RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

the VOICE for
registered nurses,
nurse practitioners
and nursing students
in Ontario

Launching the Transitions in Care and Services, Second Edition, Best Practice Guideline

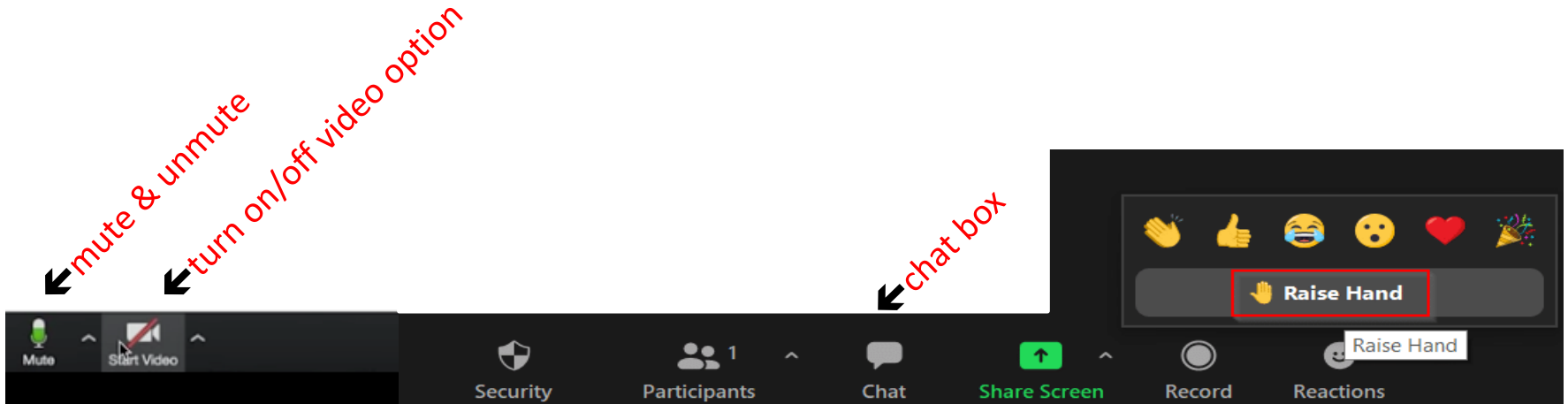
July 20, 2023
12-2 p.m. ET

RNAO.CA

Reminders

- Please keep your lines muted
- If you would like to ask a question, please use the chat box and use the “all participants” option

