

MARCH 2014

Care Transitions



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Care Transitions

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario



The Registered Nurses' Association of Ontario (RNAO) is delighted to present the first edition of the clinical best practice guideline, *Care Transitions*. Evidence-based practice supports the excellence in service that health professionals are committed to delivering every day. RNAO is delighted to provide this key resource.

We offer our heartfelt thanks to the many stakeholders that are making our vision for best practice guidelines a reality, starting with Government of Ontario, for recognizing the Registered Nurses' Association of Ontario's ability to lead the program and for providing multi-year funding; Dr. Irmajean Bajnok, director of the RNAO International Affairs and Best Practice Guidelines Centre and Dr. Monique Lloyd, the associate director, for their expertise and leadership. I also want to thank the chair of the expert panel, Dr. Nancy Pearce (clinical nurse specialist at the

Grand River Hospital in Kitchener, Ontario) for her exquisite expertise and stewardship of this guideline. Thanks also to RNAO staff Brenda Dusek, Andrea Stubbs, Grace Suva, Sarah Xiao and Anastasia Harripaul for their intense work in the production of this new guideline. Special thanks to the members of the RNAO expert panel for generously providing time and expertise to deliver a rigorous and robust clinical resource. We couldn't have done it without you!

Successful uptake of best practice guidelines requires a concerted effort from educators, clinicians, employers, policy makers and researchers. The nursing and health-care community, with their unwavering commitment and passion for excellence in patient care, have provided the expertise and countless hours of volunteer work essential to the development and revision of each guideline. Employers have responded enthusiastically by nominating best practice champions, implementing guidelines, and evaluating their impact on patients and organizations. Governments at home and abroad have joined in this journey. Together, we are building a culture of evidence-based practice.

We ask you to be sure to share this guideline with colleagues from other professions, because there is so much to learn from one another. Together, we must ensure that the public receives the best possible care every time they come in contact with us – making them the real winners in this important effort!

A handwritten signature in black ink that reads "Doris Grinspun". The signature is written in a cursive style and is underlined with a long, horizontal stroke.

Doris Grinspun, RN, MSN, PhD, LLD (Hon), O. ONT.
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How to Use this Document

This nursing best practice guideline^{G*} is a comprehensive document providing resources for evidence^G-based nursing practice and should be considered a tool, or template, intended to enhance decision making for individualized care. The guideline is intended to be reviewed and applied in accordance with both the needs of the individual organizations or practice settings^G and the needs and wishes of the client^G (*throughout this document, we use the word “client” to refer to patients, persons^G, residents, or consumers; that is the client, their family and caregivers, or parents, or substitute decision makers^G being cared for by the interprofessional team*). In addition, the guideline provides an overview of appropriate structures and supports for providing the best possible evidence-based care.

Nurses, other health-care professionals and administrators who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols, educational programs and assessments, interventions and documentation tools. Nurses in direct care will benefit from reviewing the recommendations and the evidence that supports them. We particularly recommend practice settings adapt these guidelines in formats that are user-friendly for daily use.

If your organization is adopting the guideline we recommend you follow these steps:

- a) Assess your nursing and health-care practices using the guideline’s recommendations;
- b) Identify, which recommendations will address needs or gaps in services; and
- c) Develop a plan for implementing the recommendations (implementation resources, including the Registered Nurses’ Association of Ontario’s *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* (2012b) are available on our website, www.RNAO.ca)

We are interested in hearing how you have implemented this guideline. Please contact us to share your story.

* Throughout this document, terms marked with a superscript symbol G (^G) can be found in the Glossary of Terms ([Appendix A](#)).



Purpose and Scope

Best practice guidelines are systematically developed statements to assist nurses and clients make decisions about appropriate health care (Field & Lohr, 1990). This guideline provides evidence-based recommendations for nurses and other members of the interprofessional team⁶ who are assessing and managing clients undergoing a care transition⁶.

In December 2011, the Registered Nurses' Association of Ontario (RNAO) convened focus groups with 45 experts who specialize in assessing and managing client care transitions. Their task was to determine the direction of a guideline on care transitions. The focus groups were interprofessional, made up of people who held clinical, administrative and academic roles in a variety of health-care and quality improvement organizations. They work with clients of all ages in different types of care – acute, long-term and home health care, mental health and addictions, rehabilitation and community services such as public health and community care access centres. Representatives from Accreditation Canada, Healthforce Ontario, Health Quality Ontario, Ontario Telemedicine Network and local health integration networks also participated in the focus groups.

The participants of the focus groups described transitions as non-linear; and needing to involve the rights of clients. Care transitions can occur within organizations (internal) or between them (external). To promote continuity of care and to be safe and effective, transitions require standardized processes, especially for communication and the flow of information (written or verbal), and particularly when it comes to medication reconciliation. The group recommended we focus our care transitions guideline on building the core competencies and concepts known to facilitate safe and effective transitions – those that maintain continuity of care and promote optimal outcomes for the client. Those competencies and concepts, they said, must work whether transitions are within, between or across settings or health-care providers or services.

The expert panel chosen to develop this guideline reviewed a broad range of definitions for care transitions. From that review, they established that care transitions require comprehensive plans that include both the logistical arrangements needed to move from one setting to another as well as the care involved in moving the client. Care transitions are coordinated among knowledgeable health-care providers familiar with the client's clinical status, the goals for his or her health care, and the education required for clients and their families and caregivers (Coleman & Boulton, 2003; National Transitions of Care Coalition [NTOCC] Measures Work Group, 2008; Snow et al., 2009). Because of the different types of transitions and the varied activities involved with each type, the expert panel developed its own definition, which we use throughout this guideline to cover all aspects of care transitions:

Care transitions: A set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, health-care providers or location (within, between or across settings).

The expert panel supported the focus group's recommendation that the guideline centre on building the core competencies and concepts known to facilitate safe and effective care transitions. However, it is important to acknowledge that personal preferences and unique needs of clients, and the resources available, must always be considered in the delivery of care. This document is intended to assist nurses and other members of the interprofessional team to focus on evidence-based strategies in the context of the provider-client relationship. Also, competencies vary among nurses and among the different categories of nursing professionals.

We expect individual nurses will perform only the care they have the education and experience to offer. Every nurse should consult when a person's care needs surpass their ability to act independently (College of Nurses Of Ontario [CNO], 2011). Other factors that will affect the use of this guideline include each organization's policies and procedures, government legislation, different health-care sectors and the client population. This new guideline is designed to apply to all domains of nursing practice, including clinical, administration, and education, to assist nurses to become more comfortable, confident and competent when caring for clients undergoing care transitions.

It is important that nurses, in collaborating with their interprofessional team, know and work with clients, their families and caregivers to promote safe and effective care transitions. Effective care transitions depend on coordinated interprofessional care^G that emphasizes ongoing communication among professionals and clients.

Our reference list and appendices (including a glossary, a description of how the guideline was developed and details on our literature search) follow the main guideline. See [Appendix A](#) for a glossary of terms. See [Appendices B and C](#) for the guideline development process and process for systematic review^G/search of the literature.



Photo Credit: Toronto Rehab – University Health Network

Summary of Recommendations

PRACTICE RECOMMENDATIONS ⁶		LEVEL OF EVIDENCE
1.0 Assessment	<p>Recommendation 1.1:</p> <p>Assess the client's current and evolving care requirements on admission, regularly throughout an episode of care, in response to a change in health status or care needs, at shift change and prior to discharge.</p>	Ia
	<p>Recommendation 1.2:</p> <p>Obtain a "best possible medication history" during care transitions by using a structured and systematic process to collect client medication information that includes dose, frequency and route.</p>	IIb
	<p>Recommendation 1.3:</p> <p>Assess the client for physical and psychological readiness for a care transition.</p>	III
	<p>Recommendation 1.4:</p> <p>Assess the client, their family and caregivers for factors known to affect the ability to learn self-care strategies before, during and after a transition.</p>	III
	<p>Recommendation 1.5:</p> <p>Assess the learning and information needs of the client, their family and caregivers to self-manage care before, during and after a transition.</p>	III
2.0 Planning	<p>Recommendation 2.1:</p> <p>Collaborate with the client, their family and caregivers and the interprofessional team to develop a transition plan that supports the unique needs of the client while promoting safety and continuity of care.</p>	Ia
	<p>Recommendation 2.2:</p> <p>Use effective communication to share client information among members of the interprofessional team during care transition planning.</p>	III

PRACTICE RECOMMENDATIONS ⁶		LEVEL OF EVIDENCE
3.0 Implementation	<p>Recommendation 3.1:</p> <p>Educate the client, their family and caregivers about the care transition during routine care, tailoring the information to their needs and stage of care.</p>	III
	<p>Recommendation 3.2:</p> <p>Use standardized documentation tools and communication strategies for clear and timely exchange of client information at care transitions.</p>	IIb
	<p>Recommendation 3.3:</p> <p>Obtain accurate and complete client medication information on care transition.</p>	IV
	<p>Recommendation 3.4:</p> <p>Coach the client on self-management strategies to promote belief in their ability to look after themselves on care transition.</p>	IIb

PRACTICE RECOMMENDATIONS ⁶		LEVEL OF EVIDENCE
4.0 Evaluation	<p>Recommendation 4.1:</p> <p>Evaluate the effectiveness of transition planning on the client, their family and caregivers before, during and after a transition.</p>	IV
	<p>Recommendation 4.2:</p> <p>Evaluate the effectiveness of transition planning on the continuity of care.</p>	Ia
	<p>Recommendation 4.3:</p> <p>Evaluate the effectiveness of communication and information exchange between the client, their family and caregivers and the health-care team during care transitions.</p>	IV

EDUCATION RECOMMENDATIONS ⁶		LEVEL OF EVIDENCE
5.0 Education	<p>Recommendation 5.1:</p> <p>Health-care professionals engage in continuing education to enhance the specific knowledge and skills required for effective coordination of care transitions.</p>	Ia-IV
	<p>Recommendation 5.2:</p> <p>Educational institutions and programs incorporate the guideline <i>Care Transitions</i>, into basic and interprofessional curricula so all health-care professionals are provided with the evidence-based knowledge and skills needed for assessing and managing client care transitions.</p>	IV

ORGANIZATION AND POLICY RECOMMENDATIONS ⁶		LEVEL OF EVIDENCE
6.0 Organization and policy	<p>Recommendation 6.1:</p> <p>Establish care transitions as a strategic priority to enhance the quality of client care and safety.</p>	III
	<p>Recommendation 6.2:</p> <p>Provide sufficient human, material and fiscal resources and adopt organization-wide structures necessary to support the interprofessional team with client care transitions.</p>	III
	<p>Recommendation 6.3:</p> <p>Develop organization-wide standardized policies and structured processes for medication reconciliation on care transition.</p>	III
	<p>Recommendation 6.4:</p> <p>Establish organization-wide systems for communicating client information during care transitions to meet all privacy, security and legislated regulatory requirements.</p>	IV
	<p>Recommendation 6.5:</p> <p>Include care transitions when measuring organization performance to support quality improvement initiatives for client outcomes and interprofessional team functioning.</p>	III

Interpretation of Evidence

Levels of Evidence

Ia	Evidence obtained from meta-analysis or systematic reviews ⁶ of randomized controlled trials ⁶ .
Ib	Evidence obtained from at least one randomized controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization.
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.
IV	Evidence obtained from expert committee reports or opinions or clinical experiences of respected authorities.

Adapted from "Sign grading system 1999-2012," by the Scottish Intercollegiate Guidelines Network (SIGN), 2012, in *SIGN 50: A Guideline Developer's Handbook*. Available from <http://www.sign.ac.uk/guidelines/fulltext/50/annexb.html>



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Further details are available from the Registered Nurses' Association of Ontario.

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Background

The *Excellent Care for All Act* (Ministry of Health and Long Term Care [MOHLTC], 2010) was introduced in Ontario, Canada to improve the quality^G of care and clients' experiences with the health-care system. The Act mandates the use of evidence-based care and places particular emphasis on safe, effective care transitions.

The National Transitions of Care Coalition created a Measures Work Group, which identified care transitions as a subcategory of care coordination that is not linear (NTOCC Measures Work Group, 2008). Care transitions occur in all settings – within a unit, between departments or across organizations or services (for example, from primary care to specialty care) or across health states (from living at home to assisted living) or between health-care providers (such as handovers at shift change, hospitalist to primary care practitioner) (Accreditation Canada, 2013, 2014).

In a report on care coordination, the Agency for Healthcare Research and Quality (AHRQ) said coordinating care is essential for improving quality, effectiveness and efficiency and optimizing health outcomes (McDonald et al., 2007). This report identified five common elements required for effective coordination of care:

1. Involvement of a number of participants (the sending and receiving settings, health-care providers, clients, their families and caregivers, primary care physicians or specialists);
2. Participants interdependency to carry out different activities for care coordination;
3. Participants knowledge of roles and responsibilities in the coordination of care processes, and available resources;
4. Information exchange to manage the activities required for client care; and
5. Facilitation of appropriate delivery of health-care services as a common goal.

The Avoidable Hospitalization Advisory Panel report *Enhancing the Continuum of Care* (2010) identified improving care transitions require clinical and strategic partnerships and collaboration across organization and system boundaries. It said focusing on the following six elements would make for more effective transitions:

- Client and caregiver education;
- Client management at home;
- Discharge planning;
- Improved communication between clinicians, clients and across settings;
- Medication reconciliation; and
- Primary care: follow-up in the community.

Our expert panel considered these concepts as foundational for safe and effective **Care Transitions**:

- Client-Centred Care;
- Therapeutic relationships⁶;
- Effective communication;
- Informed decision-making;
- Ethical principles;
- Confidentiality and privacy of personal health information;
- Interprofessional collaboration;
- Leadership;
- System integration; and
- Continuous quality improvement.

The panel identified the following documents, guidelines, practice standards, legislation (national and international) and organizations in support of these concepts:

Registered Nurses' Association of Ontario Guidelines:

Client Centred Care (2006a);
Developing and Sustaining Interprofessional Health Care: Optimizing Patient, Organizational, and Systems Outcomes (2013a);
Developing and Sustaining Nursing Leadership (2013b);
Establishing Therapeutic Relationships (2006b);
Supporting and Strengthening Families Through Expected and Unexpected Life Events (2006c);
Facilitating Client Centred Learning (2012a);
Strategies to Support Self-Management in Chronic Conditions (2010b).

College of Nurses of Ontario (CNO) Practice Standards and Guidelines:

Confidentiality and Privacy – Personal Health Information (2009a)
Consent (2013a);
Ethics (2009b);
Therapeutic Nurse-Client Relationship (2013b).

Accreditation Canada:

Safety in Canadian Health Care Organizations: A Focus on Transitions in Care and Required Organizational Practices (2013a).

Institute for Healthcare Improvement – How to Guides Improving Transitions to Reduce Avoidable Rehospitalizations Series from:

Hospital to: the Clinical Office Practice (2013); Skilled Nursing Facilities (2013); Home Health Care (2013).

Institute for Safe Medication Practices:

Institute for Safe Medication Practices, Canada: Medication Reconciliation (2012).

Safer Healthcare Now:

Medication Reconciliation Getting Started Kits (Acute Care, 2011a, Home Care, 2011b, Long Term Care, 2012).

World Health Organization:

High 5s Project (2006).

Ministry of Health and Long Term Care:

The Excellent Care for All Act (2010).

