

Implementing the RNAO Transitions in Care and Services BPG in ICU-to-Ward Transfers:

A Structured, Nurse-Led Transition Pathway with NQuIRE-Aligned Measurement



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Introduction

◆ ICU-to-ward transitions are high-risk events frequently associated with discontinuities in communication and post-transfer support, leading to adverse events, care fragmentation, and increased unplanned ICU readmissions. While pre-transfer handover processes are often established in many institutions, standardized post-transfer collaboration and continuity practices remain highly variable and are frequently absent from routine workflows. Evidence indicates that effective transitional care must encompass a multi-phase, system-level process extending beyond the discrete handoff moment to include pre-transfer assessment, structured transition planning, post-transfer follow-up, and patient/family engagement.

◆ Using the RNAO Transitions in Care and Services Best Practice Guideline (BPG) as an implementation framework, we focused on in-hospital ICU-to-ward transitions to strengthen assessment, planning, and follow-up processes and enable measurable quality improvement. A baseline chart audit of 62 ICU transfers-out (December 2025) confirmed substantial practice gaps across transitional care domains and directly informed the design of the structured, nurse-led pathway described below.

Purpose

This project aimed to:

1. Standardize 24–48h post-transfer follow-up
2. Establish a shared transition readiness assessment
3. Embed structured Transition Plan Summary documentation
4. Deliver patient/caregiver Transition Support Packages with teach-back
5. Align implementation monitoring with NQuIRE process and outcome indicators

Four-Core Intervention Model

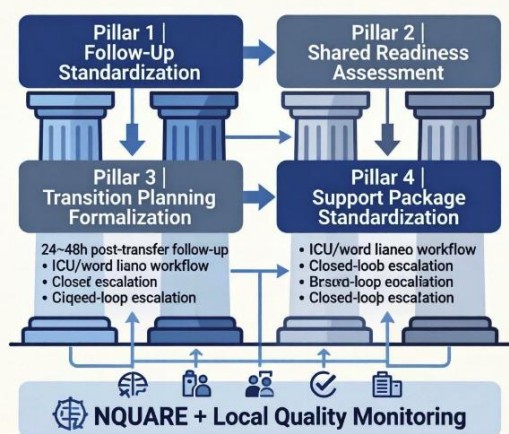


Figure 1: Project Purpose and Structured Intervention Framework

Baseline Review and Scoped Gap Analysis (Dec 2025 Transfers-Out, n=62)

Indicator	Baseline Compliance
Readiness assessment completed	24.7%
Caregiver capacity documented	12.4%
Structured SBAR handoff	11.8%
Transition Plan Summary	4.3%
48h post-transfer follow-up	0%
Checklist with closed-loop resolution	0%
Transition Support Package + teach-back	0%
Patient/caregiver participation	0%

Figure 2: Baseline Practice Gap Bar Graph

GAP ANALYSIS · BARRIERS · ACTION PLAN

Methods / Activities / Ways of Doing

A scoped gap analysis and baseline review informed intervention design. Tools were co-developed with receiving wards, including:

- Follow-up checklist
- Transition Readiness MDS fields
- Transition Plan Summary integrated into SBAR/transfer notes
- Transition Support Package

Implementation Strategies:

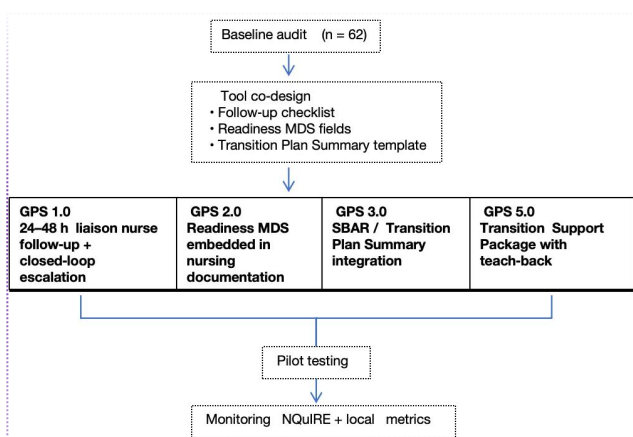


Figure 3. Structured Nurse-Led Transition Pathway

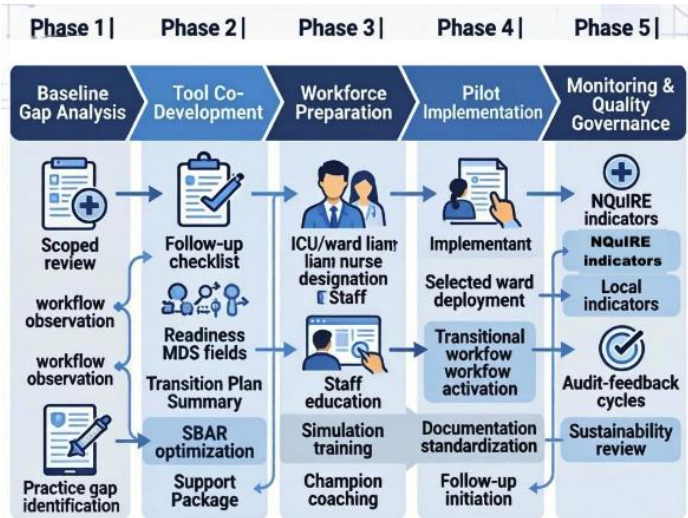


Figure 4. Implementation Workflow and Intervention Design

Next Steps / Implications

- Refine risk stratification, escalation criteria, and documentation standardization (including potential EMR integration)
- Expand implementation across additional wards through phased scale-up
- Sustain practice change through audit-feedback cycles, governance reviews, and staff competency integration
- Embed psychosocial distress screening and referral prompts within the Transition Support Package

Strategic Significance

This project offers a scalable, nurse-led implementation model for operationalizing RNAO transitional care recommendations through NQuIRE-aligned measurement and sustainable quality governance.