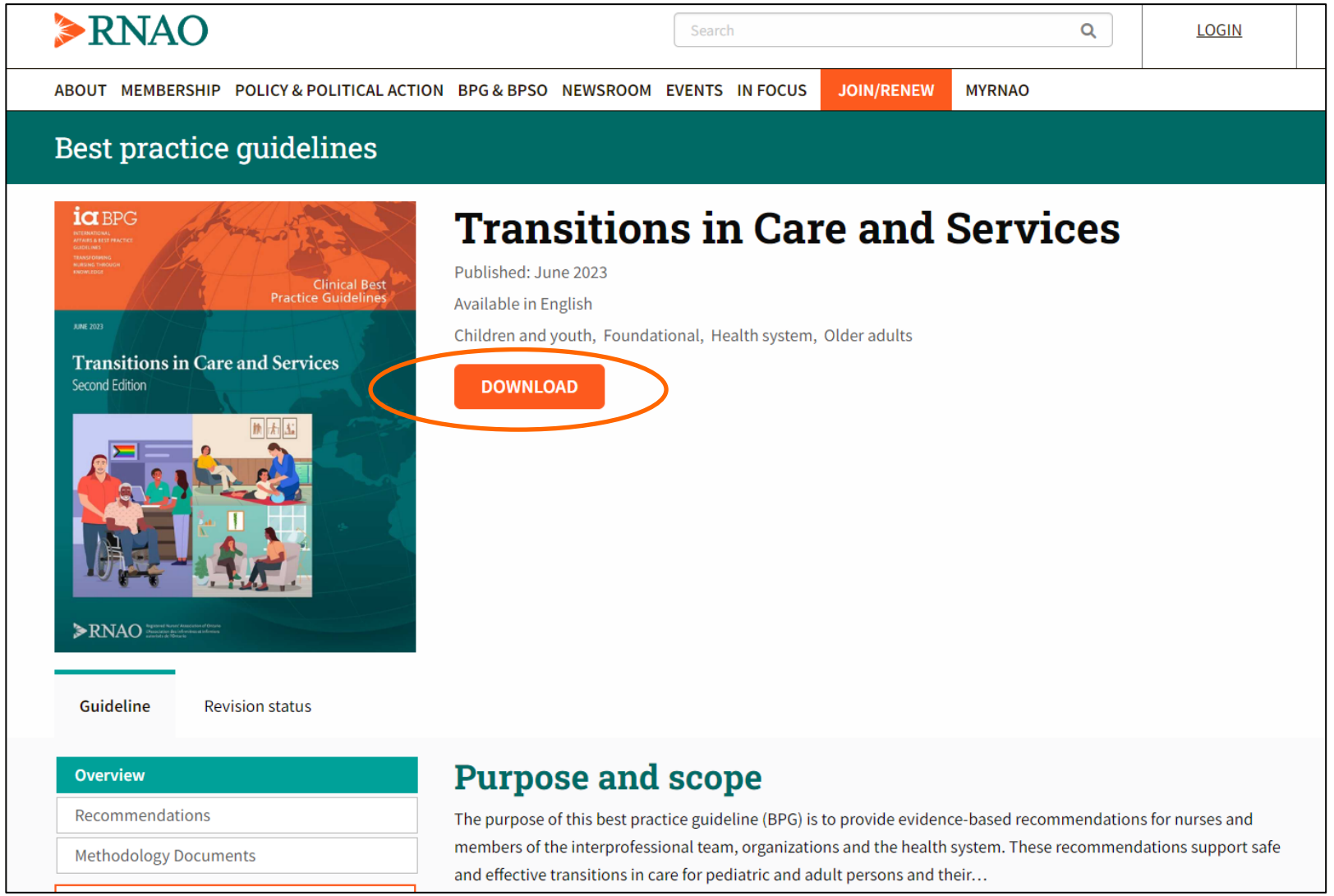
Please note: This meeting is being recorded for internal purposes only



Land Acknowledgement

https://native-land.ca/

RNAO



Download for free:
https://rnao.ca/bpg/guidelines/transitions-in-care

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Presenters

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Expert Panel Co-Chair

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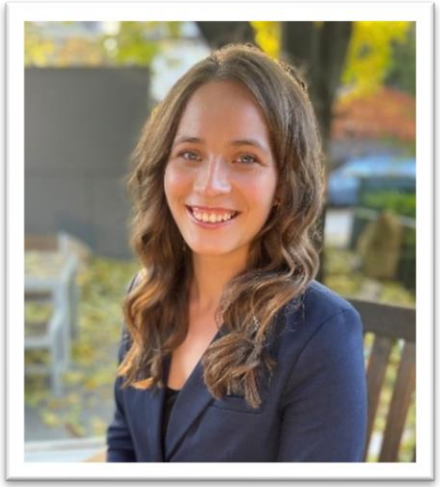
RNAO Team



Lyndsay Howitt
Senior Manger
Guideline Development & Research

Katherine Wallace
Senior Manager,
Implementation Science

Christina Medeiros
Senior Manager,
Evaluation & Monitoring

Objectives

1. Discuss the complexities of transitions in care and the value in using this BPG to improve the safety and quality of transitions

2. Provide an overview of the BPG:
   - Purpose and scope
   - Guideline development process
   - Good practice statements and recommendations

3. Discuss next steps for kickstarting implementation and evaluation of this BPG in your practice setting

Who We Are

RNAO is the professional association of Registered Nurses, Nurse Practitioners (RNs and NPs) and nursing students in Ontario, Canada

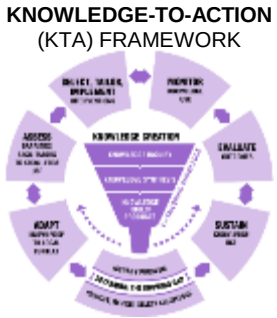
Best Practice Guideline (BPG) Program

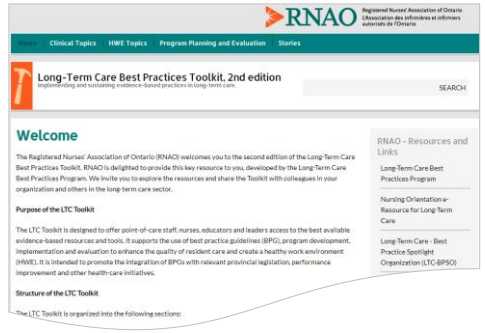
RNAO's BPG program funded by the Government of Ontario since 1999 to:

Develop, disseminate, and **actively support the uptake and sustainability** of evidence-based clinical, healthy work environment & system BPGs and to **evaluate** their impact on resident/client, provider, organizational, and health system outcomes.