Our expert panel recognized some settings lack the resources to do everything the evidence suggests for complex care transitions. Consequently, this guideline offers recommendations on evidence-based care, which nurses and other health-care professionals can use as appropriate for their clients. Interprofessional health-care teams should work closely with clients to coordinate care and minimize risk before, during and after a transition (American Medical Directors Association [AMDA], 2010; Coleman & Boulton, 2003). Nurses can positively influence client care transitions by promoting and participating in interprofessional health-care teams following these best practice guidelines.



Practice Recommendations

1.0 ASSESSMENT

RECOMMENDATION 1.1:

Assess the client's current and evolving care requirements on admission, regularly throughout an episode of care, in response to a change in health status or care needs, at shift change and prior to discharge.

Level of Evidence = Ia

Discussion of Evidence:

A client's current and evolving care requirements should be assessed on admission and reassessed regularly throughout the entire episode of care to ensure they are ready for a care transition (Accreditation Canada, 2014; Foust, 2007; Joint Commission, 2010; Laugaland, Aase, & Barach, 2012; Scottish Intercollegiate Guidelines Network [SIGN], 2010). Systematic reviews of randomized controlled trials report transition planning processes tailored to meet the assessed care needs of the individual's before, during and after a care transition are more effective in preparing the client and result in reducing the length of stay and readmission rates (Richards & Coast, 2003; Sheppard et al., 2010).

Assessing clients' needs should begin early regardless of the health-care setting (acute, long-term and home health-care or community service) (Herndon, Bones, Bradke, & Rutherford, 2013; Laugaland et al., 2012; Schall, Coleman, Rutherford, & Taylor, 2013; Sevin et al., 2013; SIGN, 2010). It is an ongoing process and particularly important to do on:

- ▣ Admission and prior to discharge;
- ▣ Change in health status, condition or circumstances (such as new diagnosis or development in the client's care needs);
- ▣ Change in care needs (such as such as concerns for safety or increased risk of harm, e.g., risk for restraint use, falls); and
- ▣ Shift change.

(Accreditation Canada, 2013, 2014; AMDA, 2010; Joint Commission, 2010; Laugaland et al., 2012).

Lack of a comprehensive client assessment on admission to identify care needs can result in re-admission, especially when transition plans are not informed by the findings from these assessments (Herndon et al., 2013; Richards & Coast, 2003; Schall et al., 2013; Sevin et al., 2013). Ongoing communication, discussion and evaluation of the client's current and evolving needs and the transition plan interventions should occur daily among health-care team members and with the client to ensure adequate provision of care on transition.

RECOMMENDATION 1.2:

Obtain a “best possible medication history” during care transitions by using a structured and systematic process to collect client medication information that includes dose, frequency and route.

Level of Evidence = IIb

Discussion of Evidence:

A systematic reviews of the literature reports communication and collaboration between the interprofessional team, the client, their family and caregivers as essential to obtain an accurate and complete list of the client’s medication and to support safe and effective care transitions (Accreditation Canada, 2013, 2014; Laugaland et al., 2012; LaMantia, Scheunemann, Viera, Busby-Whitehead, & Hanson, 2010; Terrell & Miller, 2007). Accreditation Canada (2014, pg 19) identifies medication reconciliation as essential for optimum medication management and client safety during what they term “interfaces” in care which include all care transitions where clients are at most risk for potential adverse drug events (such as at the beginning or end of service, on transfer between sites within the same organization or on transfer to another service environment).

A structured and systematic process is required for interviewing the client, their family and caregivers to reconcile client medication on care transition and reduce the risk of treatment errors because drugs or supplements taken by clients are omitted or duplicated, or wrong medications are ordered or contraindicated with new treatments. The goal is to ensure the accurate and complete transfer and documentation of medication information, and it begins with obtaining a “best possible medication history” for each client on care transition (Accreditation Canada, 2014; Chhabra et al., 2012; ISMP, 2012; LaMantia et al., 2010; Safer Healthcare Now [SHN], 2011a, 2011b, 2012).

Nurses and other interprofessional team members play an integral role in reconciling medications on care transition by obtaining the “best possible medication history”. It is important to use a systematic process that begins with interviewing the clients, their families or caregivers and at least one other source of information (such as primary care physician or pharmacist) to compile a detailed list, including dose, frequency and route, of all:

- ▣ Prescription medications;
- ▣ Non-prescription medications;
- ▣ Vitamins, and supplements; and
- ▣ Alternative or complementary therapies such as traditional holistic, or herbal remedies.

Chhabra et al. (2012) identify these barriers to obtaining information on medications:

- ▣ The client lacks knowledge about their medications;
- ▣ There is no pre-admission medication list; and
- ▣ Community health records are inaccessible.

Standardized processes and tools (such as templates) should be made available for use within organizations to facilitate effective communication between health-care providers (such as primary care providers, nurses, pharmacists) and clients, their families or caregivers for the purpose of collecting and documenting medication information on care transition.

This collection of medication information is ongoing and the information gathered is then compared and compiled into a complete and accurate list of medications to be used by all the client’s health-care providers during all care transitions.

RECOMMENDATION 1.3:

Assess the client for physical and psychological readiness for a care transition.

Level of Evidence = III

Discussion of Evidence:

Preparation of a client for a care transition must include assessing their readiness for change, both physical and psychological, and their own perceptions of their ability to cope with the transition. The nurse should observe, ask and listen for information on indicators of readiness for change including:

- Physical: mobility, pain, energy level, appetite, and difficulties with sleeping, swallowing and eating;
- Psychological: anxiety, fear, disturbances in sleep, hallucinations, amnesia, depression and post-traumatic stress;
- Cognitive: memory impairments or deficits, impaired judgment and executive functioning;
- Goals: health or recovery targets related to level of independence;
- Knowledge: skills required to manage their own health (such as knowledge of medication and side effects); and
- Environment: can they manage safely after transition.

(AMDA, 2010; Joint Commission, 2010; SIGN, 2010).

Clients need support from their families or caregivers during care transitions. The client, their family and caregivers will together experience a care transition (Ellis, 2010). Anxiety and stress can affect the client and the ability of their family or caregiver's to absorb information. Everyone (including health-care providers, organizations, and community services) has a role in supporting them through the transition. Sneath (2009) reviewed studies on parents' perceptions of their readiness for their infants' discharge and found they had many unanswered questions and felt unprepared for the discharge. Health-care providers should encourage clients and families to talk about their perceptions of their ability to manage a care transition. Ellis (2010) suggested health-care providers use the theoretical framework shown in Table 1 to understand the psychological stages individuals may go through as they adapt to a transition. Clients and their family members or caregivers may not necessarily experience every stage, or go through them in a linear order.

Table 1. Fisher's Process of Transition

STAGES	
Anxiety	The person experiences uncertainty about the future, and a lack of control.
Happiness	There is a feeling of relief that there will be a change, and a feeling of excitement that perhaps there will be a general improvement. The person also experiences satisfaction knowing that their previously held thoughts to some degree were true. Fisher describes this phase for the client as "thank goodness something at last has happened". One of the dangers in this phase is that the individual may perceive there is more to be gained from the change.
Fear	As a result of imminent change in their life, they will behave differently, which will affect not only how they see themselves, but how others see them as well.
Threat	Due to an imminent lifestyle change, they experience uncertainty regarding how to behave the "new" environment where the old rules no longer apply and new rules will be established.

STAGES	
Guilt	Re-evaluation of self occurs with self-examination of their core beliefs. Guilt can result as the person realizes that previous actions were inappropriate.
Depression	Lack of motivation and confusion. The person experiences uncertainty about their future and where they “fit-in”. Loss of identity.
Disillusionment	The awareness that the person’s values, goals and beliefs are not compatible with others. The person becomes disengaged and unmotivated.
Hostility	The person continues to use processes that repeatedly fail and do not result in positive outcomes.
Denial	Lack of acceptance of any change. The person behaves as though change has not happened, and operates in the old system of thinking.

From “Psychological transition into a residential care facility: older people’s experiences,” by J. M. Ellis, 2010, *Journal of Advanced Nursing*, 66, p. 1159. Copyright 2010 The Author. Journal compilation © 2010 Blackwell Publishing Ltd. Adapted with permission.

Psychological and physical readiness is equally important for a successful care transition (Bench & Day, 2010; Ellis, 2010; Joint Commission, 2010). Involving clients and their families or caregivers in daily rounds and care conferences is important, as it helps to prepare them for the care transition, build trust, and set the expectations. It also allows for the ongoing assessment of their physical and psychological readiness (Bench & Day, 2010; Coleman & Boulton, 2003; Herndon et al., 2013; Schall et al., 2013; Sevin et al., 2013). The assessment of the client’s and their family’s or caregiver’s psychological readiness should be incorporated into planning to assist with adaptation before, during or after a care transition – for example, adapting and timing the educational efforts to any fears, concerns and questions (Ellis, 2010; SIGN, 2010). The timing of the care transition should be based on the health-care team’s knowledge of everyone’s psychological and physical readiness.

RECOMMENDATION 1.4:

Assess the client, their family and caregivers for factors known to affect the ability to learn self-care strategies before, during and after a transition.

Level of Evidence = III

Discussion of Evidence:

Many clients will have to manage all or some of their own care after a transition. Acquiring the related knowledge and skills enhances self-sufficiency. Nurses should assess if the client is psychologically ready to learn what they need to know for self-care (RNAO, 2012a). Ability to learn is based on an individual’s readiness to unlearn past knowledge, actively construct new knowledge and adopt the actions that promote their health over time (RNAO, 2012a).

Nurses with the interprofessional team (such as occupational therapists, pharmacists, physiotherapists) should assess clients, their family and caregivers for factors known to affect the willingness to learn and ability to listen and comprehend during education sessions on self-care strategies (Joint Commission, 2010; RNAO, 2010b, 2012a; Sneath, 2009). Those factors include:

- Knowledge and ability to monitor their own health status and medical conditions;
- Level of health literacy^G and language proficiency;
- Information overload;

- Attitude, beliefs or culture^G;
- Cognitive ability to manage their condition, which may be affected by illness, lack of sleep, developmental age and cognitive impairments such as depression or medication side effects;
- Functional ability to manage self-care and daily activities;
- Support networks available, such as overall social supports or family or caregivers who have the physical and mental ability to assist them;
- Community care services, primary care and other types of providers available for the client to access; and
- Financial or other resources available to the client to obtain necessary care.

(Herndon et al., 2013; Joint Commission, 2010; Schall et al., 2013; Sevin et al., 2013; RNAO, 2010a, 2010b; Rydeman & Tornkvist, 2010). Action to manage the impact of any factor on the clients' ability to learn and look after themselves will be needed before, during and after a care transition.

Assessing the client, their family and caregivers for factors known to affect the ability to learn self-care strategies before, during or after a care transition enables the nurse, collaborating with the interprofessional team, to implement interventions that take into consideration the factors affecting their ability to understand and follow through on self-management strategies (RNAO, 2010a, 2010b, 2012a). Identification and management of factors known to impact learning for self-management enhances client satisfaction before, during and after the care transition (Bench & Day, 2010).

RECOMMENDATION 1.5:

Assess the learning and information needs of the client, their family and caregivers to self-manage care before, during and after a transition.

Level of Evidence = III

Discussion of Evidence:

It is important for nurses and interprofessional team members to assess the information needs of the client's family and their caregivers if that will help to ensure the client's readiness for a care transition (AMDA, 2010; Joint Commission, 2010; Lindsay et al., 2010; RNAO, 2006c). Clients, their family and caregivers should actively participate in identifying their learning needs and determining what information is important to them at each stage of a transition (Byrne, Orange, & Ward-Griffin, 2011). New knowledge regarding self-care is only meaningful to individuals if it reflects their needs.

The nurse and interprofessional team need to determine what the client, their family and caregivers need to learn about self-management on transition. Using open-ended questions supports conversation, where clients can explain what they know about their health and express their concerns about the impact of illness on their life at home or in another care setting (RNAO, 2010b, 2012a; Rydeman & Tornkvist, 2010). Here are some sample statements that will promote open dialogue:

- Tell me about your normal daily routine;
- Tell me about your typical meals at home;
- Tell me how you take your medications;
- Tell me what going home or being transferred to another facility means to you;
- Tell me what concerns you have about what is coming next for you, (such as transfer, and discharge); and

- Tell me what concerns you have about what comes next for your loved one (such as coming home or moving into a long-term care facility).

Many factors affect the client's ability to learn (refer to Recommendation 1.4). Health-care settings can be difficult places for learning, with high stress situations across multiple environments. It is important to create an environment that encourages and supports communication with clients and their families and caregivers to meet all their learning needs (RNAO, 2006c, 2012a). Establishing therapeutic relationships and knowing clients is essential for effective communication and interaction. Nurse-client relationships must be established to ensure the client feels safe to ask questions, explore their health status and care and seek clarity for making decisions (AMDA, 2010; CNO, 2013b; Joint Commission, 2010; RNAO, 2006b, 2012a). It is also important to develop a genuine partnership with the client, their family or caregivers and to help them through expected or unexpected life changes or events (AMDA, 2010; RNAO, 2006c).

Learning is an iterative process that can occur anywhere and at any time (RNAO, 2010b, 2012a). Using a learning framework can help the health-care team to tailor education to the learning needs of clients (RNAO, 2012a). For example, the L.E.A.R.N.S. (Listen, Establish, Adopt, Reinforce, Name [via teach-back], and Strengthen) Model assists health-care teams to transfer information to clients (RNAO, 2012a). The framework has providers *listen* to the client to *establish* the therapeutic relationship needed and *adopt* an intentional approach so learning can happen during every encounter they have with the client. The potential to increase the client's knowledge and self-care literacy can then be further improved by encouraging the client to *repeat* or *name* (teach-back) what they have learned to *reinforce and strengthen* the learning at each encounter (RNAO, 2012a).

There are multiple stages during care transitions and at each one, clients, their families and caregivers need to comprehend new health information. It is important that nurses and other members of the interprofessional team tailor information to both the client's needs and the stage of care. An example of such an approach is cited in Lindsay et al. (2010) which outlines a framework called "Timing it Right" (refer to [Appendix D](#) to view the framework). This framework provides stroke clients and their families and caregivers with information tailored to specific phases of stroke care. It was developed by Cameron and Gignac (2008) to outline potential information requirements during the event, diagnosis, stabilization, preparation, implementation, and adaptation phases of stroke-care. This framework demonstrates the importance of tailoring information to the clients' needs and the stage of care.

2.0 PLANNING

RECOMMENDATION 2.1:

Collaborate with the client, their family and caregivers and the interprofessional team to develop a transition plan that supports the unique needs of the client while promoting safety and continuity of care.

Level of Evidence = Ia

Discussion of Evidence:

A systematic review of randomized controlled trials report that structured transition plans tailored to meet the care needs of the client reduces the length of stay and readmission rate and enhances the client's, their families and caregiver's satisfaction with the care transition (refer to Recommendation 1.1) (Popejoy, 2011; Sheppard et al., 2010). A transition plan tailored to meet not only the care needs, but also the client's expectations has been shown to reduce length of stay and help minimize readmissions to hospitals (Sheppard et al., 2010). Planning must consider what information and education is required to prepare clients to manage expectations and avoid conflict during care transitions (Laugaland et al., 2012; Popejoy, 2011; Sheppard et al., 2010).

Start work on a transition plan by determining:

- ▣ The nature of the transition;
- ▣ Who needs to be involved in the planning;
- ▣ The goals and concerns of the client, their family and caregivers; and
- ▣ The information requirements of the client, their family and caregivers and of interprofessional team members at both ends (sending, receiving) of the transition.

