Results communicated with stakeholders • 85% of clinicians aware of new protocol • 70% of clinicians aware of appropriate diet codes 103 QH-Trip Implementation Foundations Workshop	

Slide	Notes
CASE STUDY Evaluation of outcomes Chart audit data collected on 21 patients from Nov 2021 to June 2022 - Significant increase – 30% of patients meeting the guidelines (i.e. on a fluid free diet on day 1) - Improvement in initiation of nutrition from 2 days to 1 day 'Fair' agreement between the diet ordered and diet prescribed Changes sustained for 9 patients after 12 months 104 Q4-TSP Implementation Foundations Workshop 104	
CASE STUDY Summary of all outcomes Interview data enriched chart audit findings and highlighted factors influencing local postoperative nutrition practices. The complexity of surgery influenced nutrition decisions: - Concern about the risk of postoperative complications - Patients' clinical status - Communication patterns, system connectivity Multidisciplinary stakeholder engagement, across ICU and ward, visibility of support from opinion leaders and dietitian champion were critical success factors. 105 Q4-TSP Implementation Foundations Workshop 105	
Sustainability, Scale & Spread 106 Q4-TSP Implementation Foundations Workshop 106	
Sustainability, Scale & Spread Maintain improvements over time and extend their impact. Know how to spread a successful implementation to another setting.  107 Q4-TSP Implementation Foundations Workshop 107	

Slide	Notes
What is sustainability in implementation? Sustainability in implementation refers to the continued use of evidence-informed practices, interventions, or innovations within routine practice after initial adoption and implementation efforts have ceased. 108 QH-TSP Implementation Foundations Workshop 108	
Key sustainability components  109 QH-TSP Implementation Foundations Workshop 109	
Plan for sustainability - Choose implementation strategies carefully. - Monitor their ability to achieve positive outcomes. - Make suitable adaptations where required.  110 QH-TSP Implementation Foundations Workshop 110	
CASE STUDY Comments about sustainability Impact of communication and system breakdowns Competing priorities in acute postoperative period The vulnerabilities in the process for receiving appropriate meals based on surgically-led decisions through to accurate and timely ordering and meal delivery act as barriers to achieving change and may require additional targeted strategies, such as integrated software for real-time updates, to improve the consistency between the written orders in the medical record and the action of orders in the food service system. 111 QH-TSP Implementation Foundations Workshop 111	

Slide	Notes
CASE STUDY Sustainment Plan Practical local strategies: • Biannual MDT education sessions embedded. • Facilitation by the ward Dietician and support from the Director of Liver Transplant Services. • Annual audits of nutrition initiation and diet upgrade practice, with feedback for all key stakeholders. Ideas from other studies: • Multilevel evaluation of facilitation strategies and clinical processes. • Facilitator attendance at weekly MDT 'huddles'. 112 QH-TSP Implementation Foundations Workshop	
A practical process for planning  113 QH-TSP Implementation Foundations Workshop	
REFLECTION  <i>"How would you discuss the value of implementation with stakeholders?"</i> 114 QH-TSP Implementation Foundations Workshop	
Close: Review Learning Objectives You can now: - Describe the purpose and practice of implementation - Identify the key stages of a structured implementation process Review your progress against your learning goal. 115 QH-TSP Implementation Foundations Workshop	

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Reflection: Foundation Module Review

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 With thanks to Professor Sharon Mickan Mosaic Health Consulting 118 QH-TROP Implementation Foundations Workshop	

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
12. **Template:** TRIP Stakeholder Matrix
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	<i>evidence-informed practice</i>
improves	<i>clinical/health outcome</i>
by	<i>benefit described in research evidence</i>
This evidence will be applied within	<i>specific health service</i>
to address	<i>important problem</i>
with the aim of achieving.....	<i>intended improvement</i>

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

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 <i>Local stakeholders:</i>	HIGH POWER HIGH INTEREST	LOW POWER HIGH INTEREST <i>Local stakeholders:</i>	Communication strategy: Empower, involve, inform Update regularly and invite to contribute to working groups
Communication strategy: Keep satisfied and informed Provide summary updates aligned with strategic priorities <i>Local stakeholders:</i>	HIGH POWER LOW INTEREST	LOW POWER LOW INTEREST <i>Local stakeholders:</i>	Communication strategy: Monitor with minimal effort Keep informed with general summaries and updates

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

PROBLEM STATEMENT:			TRIP PROJECT NAME:
INPUTS	ACTIVITIES Implementation Strategies	OUTPUTS Change Activities	OUTCOMES Short Term
			Intermediate
			Long Term
ASSUMPTIONS: Behaviour Change		EXTERNAL FACTORS: Barriers/Enablers	

A.14 Guide: QH-TRIP Program Logic Model

PROBLEM STATEMENT			TRIP PROJECT NAME
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.			What is the 'thing' you are implementing?
INPUTS The things you invest in to make the project possible. Stakeholders <i>e.g. patients, staff, project team, leaders, external partners.</i> Internal Factors/Organisational Context <i>e.g. culture and readiness, leadership support, infrastructure, resources, policies and procedures.</i> Implementation process <i>e.g. strategies, structures and mechanisms to facilitate the 'thing'.</i> Innovation Characteristics <i>e.g. evidence strength and quality, advantages/disadvantages, adaptability, complexity, compatibility.</i> System-Level Factors <i>e.g. policy directives, professional guidelines, financing, performance targets, strategic alignment, partnerships.</i>	ACTIVITIES Implementation Strategies The actions, strategies, or interventions you will carry out to implement the evidence into practice. <i>e.g. staff training, workflow redesign, stakeholder engagement, audit and feedback.</i>	OUTPUTS Change Activities The specific activities you will undertake, guided by your chosen implementation strategies. <i>e.g. staff training sessions, handouts</i>	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.
Note! Movement between activities, outputs, and outcomes is dynamic, with feedback loops created through adaptation, learning, and monitoring.			
ASSUMPTIONS: Behaviour Change Conditions that must hold true for activities to lead to outcomes. <i>e.g. Training staff will increase their confidence to use the guidelines.</i>		EXTERNAL FACTORS: Barriers/Enablers Conditions outside the project's control that may influence success. <i>e.g. organizational culture, leadership support, policy change, workforce pressures.</i>	

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.	<i>How can we make our systems and processes work better for patients?</i>	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.	<i>What is the impact of a specific intervention, factor or phenomenon on defined outcomes?</i>	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. <i>Note: Implementation research is a type of study design used in research projects.</i>	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.	<i>How can healthcare processes and systems, be redesigned to deliver safer, more efficient, and patient-centred care?</i>	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	Implementation theories and frameworks can be used to inform all the approaches above.						
	Systematic process to ensure research is used in practice to improve health outcomes.	<i>How can we ensure research evidence is used in everyday practice?</i>	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.