50 Best Practice Guidelines

Implementation Toolkits

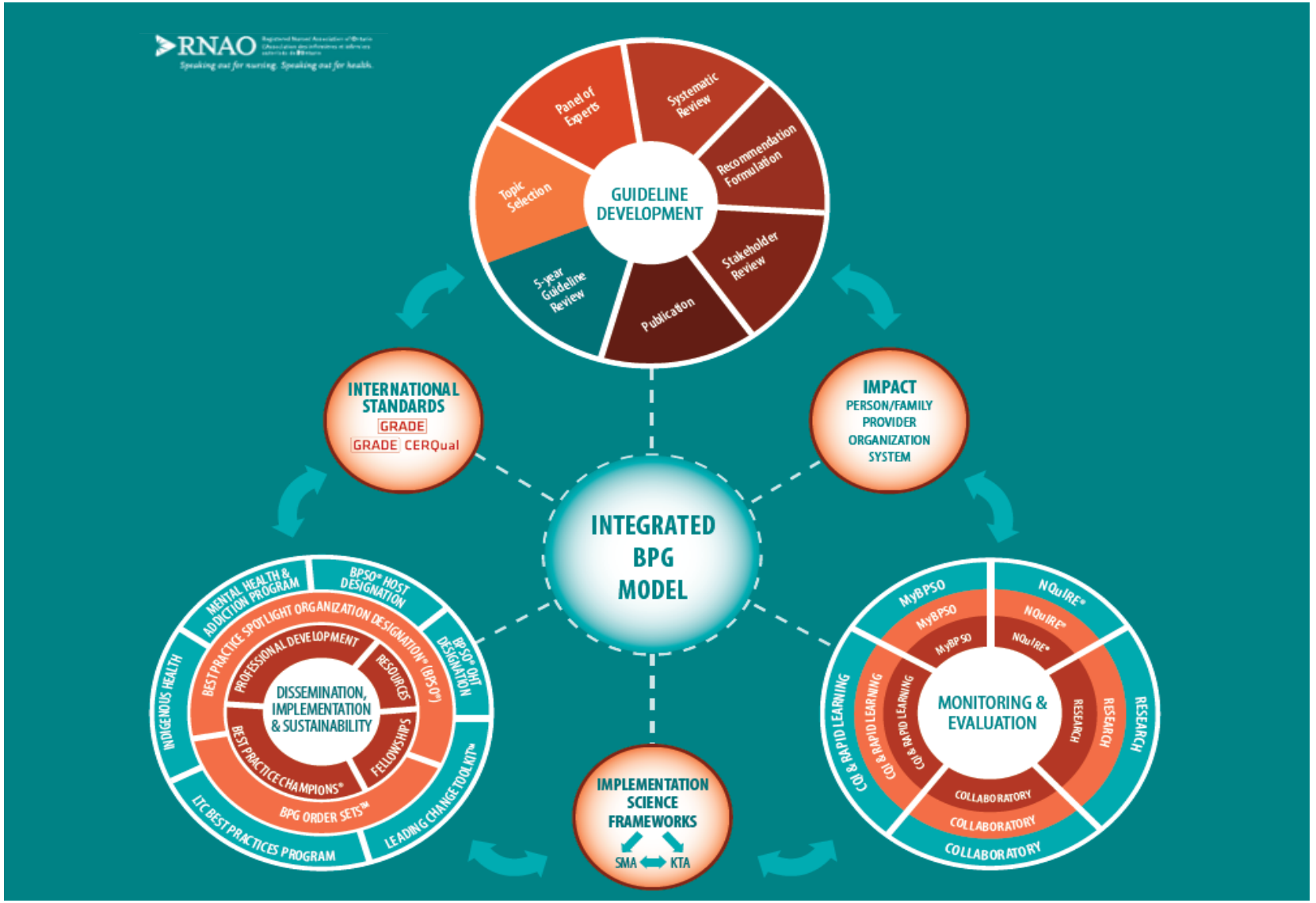




RNAO Best Practice Guideline Program

RNAO Best Practice Guideline (BPG) Program® Model (1999). Graphic updated in 2021, RNAO.ca

Grinspun D., & Bajnok I. (2018). *Transforming nursing through knowledge: Best practices for guideline development, implementation science, and evaluation*. Sigma Theta Tau International.