Care transitions affect everyone differently, which is why each plan must be tailored to the client, who might be a child, an adult, or a senior; to the nature of the move, whether that's from one unit to another, one provider to another, or to a different setting; and to the client's family or caregivers (Ellis, 2010; Munoz-Solomando, Townley, & Williams, 2010; Popejoy, 2011; Sheppard et al., 2010). Clearly, a plan for a move from acute care to long-term care would be different than one for an adolescent moving from pediatric to adult services. Both require psychological readiness but the former might focus on the older adult's adaptability to living in a new social context (Ellis, 2010). The focus for the adolescent, on the other hand, might be on his or her interactions with a new health-care provider and ability to make decisions about self-care (Munoz-Solomando et al., 2010). In each case, a transition plan would need to consider the client's information and resource needs appropriate for optimal outcomes and safety before, during and after the care transition.

Care transition meetings help the team understand the client's goals, concerns and care requirements. They are also a forum for clients, family and caregivers to contribute to the planning. Integrating a transition plan into the overall care plan helps ensure comprehensive care delivery, supports daily review of progress on preparations for the transition and facilitates coordination of care by providers to meet the transition date (Foust, 2007; Watts & Gardner, 2005). When clients, their families and caregivers participate in planning a transition, they are more accepting of change and adjust better to the transition, particularly when their wishes, concerns and goals are acknowledged and incorporated (Laugaland et al., 2012; Popejoy, 2011; Sheppard et al., 2010).

Working collaboratively, nurses can use information from planning meetings, together with the assessments that have been done, to coordinate communication of important information among team members and promote a holistic approach to the transition (Crilly, Chaboyer, & Wallis, 2006; Laugaland et al., 2012; Ong & Coiera, 2011). Topics for discussion at transition planning meetings should at a minimum include:

- ▣ Client history;
- ▣ Assessments, including functional status;
- ▣ Diagnosis, investigations and results;
- ▣ Medication and allergies;
- ▣ Safety information;
- ▣ Equipment requirements or recommendations;
- ▣ Care needs;
- ▣ Advanced directives;
- ▣ Information and education for the client, their family and caregivers;
- ▣ Consultations and discharge summaries; and
- ▣ Follow-up requirements.

(Collins, Stein, Vawdrey, Stetson, & Bakken, 2011; Kelly, 2011; LaMantia et al., 2010).

To ensure the receiving setting is ready to accept a client, the transition planning must review what the new provider will need to know, including special requirements such as equipment or medication not normally in stock, or supplies for wound care (LaMantia et al., 2010; Ong & Coiera, 2011).

During transition planning, it is important to identify the potential for conflict between health-care team members and clients, their families and caregivers due to differences in beliefs, values and wishes for care. It is important for the nurse during the transition planning process to work within the therapeutic nurse-client relationship, understand the potential for conflict and use an ethical framework to assist in decision making to ensure the unique needs of the client are met especially if conflicts arise due to these differences (CNO, 2009b).

Care transitions can be complex and require several meetings and many interprofessional team members working with the client, their family and caregivers. Nurses sometimes see transition planning as secondary to their main responsibility of delivering care, but in fact, to ensure safety and continuity, transition planning must be integrated into daily care. This allows nurses to assess current and emerging needs of clients and work to ensure up-to-date planning and preparation of the client for continuity of care and safety on transition (see Assessment Recommendations above) (Foust, 2007; Laugaland et al., 2012; RNAO, 2010b; Watts & Gardner, 2005).

RECOMMENDATION 2.2:

Use effective communication to share client information among members of the interprofessional team during care transition planning.

Level of Evidence = III

Discussion of Evidence:

Effective communication of client information between members of the interprofessional team is essential for coordinating care and preparing the client for a safe care transition (Nosbusch, Weiss, & Bobay, 2010; Riesenberg, Leitzsch, & Cunningham, 2010). It is not clear, what profession is the ideal coordinator during care transitions. However, nurses make a unique contribution by coordinating both the physical and psychological aspects of client care transitions (Ellis, 2010; Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011; Trachtenberg & Ryvicker, 2011). Nosbusch et al. (2010) emphasize that nurses can improve communication and the relationship between the interprofessional team members and the client during the care transition planning process by:

- Demonstrating a client-centred approach^G to care; and
- Participating in the decision-making processes during team-based meetings or rounds to organize and plan the care and services required by the client.

When nurses actively participate in the care transition planning and preparation processes, research demonstrates the following improved client care outcomes:

- Attendance at follow-up appointments with primary care providers;
- Client ability to articulate their discharge diagnosis;
- Client satisfaction with a holistic approach to the transition planning and preparation process;
- Knowledge of warning signs and symptoms that require immediate follow-up by health-care provider and less misinformation;
- Psychological readiness for the transition; and
- Reduction in the risk for readmission.

(Ellis, 2010; Latour et al., 2007; Naylor et al., 2011; Murray & Laditka, 2009; Riesenberg et al., 2010; Trachtenberg & Ryvicker, 2011).

Nurses are recognized for their important contributions to the transition planning process. For example, Trachtenberg and Ryvicker (2011) reviewed the Reengineered Discharge Intervention (RED) program, which includes a nurse discharge advocate role. In this program, the nurse has a discharge planning and coordinating role across interprofessional team members to ensure adequate preparation of the client, their family and caregivers for the discharge. The role includes the preparation of a client-specific post-discharge plan that takes into consideration their health literacy and language proficiency. This plan must be completed by the nurse and reviewed with the client to ensure awareness of follow-up tests and appointments, medications and information on appropriate responses to concerns or a change in their health condition. The review demonstrated nurses are strategically positioned to work with clients to prepare them for a care transition and demonstrated the RED program decreased readmission rates increased the client's understanding of their condition and improved follow-up with primary care providers.

This review and others conclude nurses are strategically positioned to work with clients to prepare them for a care transition. Nurses compensate for bureaucratic barriers by providing leadership and advocating on behalf of the client and other interprofessional team members to ensure the client is ready for the care transition (Naylor et al., 2011; Nosbusch et al., 2010). Nurses raise care concerns, document the outcome of discussions and ensure follow-up education and instruction is given to the client based on the planning requirements for the transition (Nosbusch et al., 2010). When planning for client care transitions, nurses can promote their visibility and leadership by taking the initiative and effectively communicating key client information. Nurses can also demonstrate their unique knowledge and skills within and across interprofessional teams when preparing the client, their family and caregivers for a care transition (Nosbusch et al., 2010; RNAO, 2013a, 2013b).

3.0 IMPLEMENTATION

RECOMMENDATION 3.1:

Educate the client, their family and caregivers about the care transition during routine care, tailoring the information to their needs and stage of care.

Level of Evidence = III

Discussion of Evidence:

Systematic reviews of the literature report the strongest predictor of a client's readiness for a care transition is the quality of teaching (Johnson, Sandford, & Tyndall, 2008; Weiss et al., 2007). Educating clients for care transitions should incorporate the principles of client-centred learning and also consider the learning needs of their families and caregivers (AMDA, 2010; Byrne et al., 2011; Lindsay et al., 2010; Naylor et al., 2011; RNAO, 2012a). Factors to consider when educating clients include:

- ▣ Health (physical and psychological care) requirements;
- ▣ Emotional and social factors;
- ▣ Developmental age;
- ▣ Culture and ethnic values;
- ▣ Cognitive abilities;
- ▣ Health literacy and language proficiency;
- ▣ Stage of readiness (refer to Recommendation 1.4); and
- ▣ Goals.

(Bench & Day, 2010, CNO, 2013b; Joint Commission, 2010; Lindsay et al., 2010; Johnson et al., 2008; RNAO, 2010a, 2010b, 2012a).

Nurses who are preparing clients for care transitions should remember individuals learn best when education is part of everyday routine nursing practice, reinforced and repeated verbally (refer to Recommendation 1.5) and followed up with written material (Johnson et al., 2008; SIGN, 2010). However, Bench and Day (2010) caution that giving clients too much information at once is not effective. The interprofessional team can work together with clients to develop standardized material and educational programs that are essential for transitions with certain health conditions (Johnson et al., 2008; Kelly, 2011; Kim & Soeken, 2005; Lindsay et al., 2010; Trachtenberg & Ryvicker, 2011). This collaboration can help the health-care team to convey information accurately and consistently to ensure client-centred education and readiness

for a care transition and decrease readmissions (Kim & Soeken, 2005).

For further discussion and more detailed information about client-centred learning strategies, we encourage you to consult the Registered Nurses' Association of Ontario Nursing Best Practice Guideline *Facilitating Client Centred Learning* (2012a).

RECOMMENDATION 3.2:

Use standardized documentation tools and communication strategies for clear and timely exchange of client information at care transitions.

Level of Evidence = IIb

Discussion of Evidence:

A care transition is a complex, high-risk process and ineffective information exchange can lead to adverse outcomes (Laugaland et al., 2012; Kerr, 2002). Systematic reviews of the literature found safe and effective client care transitions need clear and timely communication and documentation of client information (LaMantia et al., 2010; Murray & Laditka, 2009; Ong & Coiera, 2011; Terrell & Miller, 2007). Everyone on the team needs to understand his or her role in coordinating and disseminating accurate client information (Bost, Crilly, Wallis, Patterson, & Chaboyer, 2010; CNO, 2009a, 2009b).

To avoid repetition, duplication or omission of critical client information during information exchanges between settings or health-care providers, discussion and documentation should be streamlined and standardized to ensure clear and accurate transfer of information (CNO, 2009b). Tools and strategies to ensure clear and focused transfer of information include:

- Algorithms;
- Checklists;
- Communication exchange models;
- Structures for exchanging information – such as SBAR (Situation, Background, Assessment and Recommendation format);
- Protocols or care pathways that focus on specific care for phases of a health conditions;
- Standardized summary documents; and
- Technology – such as electronic records.

(Collins et al., 2011; CNO, 2009b; Murray & Laditka, 2009; Nosbusch et al., 2010; Parker, Lee, & Fadayevatan, 2004; Trachtenberg & Ryvicker, 2011).

Electronic client record systems provide standardized formats that assist health-care providers to find and exchange information quickly (CNO, 2009b; Helleso & Lorensen, 2005; Murray & Laditka, 2009; Riesenberget al., 2010). Continuity of care during transitions is critical to client satisfaction. However, the clear and timely exchange of client information requires the use of multiple strategies such as use of a common language and standard tools (forms, checklists, and electronic records), and transfer of accountability (at change of shift, setting or health-care provider) (CNO, 2009b, 2009c). Table 2 presents some of these strategies.

Table 2. Strategies for Effective Handoffs –
 Identified in articles on U.S. nursing handoffs in the English-language literature, January 1, 1987, to August 4, 2008.

Strategy Categories	
<p>Communication skills</p> <p><i>General communication</i></p> <ul style="list-style-type: none"> Maintain patient and family confidentiality Be concise but thorough in conveying essential information Convey information clearly; ask questions if something isn't clear Keep report patient centered <p><i>Preparation</i></p> <ul style="list-style-type: none"> Manage your time so that you're prepared to give report Gather necessary materials (such as patient charts, your own shift notes) <p><i>Transfer of responsibility</i></p> <ul style="list-style-type: none"> Verify that the person receiving report understands and accepts transfer of responsibility Delay such transfer if there are concerns about patient status or stability <p><i>Language</i></p> <ul style="list-style-type: none"> Speak clearly and at a moderate pace Use clear, specific language Keep all remarks objective; avoid judgmental statements Avoid the use of jargon, acronyms, or abbreviations <p>Standardization strategies</p> <p><i>Standardize the process</i></p> <ul style="list-style-type: none"> Provide opportunity to ask and respond to questions Develop guidelines, tools (templates, forms, checklists, scripts), policies, and procedures Use a tool to ensure that essential information is consistently included Tailor report tools as appropriate for different areas or situations (such as change of shift, patient transfer between units) Report information in the same order every time Use a verification process (such as reading back) to ensure that information is both received and understood Develop a teamwork contract and have team members sign it Use a mnemonic <p><i>During face-to-face communication</i></p> <ul style="list-style-type: none"> Use interactive questioning <p><i>During walking rounds or bedside report</i></p> <ul style="list-style-type: none"> Check equipment Check for missing information or ask additional questions Include patient and family in discussion of plans and goals <p><i>Monitor, evaluate, or audit the process</i></p> <ul style="list-style-type: none"> Create an evaluation tool Use spot checks Provide direct feedback as soon as possible Modify the process as needed Focus on system problems 	<p>Technologic solutions</p> <p><i>Use an electronic (computerized) handoff system</i></p> <ul style="list-style-type: none"> Give report in front of computer (makes it easy to look up relevant information) <p><i>Use an audio- or videotaped report</i></p> <ul style="list-style-type: none"> Plan ahead what you want to say Report information in the same order every time Stop the recorder when necessary to cut out distractions Listen to your taped reports occasionally to identify areas for improvement Ask a respected colleague to critique your report <p><i>Use a telephone-based voice technology system</i></p> <p>Environmental strategies</p> <ul style="list-style-type: none"> Limit interruptions and distractions Create a specific place for report that's well lit and quiet Maintain patient and family privacy Allow sufficient time <p>Training and education</p> <ul style="list-style-type: none"> Use real-life examples (scenarios, stories) in class and "what-if" scenarios during practice Use role-playing to teach effective handoff skills Teach assertiveness and listening skills Address hierarchical and social issues (for example, by discussing how to communicate effectively with those above and below you in the hierarchy, how social and cultural norms affect communication) Discuss and address human factors (such as stress, fatigue, sensory or information overload) Provide adequate refresher training or education Create posters, pocket cards, Web-based resources, and other tools to reinforce handoff skills <p>Staff involvement</p> <ul style="list-style-type: none"> Involve staff in the development of guidelines, tools (templates, forms, checklists, scripts), policies, and procedures Involve staff in the development of a training program <p>Leadership</p> <ul style="list-style-type: none"> Have consistent expectations for compliance Facilitate nurse–physician dialogue to identify problems and find solutions Allow adequate time to plan an implementation strategy for a new handoff process Find early adopters and champions to help demonstrate effectiveness Link the shift handoff process to performance evaluation

From "Nursing Handoffs: A Systematic Review of the Literature," by L. Riesenberg, J. Leitzsch and J. Cunningham, 2010, *American Journal of Nursing*, 110, p.24. Copyright [2010] by Wolters Kluwer Health. Reprinted with permission.

Communication and information exchange between providers and clients after a transition can reassure clients and help them manage their symptoms, recognize complications and ask questions. It can be done through follow-up phone calls or electronically (Kelly, 2011; Mistiaen & Poot, 2008).

RECOMMENDATION 3.3:

Obtain accurate and complete client medication information on care transition.

Level of Evidence = IV

Discussion of Evidence:

Medication reconciliation

Systematic reviews of the literature report communication of accurate and complete client medication information on transition (such as admission, transfer or discharge) is essential for providing excellent health care (LaMantia et al., 2010; Ong & Coiera, 2011). Medication reconciliation is a Required Organization Practice (ROP) in the Accreditation Canada Qmentum accreditation program. Accreditation Canada (2014, p.14) describes medication reconciliation as “a structured, shared process whereby health-care professionals:

1. Work with the client, family, and caregivers (as appropriate), and at least one other source of information, to generate a Best Possible Medication History (BPMH). A BPMH is a list of all medications (including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements).
2. Identify and resolve differences (discrepancies) between the BPMH and medications ordered at transition points.
3. Document and communicate up-to-date information about client medications to the client (and their next service provider, as appropriate)."

Accreditation Canada Qmentum standards assist organizations to adopt evidence-based practices known to improve the quality and safety of Canadian health care (Accreditation Canada, 2014). For organizations to meet the medication reconciliation ROPs they must reconcile clients' medications during care transitions where clients are at high risk of potential adverse drug events (refer to Recommendation 1.2). For more information about Accreditation Canada's standards for medication reconciliation refer to the *Accreditation Canada, ROP Handbook 2014*, available at <http://www.accreditation.ca/sites/default/files/rop-handbook-2014-en.pdf>.

Resources and tools are available to assist health-care providers in establishing systematic and comprehensive medication reconciliation practices. The Institute for Safe Medication Practices (Canada) and Safer Healthcare Now both have online medication reconciliation resources and tools to assist health-care providers with implementing medication reconciliation practices. They are available through their respective website at <http://www.ismp-canada.org/medrec/> and <http://www.saferhealthcarenow.ca/EN/Interventions/medrec/Pages/resources.aspx>. Tools such standardized paper or electronic forms, read-back checklists and use of dedicated personnel can be used to assist in the collection of accurate and timely medication information and to promote safety by preventing the inappropriate use of medication during care transitions (Chevalier, Parker, MacKinnon, & Sketris, 2006; Laugaland et al., 2012; Murray & Laditka, 2009).

Discharge medication history summary

For safety and follow-up medication reconciliation during care transitions, a written summary of the client's medication history should be prepared at discharge or transition listing:

- ▣ What medications were used (medical history);
- ▣ What medications were discontinued; and
- ▣ What are the current and new medication prescriptions required on transition.

(LaMantia et al., 2010; Malcolm et al., 2008).

Nurses need to be familiar with their professional standards and review their organization's policy and procedures on medication reconciliation. The accountability for medication reconciliation at care transitions is shared with all interprofessional team members caring for the client.

RECOMMENDATION 3.4:

Coach the client on self-management strategies to promote belief in their ability to look after themselves on care transition.

Level of Evidence = IIb

Discussion of Evidence:

Medication reconciliation

Self-management is a phrase for all the actions clients must undertake to achieve or maintain health, and includes belief in their own ability to manage the medical and emotional aspects of their health – to look after themselves on care transition (RNAO, 2010b, 2012a). Clients manage their own care better when nurses teach them about:

- ▣ Their condition;
- ▣ Warning signs and symptoms to watch for and how to respond to them;
- ▣ When to seek assistance; and
- ▣ Diet and treatment regimens such as medications.

(LaMantia et al., 2010; Wilkes, Cioffi, Warne, Harrison, & Vonu-Boriceanu, 2008).

Systematic reviews of the literature report clients who receive pre- and post-discharge education on care, treatment, medications and activities of daily living have favourable post-transition outcomes such as reduced readmission rates and adverse drug events and increased client and family satisfaction (Kim & Soeken, 2005; Laugaland et al., 2012, Parker et al., 2004; RNAO, 2010b, 2012a; Rydeman & Tornkvist, 2010; Scott, 2010). Coaching clients on self-management strategies helps to build their confidence in themselves. Nurses have the opportunity to coach clients on the treatment regimens and provide training on the skills required to self-manage their health conditions. For example, nurses acting as transition coaches can help ready clients for the transition by ensuring they know:

- The names of each medication;
- Why it was prescribed;
- What it does;
- The side effects of the medication and what they may signal; and
- How to take their medications correctly.

(Kim & Soeken, 2005; LaMantia et al., 2010).

Efforts to teach clients self-management skills, whether formal or informal, must be age appropriate and should cover all aspects of a transition – physical, emotional and social (Nosbusch et al., 2010; RNAO, 2010a, 2010b; Scott, 2010). Using an evidence-based education strategy such “ask-tell-ask” helps to ensure clients receive information about self-care when they are ready and receptive (refer to Recommendations 1.3, 1.4, 1.5). The “closing the loop” technique helps a nurse to assess the client’s understanding after the client’s questions have been answered (Miller & Rollnick, 2002; RNAO, 2010b, 2012a). For further information on these strategies consult the following RNAO guidelines, *Facilitating Client Centred Learning* (RNAO, 2012a) and *Strategies to Support Self-Management in Chronic Conditions* (RNAO, 2010b).

Education should also include exploring which tools will help a client with self-management, and how to use them. Medications for example, can pose risks to clients’ safety on transition if they cannot manage them. Samples of three tools designed to assist clients to keep track of their condition and medication include:

- MyMedRec: This portable health record application assists clients in keeping track of their medications, health and other information. It is available at <http://www.ismp-canada.org/medrec/>;
- My Health Passport: This is a wallet sized card that lists medical conditions, past procedures or treatments, medications, allergies and other issues. It was initially developed for youth but now available for older adults. An example is available at <https://www.sickkids.ca/myhealthpassport/>; and
- Personal Health Record: Portable paper or electronic records kept by the client on their health condition and medications are used to facilitate discussions with health-care providers after a care transition. Further information and examples of these types of records are available at http://www.caretransitions.org/caregiver_resources.asp, <https://www.inforoute.ca/index.php/progress-in-canada/experiences-and-perspectives/empowering-patients-with-personal-health-management> and <https://www.mychart.ca/>.

Clients will need education and coaching on the use of any tool and the tool’s role in helping the client to take care of themselves on care transition (Kelly, 2011).

4.0 EVALUATION

RECOMMENDATION 4.1:

Evaluate the effectiveness of transition planning on the client, their family and caregivers before, during and after a transition.

Level of Evidence = IV

Discussion of Evidence:

It is important to evaluate the effectiveness of the preparation of the client, their family and caregivers on their ability to manage care before, during and after a transition. Reviews of the literature report effective transition planning is associated with the following client outcomes; increased ability to adapt and cope; greater feelings of empowerment to self-manage care on transition; improved health outcomes and quality of life; increased client and family satisfaction with care on transition; and reduced readmission rates and adverse outcomes (Naylor et al., 2011; Parker et al., 2004; Scott, 2010; Sheppard et al., 2010).

Nurses can monitor the effectiveness of transition planning strategies to ensure the client is prepared to take care of themselves by watching for:

- Gaps in care;
- A need to clarify or reinforce self-management processes with the client, their family and caregivers;
- Whether clients know what to do in response to warning signs that indicate changes in their health;
- A need for additional resources and education; and
- Whether follow-up appointments have been made with primary care providers or specialists.

(Avoidable Hospitalization Advisory Panel, 2010; Jack et al., 2009; Foust, 2007; Parrish, O'Malley, Adams, Adams, & Coleman, 2009). It is important to understand that everyone learns differently and at a different pace. The Registered Nurses' Association of Ontario guideline *Facilitating Client Centred Learning* (2012a) suggests nurses and members of the interprofessional team allocate time for client preparation to ensure they are able to self-manage care.

RECOMMENDATION 4.2:

Evaluate the effectiveness of transition planning on the continuity of care.

Level of Evidence = Ia

Discussion of Evidence:

Systematic reviews of randomized controlled trials report that evaluation of the following planning elements improves client safety and continuity of care on care transitions:

- ▣ Starting transition planning early, well before discharge;
- ▣ Including the family and caregivers in the planning process;
- ▣ Using client-specific information and education;
- ▣ Communicating effectively with interprofessional team members, clients, their families and caregivers; and
- ▣ Ongoing support of the client after discharge such as referral to community programs or services.

(Bauer, Fitzgerald, Haesler, & Manfrin, 2009; LaMantia et al., 2010; Parker et al., 2004; Rydeman & Tornkvist, 2010; Scott, 2010).

Research indicates the following interventions are effective ways in which to monitor and evaluate the continuity of care and clients' progress and ability to take care of themselves on transition to community services:

- ▣ Case management or nurse-led case management;
- ▣ In-home assessments by specialty trained providers for high-risk clients, their family and caregivers at risk for burnout and caregiver burden;
- ▣ Liaison nurses to bridge care and services, which helps keep clients from deteriorating and supports their families and caregivers;
- ▣ Post discharge telephone follow-up;
- ▣ Primary care follow-up; and
- ▣ Tele-health facilitation with clients about their health concerns.

(Chiu & Newcomer, 2007; Dieterich, Irving, Park, & Marshall, 2010; Endacott, Elliott, & Chaboyer, 2009; Hastings & Heflin, 2005; Latour et al., 2007; Mistiaen & Poot, 2008; Morales-Asencio et al., 2008; Naylor et al., 2011; Trachtenberg & Ryvicker, 2011; Van Haastregt, Diederiks, van Rossum, de Witte, & Crebolder, 2000). However, this same research shows mixed results on which feature of each intervention improves client outcomes (e.g., whether it was the health-care provider who did the follow-up, the method of information delivery or the content of the discussion). That suggests, for example, clients at high risk for readmission (such as frail elderly with multiple chronic conditions who have experienced frequent readmissions within the same year) should be more carefully monitored and evaluated as they are being prepared to self-manage on transition to ensure continuity of care (Avoidable Hospitalization Advisory Panel, 2010; Hadjistavropoulos, Garratt, Janzen, Bourgault-Fagnou, & Spice, 2009; Herndon et al., 2013; Schall et al., 2013; Sevin et al., 2013).

RECOMMENDATION 4.3:

Evaluate the effectiveness of communication and information exchange between the client, their family and caregivers and the health-care team during care transitions.

Level of Evidence = IV

Discussion of Evidence:

Evaluating how effectively people are communicating and exchanging information is important because care transitions involve multiple complex processes and vast amounts of coordination (Ong & Coiera, 2011). Evidence consistently shows the negative impact on client safety when there is communication breakdown and inadequate information exchanged during client transitions (Ong & Coiera, 2011). Effectively communicating accurate client information is essential for safe and effective care transitions (Accreditation Canada, 2013, 2014; LaMantia et al., 2010; Laugaland et al., 2012; Riesenber et al., 2010). However, the exact elements of communicated information that lead to successful care transitions are not known (Collins et al., 2011). We do know that conflicting information or lack of information to the client impacts continuity of care, client safety and the client's ability to self-manage (Helleso & Lorensen, 2005). To enhance the transition planning process, evaluation should include the effectiveness of communication and information exchange between the team and clients, their families and caregivers as well as among health-care providers within and across organization settings (Accreditation Canada, 2013, 2014; Riesenber et al., 2010).

For the effective exchange of information, communication among health-care providers must be clear and contain critical client information such as advance directives and medication lists (LaMantia et al., 2010). Riesenber et al. (2010) and Helleso and Lorensen (2005) identify these barriers to the effective flow of client information:

- ▢ Failure to communicate, poor communication or lapses in communication between interprofessional team members;
- ▢ Illegible handwriting;
- ▢ Inaccurate communication (lengthy, irrelevant or conflicting content);
- ▢ Inaccurate recall of communicated information;
- ▢ Lack of access to information across systems; and
- ▢ Complex social systems within organizations as nurses navigate the social hierarchies of the various disciplines involved in the care of the client.

Nursing has a fundamental responsibility to identify barriers to effective communication and transfer of information between the client, their family and caregivers and members of the interprofessional team (CNO, 2008, 2011). Use of organization approved standardized processes and checklists can help to communicate client information using a systematic approach before, during and after a care transition. This approach can reduce communication barriers and assist the interprofessional team to effectively communicate client information and improve the client's, their families and caregiver's perceptions of the transition process, enhance feelings of involvement and increase satisfaction with client-provider and cross-provider relationships (Hadjistavropoulos et al., 2009).

Use of tools (such as checklists) to review transition processes related to continuity of care and client readiness for a care transition encourages effective information flow, minimizes barriers to the flow of information between clients and health-care providers and ensures care is safe and complete on transition (Hadjistavropoulos et al., 2009).

Education Recommendations

5.0 RECOMMENDATIONS FOR EDUCATION

RECOMMENDATION 5.1:

Health-care professionals engage in continuing education to enhance the specific knowledge and skills required for effective coordination of care transitions.

Level of Evidence = Ia-IV

Discussion of Evidence:

A care transition can be a complex and dynamic process requiring a team of health-care professionals with the knowledge and skills to assess and manage clients to ensure their care needs are met before, during and after a transition. Health-care providers need to learn these skills for safe and effective care transitions:

- ▣ Communicating effectively;
- ▣ Promoting client self-management;
- ▣ Reconciling medication;
- ▣ Assessing client readiness and planning for transitions; and
- ▣ Collaborating with interprofessional team members and clarifying roles.

Communicating effectively

A systematic review of randomized controlled trials and other literature report communication is a fundamental skill for nurses and ineffective communication is a key barrier to successful transitions (Chevalier et al., 2006; Murray & Laditka, 2009; Nosbusch et al., 2010; Ong & Coiera, 2011; Rhudy, Holland, & Bowles, 2008; Terrell & Miller, 2007; Young, Barhydt, Broderick, Colello, & Hannan, 2010; Zwarenstein, Goldman, & Reeves, 2009). Bost et al. (2010) identify the importance of each team member in communicating and disseminating information during client transitions – with each other and with clients, their family and caregivers. Nurses must communicate effectively with interprofessional teams to support collaborative practice; and effective communication strategies can help to successfully coordinate care at transition points (CNO, 2009c; Laugaland et al., 2012; Rhudy et al., 2008; Zwarenstein et al., 2009). Consistent and effective sharing of information promotes clients' trust and increases their confidence in their ability to manage on transition (Bench & Day, 2010; Hadjistavropoulos et al., 2009).

Riesenberg et al. (2010) suggest training and education strategies for effective interprofessional team communication should include:

- ▣ Experiential learning such as role playing;
- ▣ Addressing social and cultural factors that affect communication such as the hierarchical and social contexts of the team;
- ▣ Developing assertiveness and active listening skills; and

▫ Recognizing the impact of factors like stress, fatigue or information overload on communication. Other components of effective communication include using common language and paying attention to the conversation – what actual information is being shared (Bost et al., 2010; Ong & Coiera, 2011).

Organizational settings can enhance communication among settings and health-care providers by developing and approving use of standardized tools (Murray & Laditka, 2009). Nurses should be instructed in how and when to use them because standardized tools promote common language and limit the omission of critical information at transition points (Arora et al., 2009; Bost et al., 2010; Clarke & Persaud, 2011; Hadjistavropoulos et al., 2009; Nosbusch et al., 2010; Ong & Coiera, 2011).

Promoting client self-management

Reviews of the literature report consistent and effective sharing of information across interprofessional team members and with the client helps promotes trust and increases the client's confidence in their ability to self-manage (Bench & Day, 2010). Nurses need to know education and teaching strategies to help clients learn to self-manage (refer to Recommendation 3.1, 3.2, 3.4). For a complete description on education and teaching strategies for clients, their family and caregivers, see the Registered Nurses' Association of Ontario guideline *Strategies to Support Self-Management in Chronic Conditions* (2010b), *Facilitating Client Centred Learning*, (2012a) and *Enhancing Healthy Adolescent Development* (2010a).

Reconciling medication

Accreditation Canada (2014) identifies medication reconciliation at care transition points as a responsibility shared between the client, their family and caregivers and one or more health-care practitioners. During client transitions medication reconciliation often falls to nurses and pharmacists. This requires nurses to learn and have knowledge of their role and responsibilities in performing medication reconciliation (refer to Recommendation 3.3, 3.4). Accreditation Canada (2014) requires organizations provide documented evidence of education on roles and responsibilities for medication reconciliation to staff and health-care providers.

Assessing client readiness and planning for transitions

Nurses require the knowledge and skills to assess each client's care needs to ensure the client's physical and psychosocial readiness (refer to Recommendation 1.3 and 2.1).

To fulfill their responsibility to prepare clients for transitions, nurses need to understand how to give information and education to clients, how to line up resources or equipment for special needs at the new setting, and how to coordinate consultations with other team members such as discharge planners and social workers (Rhudy et al., 2008; Yiu, Chien, Lui, & Qin, 2011). When resources are unavailable, nurses need the skills to work with the receiving setting on other options to ensure continuity of care.