Background

Transitions in care:

- Significant points in the provision of health care during which a person's information and care needs are being transferred between health and social service providers, interprofessional teams and settings
- Require thoughtful attention, compassion and a strong emphasis on safety
- Many populations experience barriers accessing health and social services during transitions in care

Note: Whenever possible, the term 'transition' has been used intentionally in this BPG instead of the term 'discharge'.

Pages 24-27

Purpose and Scope

To provide evidence-based recommendations for nurses and members of the interprofessional team, organizations and the health system to support safe and effective transitions in care for pediatric and adult persons and their support network.

Includes transitions:

- Within organizations
- Between/across organizations and sectors
- Between healthcare and social care settings

The *Transitions in Care and Services,* Second Edition BPG is a foundational guideline for all health sectors, and central to the work of RNAO Best Practice Spotlight Organizations® and Ontario Health Teams.

Pages 6-7

Guideline Development Pillar

The Expert Panel

- Contributed knowledge & expertise to the development of this resource
- Included persons with lived experience and was interprofessional in composition
- Comprised of individuals with experience in clinical practice, education, research and policy across a range of health and social service organizations, academic institutions, practice areas and sectors

- ***Rhonda Crocker Ellacott (Co-chair)***
- ***Shirlee Sharkey (co-Chair)***
- Alykhan Abdulla
- Chantel Antone
- Susan Delisle Gosse
- Mary Egan
- Cindy Fajardo
- Katherine Hambleton
- Sasha Hill
- Sabina Iqbal
- Sandra Li-James
- Kimberly Moran
- Angeline Ng
- Kathryn Nichol
- Julie Perl
- Carolyn Roberts
- Suzanne Saulnier
- Judy Smith
- Verónica Tíscar-González
- Jennifer Thomas
- Dania Versailles

The guideline also underwent stakeholder review by **over 100 reviewers** from diverse roles and settings.

Developed in consultation with Best Practice Spotlight Organization Ontario Health Teams (BPSO OHT)

BPSO

RNAO
BEST PRACTICE
SPOTLIGHT
ORGANIZATION
OHT

For integrated systems of care

GOAL: To optimize patient outcomes through evidence-based practice and robust staff engagement

The RNAO Team

Guideline Development

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Illustrations

Nishant Bajaj, Web and Graphic Designer

Executive Stewardship

Heather McConnell, Director, IABPG Centre
Doris Grinspun, Chief Executive Officer

GRADE Methodology

Good Practice Statements

- **'Common sense' actions that must be done in practice but are not always happening (**hence the need to reinforce them in the BPG)
- We have high certainty that the benefits outweigh the harms → a systematic review is not needed
- Researchers may no longer be conducting studies on the topic, or the alternative may be unethical
- Do not receive a rating (strong or conditional) but should be interpreted as strong recommendations

Recommendations

- **Actions developed based on evidence from a systematic review**
- They answer a research question about whether an action or intervention should (or should not) be done
- Determined to be *strong* or *conditional* by considering:
  - the benefits and harms;
  - the certainty in the evidence;
  - values and preferences; and
  - the impact on health equity.