Collaborating with interprofessional team members and clarifying roles

Health-care systems and organizations are complex and have a variety of social structures and hierarchies (Naylor et al., 2011; Murray & Laditka, 2009; Riesenberget al., 2010; Trachtenberg & Ryvicker, 2011). They also have different policies, procedures and professionals involved in client transitions. This can lead to confusion over who does what and may result in nurses identifying other professionals as responsible for many aspects of the client's care transition (Yiu et al., 2011). One study found nurses did not see educating clients for post-discharge medication adherence as their role (Kendall & Deacon-Crouch, 2007).

To be an effective member of the interprofessional team and avoid role confusion and invisibility, nurses must understand their pivotal role in preparing clients for a care transition (Laugaland et al., 2012; Nosbusch et al., 2010; Rhudy et al., 2008; Yiu et al., 2011). Rhudy et al. (2008) and Yiu et al. (2011) say that for nurses to be effective coordinators of information during client transitions they must:

- ▣ Participate in client rounds;
- ▣ Supply an overview of client needs and health concerns;
- ▣ Provide status updates; and
- ▣ Take the initiative to develop, implement and coordinate the delivery and flow of important pre-transition client information among interprofessional team members prior to the transition date.

Nurses need the education, knowledge and skills to communicate effectively; plan, implement and navigate transition planning processes; and critically think to be able to coordinate care and the flow of information for successful client outcomes during care transitions (Rhudy et al., 2008; Zwarenstein et al., 2009).

RECOMMENDATION 5.2:

Educational institutions and programs incorporate the guideline *Care Transitions*, into basic and interprofessional curricula so all health-care professionals are provided with the evidence-based knowledge and skills needed for assessing and managing client care transitions.

Level of Evidence = IV

Discussion of Evidence:

Members of the interprofessional team play a vital role in preparing a client for a care transition and are pivotal to continuity in care, minimizing risk and ensuring the client's needs are met before, during and after a transition (AMDA, 2010; Coleman & Boulton, 2003). Students of nursing and other health-care professions should be taught the aspects of care known to support care transitions and be able to demonstrate at entry to practice the clinical competency to assess and manage transitions, regardless of the client group or setting.

Undergraduate nursing education must emphasize effective assessment and management of client care transitions. In evaluations of discharge planning processes, Nosbusch et al. (2010) identified a tendency for the role of nurses to be invisible. To help promote themselves as valuable and trusted team members, nurses need to increase their visibility by demonstrating their skills and expertise in coordinating care and in preparing clients for transitions. Nurses must understand their role and responsibilities in the interprofessional team and demonstrate these behaviours in interactions with clients, their families and caregivers and with the interprofessional team (Ellis, 2010; Kendall & Deacon-Crouch, 2007; Nosbusch et al., 2010; Ong & Coiero, 2011; Rhudy et al., 2008; RNAO, 2013; Yiu et al., 2011).

To ensure health-care professionals are provided with the evidence-based knowledge, skills and tools needed to assist in assessing and managing clients care transitions, the Registered Nurses' Association of Ontario expert panel suggests incorporating this best practice guideline, *Care Transitions* into interprofessional curricula.

Organization and Policy Recommendations

6.0 RECOMMENDATIONS FOR ORGANIZATION AND POLICY

RECOMMENDATION 6.1:

Establish care transitions as a strategic priority to enhance the quality of client care and safety.

Level of Evidence = III

Discussion of Evidence:

Organizations dedicated to quality and safety must work with their own personnel and community partners to improve the internal and external processes for care transition within, across or between settings and health-care providers (Accreditation Canada, 2013). Organization strategies highlighted in the evidence focus on structures and processes known to support the assessment of clients and management of transitions (refer to [Appendix E](#) for examples). Establishing care transitions as a strategic priority will assist organizations to improve the processes known to support safe and effective care transitions and minimize the risks for optimal client outcomes.

The effectiveness of any model adopted by an organization for care transitions is strongly influenced by the culture and leadership. Organizations that establish care transitions as a strategic priority support their leaders to develop and adopt roles and responsibilities for care transitions that align with the recommendations in this best practice guideline. Roles designed to coordinate transition planning must support effective assessment and management of the client, and include responsibility for meeting client care requirements (Foust, 2007; Parrish et al., 2009).

Organizations that establish care transitions as a strategic priority to improve the quality and safety of client care need to consider their unique characteristics when adopting structures or models to improve care transitions. These characteristics include the population served, team members' roles and responsibilities, how team members interact, values and beliefs, available resources and the network of partners (Martin, 2007). Everyone in the organization and external partners must make improving client transitions a priority. Establishing care transitions as a strategic priority enhances the development of a system-wide approach and encourages the shared development of improvement strategies such as care pathways within and between organizations and compatible technology and standardized documentation practices.

RECOMMENDATION 6.2:

Provide sufficient human, material and fiscal resources and adopt organization-wide structures necessary to support the interprofessional team with client care transitions.

Level of Evidence = III

Discussion of Evidence:

Research on care transitions has identified many types of organization-wide structures that enhance interprofessional team communication and coordination of care during transitions (refer to [Appendix E](#) for structures used in organizations to support care transitions). Some of these structures focus on chronically ill adults, older adults or individuals with mental health disorders; however they have similar features such as assigning a nurse to be case manager, clinical manager or leader of the transition process, and combining nurse-led home visits with telephone follow-up after discharge (Bauer et al., 2009; Callaghan, Eales, Coates, & Bowers, 2003; Cox & Wilson, 2003; Naylor et al., 2011).

Each support structure considered to enhance care transition processes must be assessed for their impact, including what resources it will take to implement them and then to sustain their use over time. For example, evidence supports nurses acting as navigators, discharge coordinators and outreach liaisons to identify and communicate clients' needs (Bowles, Foust, & Naylor, 2003; Nosbusch et al., 2010; Parker et al., 2004). However, these roles require mentorship and partnerships among a network of interprofessional team members both within and external to the organization (Ehrlich, Kendall, & Muenchberger, 2011; Woodward, Abelson, Tedford, & Hutchison, 2004; Yau, Leung, Yeoh, & Chow, 2005). When introducing these roles an organization must consider what is required to fill and maintain them over time (Fillion et al., 2012).

Because organizations are complex with different clients and interprofessional team members, there is no single system support recommended for widespread adoption. Any system support chosen should aim to enhance communication, coordination and continuity of care and ensure high-quality outcomes for clients. However, as organizations move to electronic records, there are many websites available with tools and resources that assist with the coordination and communication of client care before, during and after a transition (refer to [Appendix F](#)).

RECOMMENDATION 6.3:

Develop organization-wide standardized policies and structured processes for medication reconciliation on care transition.

Level of Evidence = III

Discussion of Evidence:

Client safety on care transition is enhanced by ensuring more accurate and complete transfer of medication information (Accreditation Canada, 2013, 2014; ISMP, 2012; Parker et al., 2004; Terrell & Miller, 2007). Organizations must demonstrate a plan is in place to implement and sustain medication reconciliation processes that is led by an interprofessional team (Accreditation Canada, 2014).

Organizations should have standardized policies and structured processes and templates in place to guide health-care providers through the systematic steps necessary to achieve the “best possible medication history” for medication reconciliation. This allows organizations to meet Accreditation Canada’s Required Organizational Practices (2014) to: (a) develop a strategy to partner with clients, their families and caregivers, and at least one other source of information (such as primary care physician, pharmacist) to obtain the best possible medication history; (b) identify and resolve discrepancies, reduce the risk of omitting or duplicating medications from the record, or getting the orders wrong on care transition; and (c) document and communicate up-to date information (refer to Recommendation 1.2, 3.3 and 3.4) (Accreditation Canada, 2014; Accreditation Canada, the Canadian Institute for Health Information, the Canadian Patient Safety Institute, & the Institute for Safe Medication Practices Canada, 2012; ISMP, 2012).

In ambulatory, home and community care, Accreditation Canada (2014) requires organizations to identify and document the types of clients who require medication reconciliation (at risk of potential adverse drug events). A medication risk assessment tool to identify clients at risk is available in the Safer Healthcare Now Medication Reconciliation Getting Started Kit (refer to Recommendation 3.3).

Accreditation Canada (2014) also requires organizations to define roles and responsibilities for completing medication reconciliation and evidence of education provided to staff and health-care providers responsible for the process. There are numerous on-line resources for improving medication reconciliation (refer to [Appendix F](#) for a list of websites on medication reconciliation). One source is the World Health Organization (WHO), which made medication accuracy on transition part of its High 5s Project, launched in 2006 to encourage the global adoption of standardized client safety solutions. WHO offers organizations standard operating protocols to prevent medication errors caused by incomplete or miscommunicated information. More information on standard operating protocols for medication reconciliation is available at: <http://www.who.int/patientsafety/implementation/solutions/high5s/en/index.html>.

RECOMMENDATION 6.4:

Establish organization-wide systems for communicating client information during care transitions to meet all privacy, security and legislated regulatory requirements.

Level of Evidence = IV

Discussion of Evidence:

Health-care organizations are subject to privacy legislation requiring them to develop and implement policies and procedures for sharing client information while protecting privacy and confidentiality. For example, the Personal Health Information Protection Act (PHIPA) (2004) is Ontario’s legislation for balancing the right of clients to privacy and the need to share their health information. The Quality of Care Information Protection Act (QOCIPA) (2004) is specific to health-care providers when sharing client information for the purpose of improving care during Quality of Care reviews by a committee. These Acts support the organization’s development of policies and procedures to guide health-care providers to safely and effectively exchange information on client transition, while protecting the client’s rights to privacy and confidentiality.

A care transition consists of many interactions involving the communication of sensitive client information across multiple health-care providers and settings. Nurses communicate in many ways – including verbally, electronically, by

fax and through paper documentation – when preparing clients for a transition, and they are responsible for ensuring the communication of client information through these means meets regulatory requirements for privacy and security. Additionally, any exchange of client information at any time (shift-to-shift handovers, daily rounds, discharge planning, client, family and caregiver meetings, or referrals to community services), whether internal or external, requires the nurse to adhere to the privacy, confidentiality and security regulations for the safe exchange of client information (CNO, 2009a). Nurses must also adhere to their organization’s policies and procedures and their professional standards on the management, flow and sharing of client information during a care transition.

Furthermore, the Registered Nurses’ Association of Ontario expert panel recommends that an individual within the organization be designated to act as the main contact for nurses and interprofessional team members who have questions about confidentiality and privacy when communicating client information on care transition.

RECOMMENDATION 6.5:

Include care transitions when measuring organization performance to support quality improvement initiatives for client outcomes and interprofessional team functioning.

Level of Evidence = III

Discussion of Evidence:

Improving quality of care and accountability during transitions requires mandatory reporting by organizations of how they are doing according to standardized metrics (AMDA, 2010; Naylor et al., 2011). However, client transitions are a relatively new focus in health-care performance measurement. Evaluating the process is challenging due to different client populations, types of transitions (such as home to long-term care, or acute care to community care) and at what point in the continuum of care it occurs (AMDA, 2010).

In Ontario, the Excellent Care for All Act (ECFAA) (MOHLTC, 2010), available at <http://health.gov.on.ca/en/public/programs/ecfa/default.aspx/>, requires hospitals and health-care providers to assess the client’s care experience, focus on continuous quality improvement, ensure the client is at the centre of the health-care system and make certain care decisions are based on the best evidence and standards. The Act also requires hospitals and health-care providers to implement quality improvement plans for delivery and performance. For more information on this Act and quality improvement plans, a guidance document for Ontario Hospitals is available at <http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/qualityimprove/QIPGuidanceDocument.pdf>. Quality improvement plans must be guided by an evaluation of client outcomes including how the interprofessional team functions and contributes to those outcomes.

Plans should be informed by surveys of client, employee and service-provider satisfaction with the organization’s care processes. They should have performance targets for improvement and indicators for measuring a care transition from the client’s, their families and caregiver’s perspectives (AMDA, 2010; Kelly, 2011). Other quality indicators should measure health outcomes, quality of life, perception of care, use of resources and referral and information systems, and the costs of ineffective client transitions (such as readmissions) (Naylor, 2002). For example, the Institute for Safe Medication Practices Canada recommends in the report *Optimizing Communication about Medications at Transitions of Care in Ontario* (2010) that family health teams make medication reconciliation part of their quality improvement

plans and measure the impact of medication reconciliation on outcomes such as readmission to hospital. Internationally, the World Health Organization's (WHO) High 5s Project (refer to Recommendation 6.3) suggests evaluating any new standardized client safety solution, including medication reconciliation. It suggests this approach for evaluating medication reconciliation:

- ▣ Use a standardized policy and structured process and outcome measures to review the hospital's performance over time on collecting and communicating medication-related information and detecting and reconciling discrepancies and compare the findings to other hospitals;
- ▣ Conduct detailed analyses of adverse drug events when they occur; and
- ▣ Collect qualitative information on medication reconciliation processes from direct observation and interviews with leadership and staff (refer to [Appendix F](#) for the WHO website link to the standard operating protocol fact sheet for evaluation parameters for medication reconciliation).

Interprofessional team functioning is also key for continuity of care and optimum client outcomes on transition (van Servellen, Fongwa, & D'Errico, 2006). Quality improvement initiatives should therefore evaluate the effectiveness of the team's coordination and communication. The Avoidable Hospitalization Advisory Panel report *Enhancing the Continuum of Care* (2010) said improving transitions and optimizing client outcomes requires evaluation of:

- ▣ Client education on the transition and their ability to self-manage at home;
- ▣ Discharge planning processes;
- ▣ Interprofessional team communication; and
- ▣ Timely follow-up in the community.



Research Gaps and Future Implications

The Registered Nurses’ Association of Ontario (RNAO) expert panel, in reviewing the evidence for this guideline, identified these priority areas for research (see Table 3). They are broadly categorized into practice, outcome and health-system research.

Table 3. Priority Practice, Outcomes and Health System Research Areas

CATEGORY	PRIORITY RESEARCH AREA
Practice research	Effective approaches to medication reconciliation across different settings.
	The knowledge and skills required to improve interprofessional team communication during care transitions.
	Interprofessional team practices that optimize information flow during handovers in care.
	Education strategies that optimize the client’s knowledge and readiness for self-management for a transition.
	The profiles and characteristics of long-term care residents who are readmitted to emergency departments.
	The effect of electronic documentation systems with embedded transition-related tools on continuity of care.

RECOMMENDATIONS

CATEGORY	PRIORITY RESEARCH AREA
Outcome research	The interventions that optimize client satisfaction and health outcomes during care transitions.
	The interventions before during and after a transition that prevent readmission or inappropriate transfer of residents from long-term care to emergency departments.
	The generalizability of the “Timing it Right” framework (Cameron and Gignac, 2008) in client populations who do not have stroke.
	The best practices for organizations that optimize client outcomes across non-traditional transition points.
	The organization models, systems, structures and cultures that enhance interprofessional team management of client transitions.
	The valid and reliable tools that optimize coordination and communication of information during care transitions.
	The care models or support structures that promote continuity of care during care transitions.
Health-system research	The operational definitions for a) high-quality care transitions, and b) performance metrics used to measure care transition outcomes.
	The health system structures that support the case management of complex clients before, during and after a care transition.
	The effects of electronic systems on communication and transfer of client information during care transitions.

This list, although not exhaustive, is an attempt to identify and rank the research needed in this area. Many of our recommendations are based on quantitative and qualitative research evidence. Other recommendations are based on consensus or expert opinion. Further substantive research is required to validate the expert opinion. Better evidence will lead to improved practice and outcomes for clients undergoing care transitions.