Lotfi et al. 2022, Dewidar et al., 2022

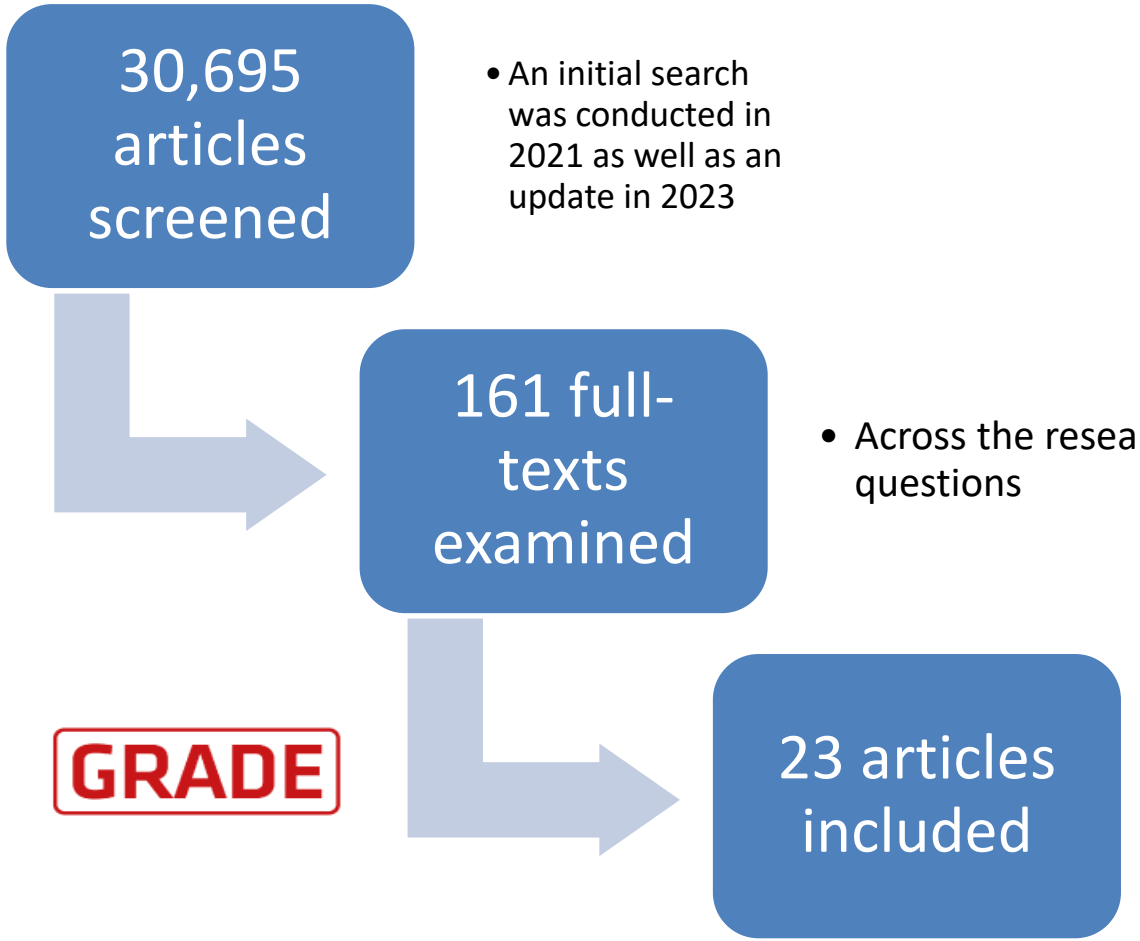
****Both are action oriented statements and follow the same process for implementation**** *Pages 9-10*

Strong and Conditional Recommendations

STRONG RECOMMENDATION	CONDITIONAL RECOMMENDATION
• good quality (high or moderate certainty) evidence	• low or very low certainty evidence
• benefits of a recommended action outweigh harms • most persons will benefit from the recommended practice	• benefits of a recommended action probably outweigh harms • majority of person could receive the recommended action
• there is little variability in values and preferences	• there is greater variability in values and preferences • there is a need to consider a person's values and preferences more carefully than usual

Schunemann et al., 2013

Guideline Development Methodology



- An initial search was conducted in 2021 as well as an update in 2023
- Across the research questions

Recommendation Question #1: Should support from a system navigator be recommended or not for persons encountering a transition in care?

Recommendation Question #2: Should a formal interprofessional cross-sectoral approach be recommended or not to support persons encountering a transition in care?

Refer to Appendix C: BPG development methods (Pages 96-112)

How to Read the Recommendations

A) Recommendation Statement Box

RECOMMENDATION 5.1:

The expert panel suggests that navigation support be provided by health or social service providers for persons with complex care needs encountering a transition in care. This support includes regular follow-up by the provider(s) to assess and respond to the person's current and evolving health and social care needs.