Implementation Strategies

Implementing guidelines at the point of care is multifaceted and challenging; it takes more than awareness and distribution of guidelines to get people to change how they practice. Guidelines must be adapted for each practice setting in a systematic and participatory way, to ensure recommendations fit the local context (Harrison, Graham, Fervers & Hoek, 2013). The Registered Nurses' Association's (RNAO) *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* (RNAO, 2012b) provides an evidence-informed process for doing that.

The *Toolkit* is based on emerging evidence that successful uptake of best practice in health care is more likely when:

- ▢ Leaders at all levels are committed to supporting guideline implementation;
- ▢ Guidelines are selected for implementation through a systematic, participatory process;
- ▢ Stakeholders for whom the guideline is relevant are identified and engaged in the implementation;
- ▢ Environmental readiness for implementing guidelines is assessed;
- ▢ The guideline is tailored to the local context;
- ▢ Barriers and facilitators to using the guideline are assessed and addressed;
- ▢ Interventions to promote use of the guideline are selected;
- ▢ Use of the guideline is systematically monitored and sustained;
- ▢ Evaluation of the guideline's impact is embedded in the process; and
- ▢ There are adequate resources to complete all aspects of the implementation.

The *Toolkit* (RNAO, 2012b) uses the “Knowledge-to-Action” framework (Straus, Tetroe, Graham, Zwarenstein, & Bhattacharyya, 2009) to demonstrate the process steps required for knowledge inquiry and synthesis. It also guides the adaptation of the new knowledge to the local context and implementation. This framework suggests identifying and using knowledge tools such as guidelines, to identify gaps and to begin the process of tailoring the new knowledge to local settings.

RNAO is committed to widespread deployment and implementation of our guidelines. We use a coordinated approach to dissemination, incorporating a variety of strategies, including the Nursing Best Practice Champion Network®, which develops the capacity of individual nurses to foster awareness, engagement and adoption of BPGs; and the Best Practice Spotlight Organization® (BPSO®) designation, which supports implementation at the organization and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate and sustain multiple RNAO best practice guidelines. In addition, we offer capacity-building learning institutes on specific guidelines and their implementation annually (RNAO, 2012b).

Information about our implementation strategies can be found at:

- ▢ RNAO Best Practice Champions Network: <http://rnao.ca/bpg/get-involved/champions>
- ▢ RNAO Best Practice Spotlight Organizations: <http://rnao.ca/bpg/bpso>
- ▢ RNAO capacity-building learning institutes and other professional development opportunities: <http://rnao.ca/events>
- ▢ RNAO's nursing order sets^G as a tool to facilitate BPG implementation, please email BNOS@rnao.ca.

Evaluating and Monitoring this Guideline

As you implement the recommendations in this guideline, we ask you to consider how you will monitor and evaluate its implementation and impact.

Table 4 is based on a framework outlined in the Registered Nurses' Association's *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* (RNAO, 2012b) and illustrates some specific indicators for monitoring and evaluating of this guideline.

TABLE 4. Structure, Process and Outcome Indicators for Monitoring and Evaluating this Guideline

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Objectives	To evaluate the supports in the organization that allows nurses and the interprofessional team to integrate best practices associated with care transitions into their practice.	To evaluate changes in practice that lead to towards improved outcomes for clients undergoing care transitions.	To evaluate the impact of implementing the guideline recommendations.
System	System structures in place to support organization settings and health-care providers promote safe and effective client transitions within, between or across settings such as legislation.	System wide processes are implemented to support transitions within, between and across settings and health providers.	<ul style="list-style-type: none"> ▣ % of adverse events related to care transitions ▣ % of costs associated with ineffective care transitions related to duplication of diagnostic test and treatments ▣ % of readmission rates due to ineffective transition processes

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
<p>Organization</p>	<p>Organization structures support client transitions within, between or across settings or health-care providers:</p> <ul style="list-style-type: none"> ▫ Communication and information flow mechanisms in place ▫ Availability of personnel designated to assist with client transitions for continuity of care ▫ Education/training availability for interprofessional team collaboration during care transitions 	<p>Facility has adopted and implemented policies and procedures to guide care transitions.</p> <p>Facility provides appropriate in-service training and education programs for health-care professionals at all levels on managing care transitions.</p> <p>Organization utilizes a standard form/approach to provide essential client information to receiving entities in care transitions.</p> <p>Organization has systems, structures and processes to ensure documentation of and access to essential client information (such as health conditions or problems, allergies, height, weight, vital signs, medication profile, advanced care directives) is routinely obtained and sent on transition (such as transfer to long term care).</p> <p>Organization has regulations for the transfer of client information that ensures privacy and confidentiality.</p>	<ul style="list-style-type: none"> ▫ % of avoidable multiple care transitions ▫ % of avoidable readmissions from post-discharge complications or adverse events ▫ % of costs associated with readmissions ▫ % of duplication of diagnostic tests and treatments ▫ % of adverse events on care transition related to poor medication reconciliation ▫ % of information and safety privacy breaches on care transition ▫ % staff receiving training on care transition ▫ % of critical incidents related to lack of information, communication or documentation of critical health conditions and problems, allergies, medication, advanced directives (such as do not resuscitate status) on care transition ▫ % met of Accreditation Canada’s tests of compliance for communication, and medication reconciliation

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Nurse	Educational programs are in place related to the uptake and optimized use of nursing best practices for management of client transitions.	Nursing staff and staff designated as responsible for managing care transitions receive education and training.	<ul style="list-style-type: none"> ▫ % of nurses educated and trained on concepts, policy and procedures and documentation systems for managing care transitions ▫ % of nurses' satisfied with the planning experience and the quality of interaction and collaboration among interprofessional team members involved in care transition processes
Client	Education programs are available to assist clients and family and caregivers to manage care needs on transitions.	<p>Clients receive verbal information and education and follow-up written information based on their needs on care transition in relation to:</p> <ul style="list-style-type: none"> ▫ Medication ▫ Self-Management ▫ Follow-up with health-care providers ▫ Warning signs and symptoms of when to seek assistance from health-care providers <p>Family and caregivers are assessed for ability to support client's care post discharge.</p>	<ul style="list-style-type: none"> ▫ % clients with a pre-discharge needs assessment ▫ % clients whose discharge information is completed in a discharge summary (electronic, written or verbal form) for successful transition to other setting or health-care providers ▫ % of clients with documented transition plan incorporated into plan of care ▫ % of clients satisfied with transition processes ▫ % of clients who self-manage care related to: <ul style="list-style-type: none"> ● medication list ● follow-up appointments ● warning signs and symptoms to be aware of and seek assistance for ▫ % of clients who seek help for warning signs and symptoms

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
			<ul style="list-style-type: none"> ▣ % of clients, family and caregivers educated for each stage of the transition process ▣ % of total time spent on client/family and caregivers education during encounters with interprofessional team ▣ % of clients identified at risk on transition related to safety ▣ % clients who reported satisfaction with quality of life on transition ▣ % of clients who reported satisfaction with care transition ▣ % of medication incidents due to inadequate medication reconciliation on client transition ▣ % of clients readmitted within ≤30 days post transition (includes hospital and emergency room visits)
Financial costs	Mechanism in place to assess costs of managing client transitions (such as case coordinator, navigator, APN in role of transition coordinator, discharge planner).	Yearly budget costs for: <ul style="list-style-type: none"> ▣ Staffing for support of client transitions ▣ Client equipment ▣ Tools for enabling communication and practice (such as assessments, nursing order sets, care plans) 	<ul style="list-style-type: none"> ▣ % of alternate level of care, length of stay costs related to care transition delays ▣ % of readmission to hospital settings (includes emergency room visits) from long-term care within 30 days of transition ▣ % of costs related to adverse client-outcomes post care transition

Other RNAO Resources for Evaluation and Monitoring of Best Practice Guidelines:

- ▣ Nursing Quality Indicators for Reporting and Evaluation (NQuIRE®) were designed for RNAO's Best Practice Spotlight Organizations® (BPSO®) to systematically monitor the progress and evaluate the outcomes of implementing RNAO best practice guidelines in their organizations. NQuIRE® is the first international quality improvement initiative of its kind consisting of a database of quality indicators derived from recommendations of selected RNAO's clinical best practice guidelines. Please [visit http://rnao.ca/bpg/initiatives/nquire](http://rnao.ca/bpg/initiatives/nquire) for more information.
- ▣ Objective evaluation can be done through regular review of nursing order sets (a group of evidence-based interventions that are specific to the domain of nursing) and their effect on the client's health outcomes. Nursing order sets embedded in clinical information systems simplify this process through electronic data capture. Please visit <http://rnao.ca/bpg/initiatives/nursing-order-sets> for more information.



Process for Update and Review of the Guideline

The Registered Nurses' Association of Ontario (RNAO) commits to update its best practice guidelines as follows:

1. Each nursing BPG will be reviewed by a team of specialists in the topic area every five years following publication of the previous edition.
2. Best Practice Guideline Program staff regularly monitor for new systematic reviews, randomized controlled trials, and other relevant literature in the field.
3. Based on that monitoring, staff may recommend an earlier revision. Appropriate consultation with members of the original expert panel and other specialists and experts in the field will help inform the decision to review and revise the guidelines earlier than planned.
4. Three months prior to the review milestone, the staff commences planning of review by:
 - a) Inviting specialists in the field to participate on the expert panel. It will be comprised of members from the original expert panel as well as other recommended specialists and experts.
 - b) Compiling feedback received and questions encountered during the implementation, including comments and experiences of Best Practice Spotlight Organizations® and other implementation sites regarding their experience.
 - c) Compiling new clinical practice guidelines^G in the field and conducting a systematic review of the evidence.
 - d) Developing a detailed work plan with target dates and deliverables for developing a new edition of the guideline.
5. New editions of guidelines will be disseminated based on established structures and processes.



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Appendix A: Glossary of Terms

Best practice guideline: Systematically developed statements to assist practitioner and client decisions about appropriate health care for specific clinical (practice) circumstances (Field & Lohr, 1990).

Care transitions: A set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, health-care providers or location (within, between or across settings) (Coleman & Boulton, 2003). Accreditation Canada (2013, 2014) identify care transitions as (but not limited to) any of the following: visits to primary care providers, referral to a specialists or health services or providers, handovers at shift change, transfers or discharges, or relocations to another health-care setting (also see Interfaces of care).

Client: A client may be an individual (patient, person, resident, or consumer) and include family members, parents or caregivers, substitute decision makers, groups or members of the community (CNO, 2013b; Mental Health Commission of Canada, 2009). See Substitute Decision Maker.

Client-centred approach: An approach in which clients are viewed as whole; it is not merely about delivering services where the client is located. The client-centred care approach involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making (CNO, 2013b; RNAO, 2006a).

Clinical practice guideline: See best practice guideline.

Consensus: A process for making policy decisions, not a scientific method for creating new knowledge. Consensus development makes the best use of available information, be that scientific data or the collective wisdom of the participants (Black et al., 1999).

Culture: Culture refers to the shared and learned values, beliefs, norms and ways of life of an individual or a group. It influences thinking, decisions and actions (CNO, 2013b).

Education recommendations: Statements of educational requirements and educational approaches or/strategies for the introduction, implementation and sustainability of the best practice guideline.

Evidence: Evidence is information that comes closest to the facts of a matter. The form it takes depends on context. The findings from high-quality, methodologically appropriate research, provide the most accurate evidence. As research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to, or stand-ins for research. The evidence base for a decision involves combining the multiple forms of evidence and balancing rigor with expedience while privileging the former over the latter (Canadian Health Services Research Foundation, 2006).

Health literacy: The knowledge and competences required of clients to meet the complex demands of their health (Sorensen et al., 2012).

Interfaces of care: Where “clients are at risk potential adverse drug events includes beginning of service, transfer of care between sites within the same organization, transfer to another service environment (e.g., client moves from a renal program to a long-term care facility), or end of service” (Accreditation Canada, 2014, pg 20). Also see Care transitions.

Interprofessional care: Interprofessional care is the provision of comprehensive health services to clients by multiple health-care providers who work collaboratively to deliver quality care within and across settings (Health Care Innovation Workgroup, 2012; RNAO, 2013a).

Nursing order set: A nursing order set is a group of evidence-based interventions that are specific to the domain of nursing; it is ordered independently by nurses (i.e., without a physician’s signature) to standardize the care provided for a specific clinical condition or situation (in this case, care transitions).

Organization and policy recommendations: Statements of conditions required for a practice setting that enables successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader government or societal level.

Practice recommendations: Statements of best practice directed at the practice of health-care professionals; ideally they are based on evidence.

Psychological readiness: A client’s ability to adapt to a new social context, accept the changing circumstances and develop ways or strategies to make the new context work for them, hence gaining control and turning the situation or transition into a positive experience (Ellis, 2010).

Quality: The degree to which health-care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (WHO, 2009).

Randomized controlled trials: Clinical trials that involve at least one test treatment and one control treatment, concurrent enrolment and follow-up of the test- and control-treated groups, and in which the treatments to be administered are selected by a random process.

Settings: In relation to client care transitions, settings refer to any “transfer between different locations or different levels of care within the same location. Representative locations include (but are not limited to) hospitals, emergency departments, sub-acute and post-acute nursing facilities, the client’s home, primary and specialty care offices, and long-term care facilities” (Accreditation Canada, 2014; Coleman & Boulton, 2003). See care transition.

Stakeholder: An individual, group, or organization with a vested interest in the decisions and actions of organizations that may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem.

Substitute decision maker: A person identified by the Ministry of Health and Long-Term Care: *Health Care Consent Act, 1996* (HCCA) who makes treatment decisions on a continuous basis for someone who is deemed mentally incapable. The HCCA provides a hierarchy of persons eligible, usually a spouse, partner or relative. A power of attorney for personal care (treatment) may not be the same individual who has power of attorney for property (CNO, 2013a; Health Canada, 2006).

Systematic review: The Cochrane Collaboration (2011) says “a systematic review attempts to collate all empirical evidence that fits pre-specified eligibility criteria in order to answer a specific research question.” A systematic review uses systematic, explicit and reproducible methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the review (The Cochrane Collaboration, 2011).

Therapeutic relationship: The therapeutic relationship is grounded in an interpersonal process that occurs between the nurse and the client(s). Therapeutic relationship is a purposeful, goal-directed relationship that is directed at advancing the best interest and outcome of the client (CNO, 2013b; RNAO, 2006b).

Appendix B: Guideline Development Process

The Registered Nurses' Association of Ontario (RNAO) has made a commitment to ensure this best practice guideline is based on best available evidence. In order to meet this commitment, a monitoring and revision process has been established for each guideline every five years.

For this new guideline, RNAO assembled an expert panel of health-care professionals with particular expertise in this practice area. A systematic review of the evidence took into consideration the purpose and scope of the guideline and was supported by six clinical questions. It captured relevant literature and guidelines published between January 2002 and June 2012. These are the research questions that guided the systematic review:

1. What are the most effective assessment and management strategies to ensure continuity of care and safe optimal client outcomes during care transitions?
2. What safety and monitoring strategies should be considered to ensure continuity of care and safe optimal client outcomes during care transitions?
3. What educational supports do nurses and other health-care providers require to effectively assess and manage client care transitions?
4. What organization characteristics support nurses and other health-care providers to effectively assess and manage client care transitions?

This new guideline, *Care Transitions* (2013) is the result of the expert panel's work to integrate the most current and best evidence and ensure the validity, appropriateness and safety of the guideline recommendations with supporting evidence.



Appendix C: Process for Systematic Review and Search Strategy

Guideline Review

The Registered Nurses' Association of Ontario (RNAO) guideline development team's project coordinator searched an established list of websites for guidelines and other relevant content published between January 2002 and May 2012. This list was compiled based on knowledge of evidence-based practice websites and recommendations from the literature. Detailed information about the search strategy for existing guidelines, including the list of websites searched and inclusion criteria, is available online at www.RNAO.ca. Guidelines were also identified by members of the expert panel.

Members of the expert panel critically appraised 12 international guidelines using the *Appraisal of Guidelines for Research and Evaluation Instrument II* (Brouwers et al., 2010). From this review, the following six guidelines were selected to inform the review process:

Joint Commission Resources/Joint Commission International. (2010). *Improving Communication During Transitions of Care*. Oakbrook Terrace, I Illinois: Joint Commission Resources, ISBN: 9781599404097.

Lindsay, M. P., Gubitz, G., Bayley, M., Hill, M. D., Davies-Schinkel, C., Singh, S., & Phillips, S. On behalf of the Canadian Stroke Strategy Best Practices and Standards Writing Group. (2010). *Canadian Best Practice Recommendations for Stroke Care* (Update 2010). Ottawa, Ontario Canada: Canadian Stroke Network.

Malcolm, J., Arnold, O., Howlett, J. G., Ducharme, A., Ezekowitz, J. A., Gardner, M. J.,... White, M. (2008). *Canadian Cardiovascular Society Consensus Conference Guidelines On Heart Failure – 2008 Update: Best Practices for the Transition of Care of Heart Failure Patients, and the Recognition, Investigation and Treatment of Cardiomyopathies*. *Canadian Journal of Cardiology*, 24(1), 21–40.

American Medical Directors Association. (2010). *Transitions of Care in the Long-Term Care Continuum Clinical Practice Guideline*. Columbia, MD: AMDA.

Scottish Intercollegiate Guidelines Network. (2010). *Management of Patients with Stroke: Rehabilitation, Prevention and Management of Complications, and Discharge Planning. A National Clinical Guideline*. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN), 1-101. SIGN publication: number 118.

Registered Nurses' Association of Ontario. (2010). *Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients*. Toronto, Canada. Registered Nurses' Association of Ontario.

Systematic Review

Concurrent with the review of existing guidelines, a search for recent literature relevant to the scope of the guideline was conducted with guidance from the chair of RNAO's expert panel. The systematic literature search was conducted by a health-sciences librarian. The search, limited to English-language articles published between January 2002 and August 2012, was applied to CINAHL, Embase, DARE, Medline, Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews, ERIC, Joanna Briggs, and PsycINFO databases. The initial search for relevant studies pertaining to questions 1 and 2 returned 7937 articles. Due to the volume of research, the inclusion criteria for study methodology was changed and limited to meta-analysis, systematic reviews, integrative reviews, randomized controlled trials and qualitative evidence syntheses. Detailed information about the search strategy for the systematic review, including the inclusion and exclusion criteria as well as search terms, is available online at www.RNAO.ca. Two research associates (master's prepared nurses) independently assessed the eligibility of studies according to the established inclusion and exclusion criteria. RNAO's best practice guideline program manager working with the expert panel, resolved disagreements.

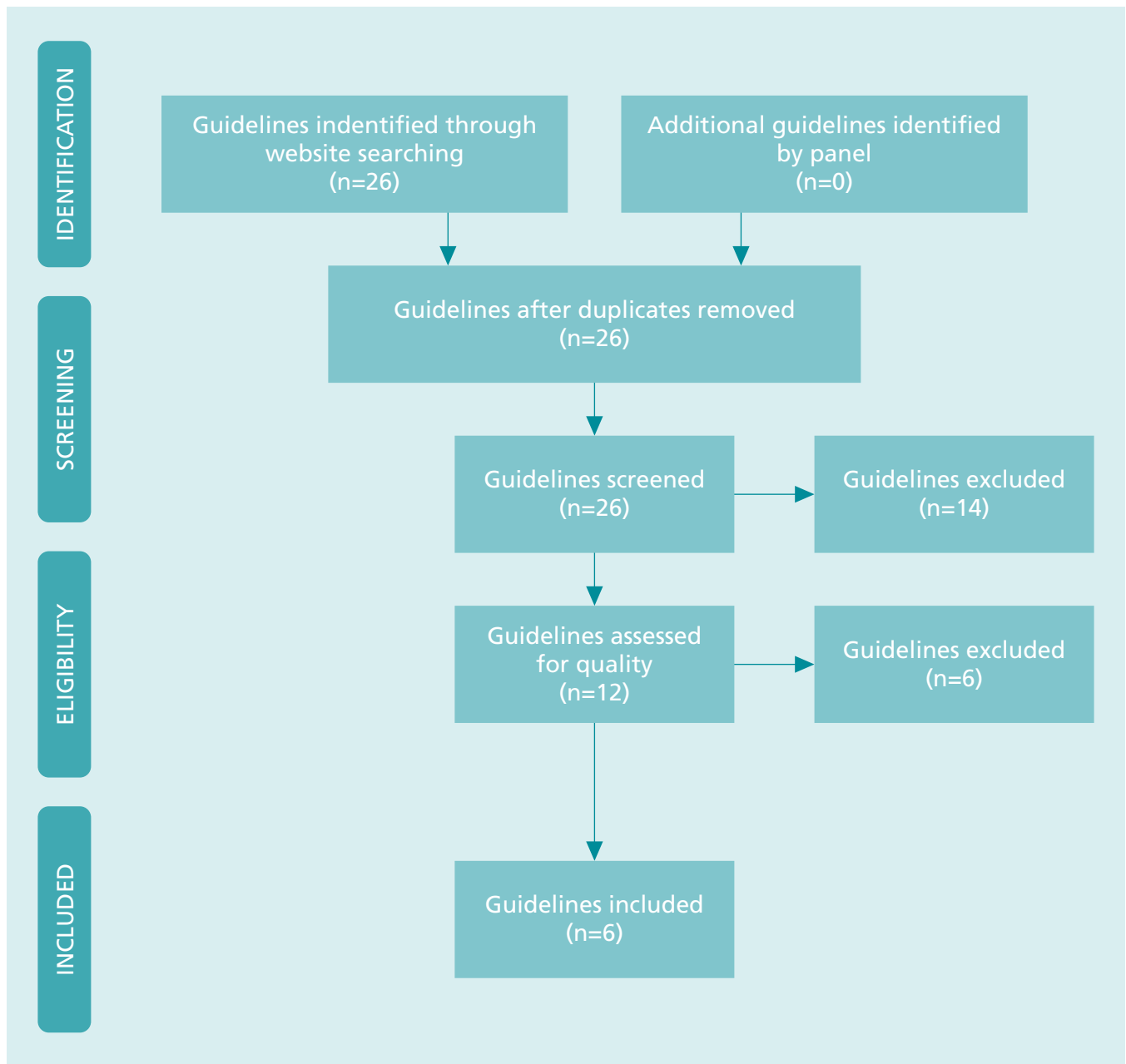
Quality appraisal scores for 16 papers (a random sample of 13% of articles eligible for data extraction and quality appraisal) were independently assessed by RNAO's best practice guideline research associates. Acceptable inter-rater agreement (kappa statistic, $K=0.71$) justified proceeding with quality appraisal and data extraction by dividing the remaining studies equally between the two research associates (Fleiss, Levin, & Paik, 2003). A final summary of literature findings was completed. The comprehensive data tables and summary were provided to all RNAO's expert panel members. In October 2012, the expert panel convened to develop and achieve consensus on guideline recommendations and discussion of evidence.

This guideline is a culmination of the findings from the literature. The following flow diagrams of the review process for guidelines and articles are presented according to PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009).

A complete Bibliography of all articles screened for inclusion is available at <http://RNAO.ca/bpg/guidelines/care-transitions>

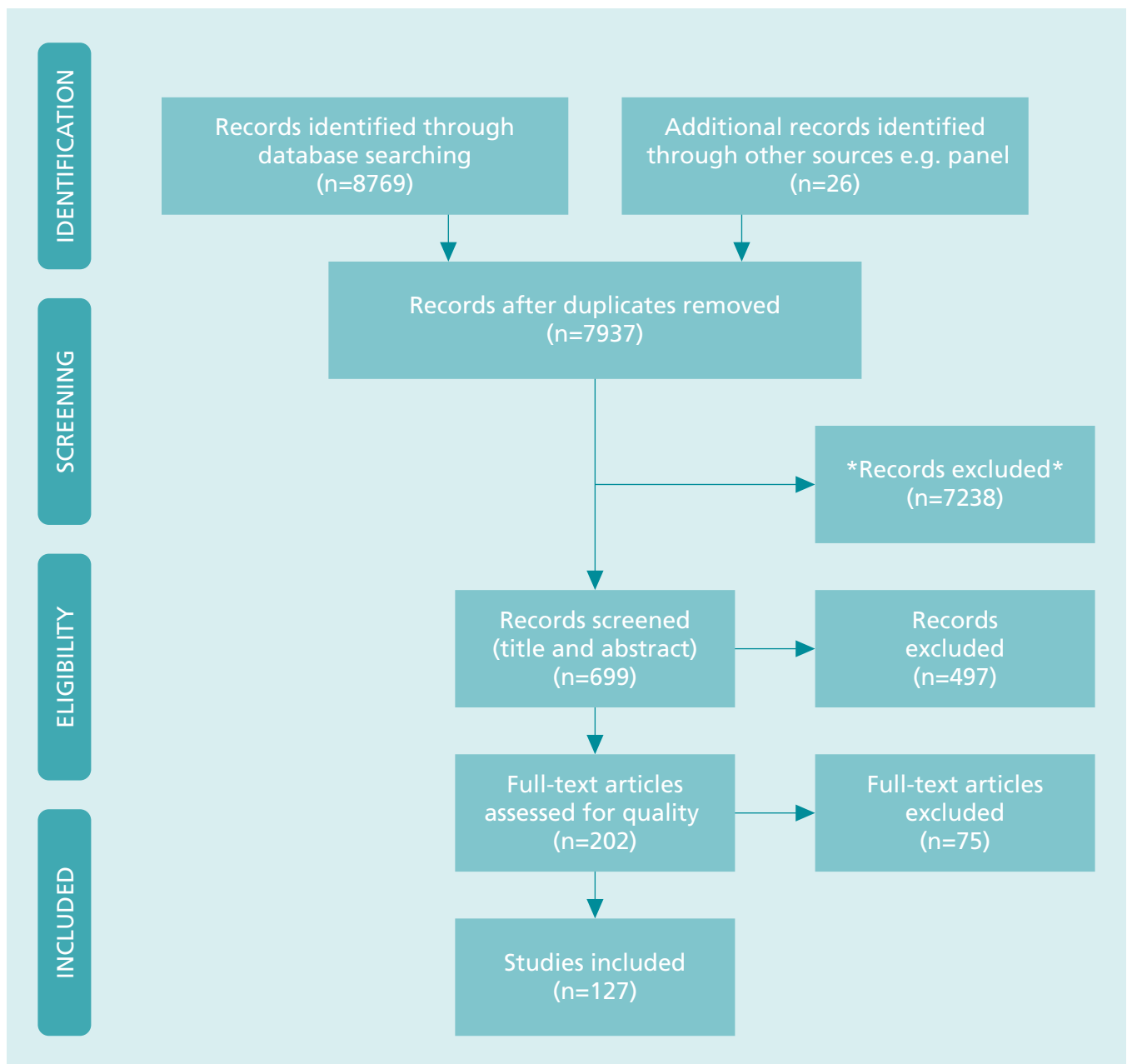


Guideline Review Process Flow Diagram



Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D.G. Altman, and The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *BMJ* 339, b2535, doi: 10.1136/bmj.b2535

Article Review Process Flow Diagram



Records excluded: not within scope and due to volume of studies.

Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D.G. Altman, and The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *BMJ* 339, b2535, doi: 10.1136/bmj.b2535

Appendix D: Example Framework: “Timing it Right”

PHASE	TIME	SETTING	CARE FOCUS	CAREGIVER SUPPORT NEEDS	CAREGIVER OUTCOMES
Event/ Diagnosis	Acute phase of illness Short duration	Acute care hospital	Professional care Focus is on diagnosis and surviving the current event Family care Concern for survival Not aware of what the IC role may entail as a result of this illness event	Information: diagnosis, prognosis, and current treatment Emotional: someone to talk to Training: not required at this time Appraisal: not required at this time	Knowledge: survival/prognosis Enhanced informed decision making regarding treatment Emotional distress
Stabilization	Shortly after patient has stabilized Short duration	Acute care hospital	Professional care Patient has stabilized Focused on specific markers (e.g., mobility) Family care Critical event over Still much uncertainty about future	Information: cause of event, current care needs Emotional: someone to talk Training: initial training to assist with ADL and rehab therapies Appraisal: not required at this time	Information outcomes: awareness about cause Training outcomes: confidence in supporting ADL activities Emotional distress

PHASE	TIME	SETTING	CARE FOCUS	CAREGIVER SUPPORT NEEDS	CAREGIVER OUTCOMES
Preparation	Before patient goes home Short to moderate duration	Acute care hospital or rehabilitation facility	Professional care Clinical emphasis on discharge or in-patient rehab Safety in ADL Secondary prevention introduced Family care Shift focus to care needs when CR returns to community Concerns about ability to meet care recipient's needs in community	Information: ability and how to access community resources Emotional: mounting anxiety and uncertainty about the future, social support Training: some practice of new ADL skills and rehab therapies Appraisal: feedback about ADL supporting activities	Knowledge: re community resources Caregiving self-confidence/self-efficacy Emotional distress Anxiety Perceived social support
Implementation	First few months after patient returns home Moderate duration	Home	Professional care Adaptation to community living Community services Family physician Learning the ropes and recognizes there is still much to learn about providing care Interaction with community services Start to recognize the personal costs of caregiving (e.g., lifestyle and emotional health)	Information: everyday management of ongoing activities Information: potential impact of providing care on caregiver everyday life and health Emotional: fear and anxiety of adapting to providing care in the home Training: additional support to manage care in the home Appraisal: feedback about how they are managing in the home	Improved self-efficacy in managing care Use of community services Perceived social support Emotional support Psychological well-being

PHASE	TIME	SETTING	CARE FOCUS	CAREGIVER SUPPORT NEEDS	CAREGIVER OUTCOMES
Adaptation	After a period of adjustment in the home Long duration	Home	Professional care Care recipient has adapted to living in the home Limited professional care Community reintegration Secondary prevention Family care Concern for care recipient community reintegration Caregivers increasingly confident in their caregiving activities Caregivers experience personal consequences of care Focus on future caregiving needs, their own needs as well as the care recipient	Information and training: focus on caregiver participation in valued activities and interests Information: accessible work and community options (e.g., movie, restaurants) Information: recognition of and planning for the future including future health crisis/ events that may change caregiving demands, what if caregiver gets sick? Emotional: support from others in similar situations, e.g., support groups Emotional: relationship changes Training: assisting with SS community integration Appraisal: continued feedback on how they are managing in the home	Patient community reintegration Perceived social support Decrease in emotional distress Increase in psychological well-being Increased participation in valued activities

From “Timing it Right: A conceptual framework for addressing the support needs of family caregivers to stroke survivors from the hospital to the home,” by J. I. Cameron and M.A.M. Gignac, 2008, *Patient Education and Counseling*, 70, p. 305. Copyright [2008] by Elsevier. Reprinted with permission.

Appendix E: Example: Structures in Organizations to Support Care Transitions

TYPE OF STRUCTURE	COMPONENTS	
<i>Nurse case management</i>	<ul style="list-style-type: none"> ▫ Used with frail older adults in rehabilitation hospital to transition to a home setting; ▫ Interprofessional team partnership (a nurse manager working with a geriatrician); ▫ Access to integrated service environments for coordination and facilitation of appropriate and timely services (nurse case manager has access to hospital inpatient service, hospital-based day rehabilitation service, ad hoc medical consultation, as well as community services such as home care and respite care); and ▫ Clients to have timely access to the nurse case manager (clients have a direct line to the manager). 	Yau et al. (2005)
<i>Home care service model</i>	<ul style="list-style-type: none"> ▫ Nurse-led case management; ▫ Streamlined access to health-care services and resources; and ▫ Focus on clients' functional ability and caregiver burden. 	Morales-Ascenio et al. (2008)
<i>Discharge planning conferences</i>	<ul style="list-style-type: none"> ▫ Client participation; ▫ Focus on education of client, their family and caregivers to make informed decisions; ▫ Timing and location of scheduled meetings to meet the client's needs; and ▫ Conscious use of language that facilitates the discussion and does not create barriers. 	Efrainsson, Sandman, Hyden, and Rasmussen, (2004)

TYPE OF STRUCTURE	COMPONENTS	
<i>Intensive case management</i>	<ul style="list-style-type: none"> ▫ Community-based package of care for provision of long term care for severely mentally ill clients who do not need immediate admission; ▫ Evolved from 2 models: Assertive Community Treatment and Case Management; ▫ Involves smaller caseload and high intensity care; ▫ Requires training for mental health workers; and ▫ Known to increase client satisfaction with care. 	Dieterich et al. (2010)
<i>Transitional discharge model</i>	<ul style="list-style-type: none"> ▫ Peer support volunteers and inpatient staff to support the client with mental health disorders; ▫ Act as a bridge on client transition to community care provider(s); and ▫ Requires effective resourcing, organization readiness and change management activities for successful implementation. 	Martin (2007)
<i>Primary care outreach service by emergency department-trained nurses</i>	<ul style="list-style-type: none"> ▫ Involves outreach services by Emergency Department-trained nurses; and ▫ For prevention of Long Term Care Home transfers to the Emergency Department. 	Codde et al. (2010)
<i>Post-hospital discharge case management</i>	<ul style="list-style-type: none"> ▫ Focus on hospitalized older adults; and ▫ Use of knowledgeable staff to provide case management on discharge from the hospital. 	Popejoy (2011); Parker et al. (2004)
<i>PACT – Patient assessment, assertive: communication, continuum of care, teamwork with trust</i>	<ul style="list-style-type: none"> ▫ Uses handover prompt card template for shift-to-shift and person-to-person handover; and ▫ Standardized reporting templates or scripts to communicate client issues to primary care provider or most responsible physician. 	Clark, Squire, Heyme, Mickle, and Petrie (2009)

TYPE OF STRUCTURE	COMPONENTS	
<i>Project Red – Reengineered hospital discharge program</i>	<ul style="list-style-type: none"> ▫ Use of nurse discharge advocate to develop and coordinate clients hospital discharge plan and ensure onsite preparation of clients; ▫ Creation of a personalized post-hospitalization discharge booklet for the client appropriate to their health literacy and language proficiency levels; ▫ Booklet outlines the essential education information, provider contacts, future scheduled appointments, outstanding test results, medication schedule; ▫ Booklet is given to the client prior to discharge and a copy faxed along with the discharge summary to the primary care provider; and ▫ Post-discharge phone follow-up in two to four days by clinical pharmacist. 	Jack et al. (2009)
<i>Improving transitions for young people from child to adolescent mental health services</i>	<ul style="list-style-type: none"> ▫ Suggest organizations review and identify elements of good practices that support effective transitions for young people who move from child to adolescent mental health services; ▫ Local health services should examine transition practices and adapt them to cater to the needs of young people they serve; and ▫ All models of care must identify any transition points so that they can be incorporated into care pathways and service delivery models. 	Munoz-Solomando et al. (2010)
ROLES	COMPONENTS	
<i>Liaison nurse role</i>	<ul style="list-style-type: none"> ▫ Role used on client move from ICU to ward; ▫ Use dedicated staff to support transitional processes; ▫ Team of nurses trained in critical care used to provide clinical support and advice on hospital wards; and 	Baker-McClearn & Carmel (2008); Chaboyer, Foster, Foster, & Kendall (2004); Chaboyer et al. (2012)

ROLES	COMPONENTS	
<p><i>Other titles for nurses in transition roles</i></p>	<p>Nurse as:</p> <ul style="list-style-type: none"> ▫ Champion; ▫ Clinical nurse specialist; ▫ Discharge coordinator/facilitator; ▫ Mediator; ▫ Navigator; and ▫ Nurse discharge advocate. 	<p>Anderson, Helms & Kelly (2004); Bowles et al. (2003); Caffin, Linton, & Pellegrini (2007); Enguidanos, Gibbs, & Jamison (2012); Finn et al. (2011); Jack et al. (2009); Lee et al. (2011); Nosbusch et al. (2010); Parker et al. (2004)</p>
OTHER TRANSITION SUPPORT STRUCTURES	COMPONENTS	
<p><i>Integrated care pathways for orthopaedics (femur neck fracture)</i></p>	<ul style="list-style-type: none"> ▫ Pathways used to enhance interprofessional team collaboration and communication and subsequently support effective and safe transitions; and ▫ Integrating practice found considerable improvement in client management in reduction in the length of stay. 	<p>Atwal and Caldwell (2002)</p>
<p><i>Successful organization pathways</i></p>	<ul style="list-style-type: none"> ▫ Pathway is supported by the executive board to be used as an organization strategy and vision for care. Supported by executive board; ▫ Must have strong client-centred structures in place; ▫ Clear communication path for why and how pathways are to be used by staff; and ▫ Pathways facilitate within and between organization communications. 	<p>Gerven, Vanhaecht, Deneckere, Vleugels, & Sermeus (2010)</p>

OTHER TRANSITION SUPPORT STRUCTURES	COMPONENTS	
<i>Intervention toolkit to prevent readmissions of elderly</i>	<ul style="list-style-type: none"> ▫ Admission form with geriatric cues; ▫ Facsimile to primary care provider; ▫ Use of a standardized worksheet among interprofessional team members to identify barriers to discharge; ▫ Pharmacist–physician collaboration on medication reconciliation; and ▫ Pre-discharge planning appointments. 	Dedhia et al. (2009)
<i>Discharge teaching</i>	<ul style="list-style-type: none"> ▫ Focus on neonate intensive care unit setting; ▫ Increase in discharge teaching content for parents; and ▫ Includes peer support as part of program. 	Sneath (2009)

OTHER TRANSITION SUPPORT STRUCTURES	COMPONENTS	
<p><i>Policy and procedures to guide the process for:</i></p> <p><i>1. Handovers;</i></p> <p><i>2. Transfer of information; and</i></p> <p><i>3. Assessment and referrals.</i></p>	<p>1. Handovers:</p> <ul style="list-style-type: none"> ▫ Necessary to consider the type of handover process (bedside handover with client validation to ensure accuracy or standard verbal report, taped report); ▫ Consider documentation requirements; ▫ Written versus verbal handoffs between care providers; and ▫ Should address use of rough notes (Are notes kept in client health record or disposed of?). 	<p>McMurray, Chaboyer, & Wallis (2010); McSweeney, Lightdale, Vinci, & Moses (2011); Riesenberget al. (2010); Trachtenberg and Ryvicker (2011)</p>
	<p>2. Transfer of Information:</p> <ul style="list-style-type: none"> ▫ Consider role and responsibilities (who is responsible for cross-checking the transfer reports for diagnosis, medication reconciliation, treatment intervention accuracy) on transition. 	<p>Perren, Conte, DeBitonti, Limoni, & Merlani (2008)</p>
	<p>3. Assessment and Referrals:</p> <ul style="list-style-type: none"> ▫ Use standardized, reliable, and valid instruments for assessments for service and service referrals across service providers and settings; and ▫ Use of standardized referral forms. 	<p>Bowles et al. (2003)</p>

OTHER TRANSITION SUPPORT STRUCTURES	COMPONENTS	
<p><i>Standardized communication and documentation systems</i></p>	<p>Use of any of the following:</p> <ul style="list-style-type: none"> ▫ Framework or structure to guide client handovers or transitions; ▫ Discharge preparation summary sheet; ▫ Checklists (paper or electronic format); ▫ Handover instruments or protocol used when moving a client (from ICU to ward); ▫ Handover sheet with standardized information required for information exchanges between health-care providers and any concerns regarding client discharge); ▫ ICU discharge planning booklet focused on what clients/ families can expect on discharge to the ward (such as lower nurse-client ratios and ward routines); ▫ Discharge alert sheets to facilitate staffing levels on the ward receiving the client. ▫ Integrated electronic documentation systems within point of care systems such as electronic medical health record (EMR) and hospital information systems (HIS's) and electronic health records (EHR's) for inter-organization and external organization continuity of care; ▫ Transfer forms (paper but encourage electronic formats); ▫ Electronic discharge summaries; ▫ Use of health information and communication technology for example, electronic whiteboards for handovers in emergency departments; and ▫ Written information tailored to meet client's needs following verbal education or after any information exchange (client brochures with tips for when discharge). 	<p>Arora et al. (2009); Brown et al. (2009); Bost et al. (2010); Chaboyer et al. (2004); Chaboyer et al., (2012); Collins et al. (2011); Hadjistavropoulos et al. (2009); Helleso and Lorensen (2005); Johnson et al. (2008); Kerr (2002); McFetridge, Gillespie, Goode, & Melby (2007); Nagpal et al. (2010); Perren et al. (2008); Segall et al. (2012); Staggers and Jennings (2009); Terrell and Miller (2007); Wayne et al. (2008)</p>

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Appendix F: Care Transitions – Tools and Resources Websites

RESOURCE	ORGANIZATION	NURSING LED INTERVENTIONS?	URL
BOOSTing Care Transitions	Society of Hospital Medicine, USA	No	http://www.hospitalmedicine.org/ResourceRoom/Redesign/RR_CareTransitions/html_CC/01HowtoUse/00_Howtouse.cfm
Care Transitions Intervention	Dr. Eric Coleman, Colorado, USA	No "Transitions Coach"	http://www.caretransitions.org/structure.asp
Care Transition Toolkit – Health Binder	Hartford Institute for Geriatric Nursing	Patient Toolkit: Template Forms for Medication, Tips for Talking to Doctor, Discharge Planning Checklist, Staying Healthy Tips etc.	http://www.hartfordign.org/practice/caretransitions/
High 5s Project	World Health Organization (WHO)	General Information on Scope of Project	https://www.high5s.org/bin/view/Main/WebHome
High 5s Project	WHO	Standard Operating Protocol Fact Sheet: Medication Reconciliation	http://www.who.int/patientsafety/implementation/solutions/high5s/ps_med_rec_fs_Mar_2011.pdf
Interact II Interventions to reduce acute care transfers from nursing home	Centers for Medicare and Medicaid Services, Commonwealth Fund	No Tools include Transfer form	http://interact2.net/

RESOURCE	ORGANIZATION	NURSING LED INTERVENTIONS?	URL
Medication Reconciliation	Institute for Safe Medication Practices (ISMP)	Yes Tools and education resources for medication reconciliation	http://www.ismp-canada.org/medrec/
	Safer Healthcare Now (SHN)	Getting Started Kit for Acute Care, Long Term Care and Home Care	http://www.saferhealthcarenow.ca/EN/Interventions/medrec/Pages/resources.aspx
Project RED Reengineering Discharge	Joint Commission, AHRQ, USA (Dr. Brian Jack, Boston)	Yes "Nurse Discharge Advocate"	http://www.jcrinc.com/AHRQ-Project-Red/ http://www.ahrq.gov/news/kt/red/redfaq.htm
Transitions of Care Measures	National Transitions of Care Coalition, USA	No Structure, process, outcome measurement tools	http://www.ntocc.org/Portals/0/PDF/Resources/TransitionsOfCareMeasures.pdf http://www.ntocc.org/WhoWeServe/HealthCareProfessionals.aspx
Transitional Care Model	Dr. Mary Naylor, USA	Yes Transitional Care Nurse	http://www.innovativecaremodels.com/care_models/21/overview
Taking care of myself	AHRQ	No Client resources	http://www.ahrq.gov/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome/index.html
Transition to Adult Healthcare Services	Provincial Council of Childrens and Maternal Health	Yes Multiple documents/resources/tools have clinical applicability for pediatric and adult health-care providers in helping youth and their families who will be, or have already been, transitioned to adult services.	http://pcmch.on.ca/initiatives/transition-adult-healthcare-services

Appendix G: Description of the Toolkit

Best practice guidelines can only be successfully implemented if planning, resources, organization and administrative supports are adequate and there is appropriate facilitation. In this light, the Registered Nurses' Association of Ontario (RNAO), through an expert panel of nurses, researchers and administrators, has developed the *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* (2012b). The *Toolkit* is based on available evidence, theoretical perspectives and consensus. We recommend the *Toolkit* for guiding the implementation of any clinical practice guideline in a health-care organization.

The *Toolkit* provides step-by-step directions to individuals and groups involved in planning, coordinating and facilitating the guideline implementation. These steps reflect a process that is dynamic and iterative rather than linear. Therefore, at each phase preparation for the next phases and reflection on the previous phase is essential. Specifically, the *Toolkit* addresses the following key steps, as illustrated in the “Knowledge to Action” framework (RNAO, 2012b; Straus et al., 2009) in implementing a guideline:

1. Identify problem: identify, review, select knowledge (Best Practice Guideline).
2. Adapt knowledge to local context:
 - Assess barriers and facilitators to knowledge use; and
 - Identify resources.
3. Select, tailor and implement interventions.
4. Monitor knowledge use.
5. Evaluate outcomes.
6. Sustain knowledge use.

Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The *Toolkit* is one key resource for managing this process. The *Toolkit* can be downloaded at <http://RNAO.ca/bpg>.

Endorsement



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Driving Quality Health Services • Force motrice de la qualité des services de santé

February 18, 2014

Dr. Doris Grinspun
Chief Executive Officer
Registered Nurses' Association of Ontario
158 Pearl Street
Toronto, ON
M5H 1L3

Dear Dr. Grinspun,

On behalf of the Accreditation Canada, I am pleased to convey Accreditation Canada's endorsement of RNAO's evidence-based clinical Best Practice Guideline on Care Transitions.

As you know, the Accreditation Canada Qmentum program is designed to improve client outcomes and health system performance. Though the onsite survey conducted every four years by peer reviewers, Accreditation Canada evaluates the extent to which an enrolled organization meets standards. An accreditation report identifies the strengths and areas for improvement that will enhance the safety and quality of care within the organization. The organization uses the report to create and implement action plans to enhance their performance.

The RNAO guideline recommendations will support organizations and health-care providers to meet the standard requirements related to Care Transitions. The RNAO rigorous process has resulted in a set of evidence-based recommendations related to nursing and interprofessional practice, organizations and the system that will contribute to improved outcomes before, during and after care transitions. This guideline will greatly contribute to our ability to assist participating organizations in enhancing the safety and quality of care associated with care transitions.

Congratulations on this important work!

With warm regards,

Wendy Nicklin
President and Chief Executive Officer

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INTERNATIONAL
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TRANSFORMING
NURSING THROUGH
KNOWLEDGE

Clinical Best Practice Guidelines

MARCH 2014

Care Transitions

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