Strength of the recommendation: Conditional

Certainty of the evidence of effects: Very low

B) Discussion of Evidence:

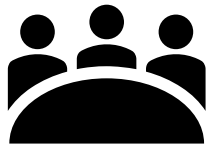
1) **Benefits & Harms**
2) **Values & Preferences**
3) **Health Equity**
4) **Expert Panel Justification of Recommendation**
5) **Implementation tips**
6) **Supporting Resources**

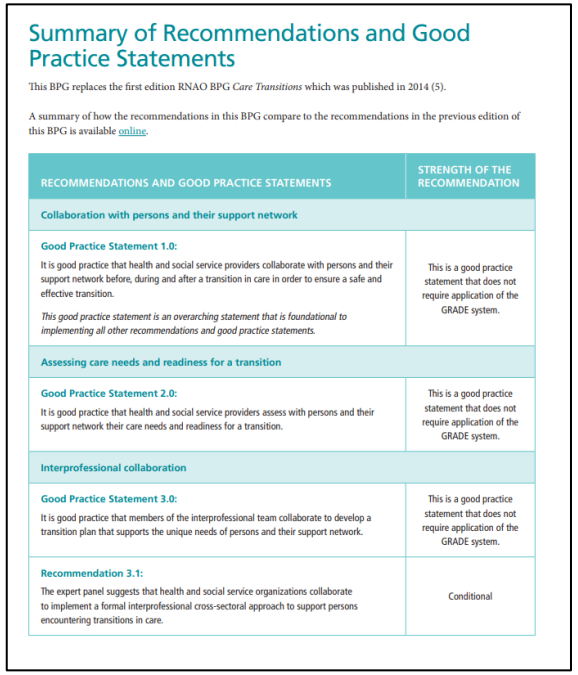
Page 16

Good Practice Statements and Recommendations

Five broad areas:

- collaboration with persons and their support network
- assessing care needs and readiness for a transition
- interprofessional collaboration
- review of medication history
- navigation support





Summary of Recommendations and Good Practice Statements

This BPG replaces the first edition RNAO BPG *Care Transitions* which was published in 2014 (5).

A summary of how the recommendations in this BPG compare to the recommendations in the previous edition of this BPG is available online.

RECOMMENDATIONS AND GOOD PRACTICE STATEMENTS	STRENGTH OF THE RECOMMENDATION
Collaboration with persons and their support network	
Good Practice Statement 1.0: It is good practice that health and social service providers collaborate with persons and their support network before, during and after a transition in care in order to ensure a safe and effective transition. *This good practice statement is an overarching statement that is foundational to implementing all other recommendations and good practice statements.*	This is a good practice statement that does not require application of the GRADE system.
Assessing care needs and readiness for a transition	
Good Practice Statement 2.0: It is good practice that health and social service providers assess with persons and their support network their care needs and readiness for a transition.	This is a good practice statement that does not require application of the GRADE system.
Interprofessional collaboration	
Good Practice Statement 3.0: It is good practice that members of the interprofessional team collaborate to develop a transition plan that supports the unique needs of persons and their support network.	This is a good practice statement that does not require application of the GRADE system.
Recommendation 3.1: The expert panel suggests that health and social service organizations collaborate to implement a formal interprofessional cross-sectoral approach to support persons encountering transitions in care.	Conditional

Pages 12-13

Collaboration with Persons and their Support Network

GOOD PRACTICE STATEMENT 1.0:

It is good practice that health and social service providers collaborate with persons and their support network before, during and after a transition in care in order to ensure a safe and effective transition.

This good practice statement is an overarching statement that is foundational to implementing all other recommendations and good practice statements.

- When people receive information they can understand and act upon, they are better equipped to manage their needs following a transition in care
- Lack of collaboration can result in inappropriate care plans and anxiety for persons and their support network
- To achieve the best outcomes, it is important to use a shared decision-making process

Pages 28-34

Assessing Care Needs and Readiness for a Transition

GOOD PRACTICE STATEMENT 2.0:

It is good practice that health and social service providers assess with persons and their support network their care needs and readiness for a transition.

- Assessing readiness is a central component of transition planning. Low levels of readiness can lead to:
  - feeling unprepared to self-manage care;
  - difficulties coping, and;
  - a higher likelihood of hospital readmission

- Assessments identify the type of care and assistance required following a transition, and barriers that may prevent a smooth transition

- The expert panel highlighted that providers should avoid repeating assessments unnecessarily
  - It can be frustrating for people to repeat their story multiple times
  - Providers should review previous assessments and build on them, highlighting similarities and changes

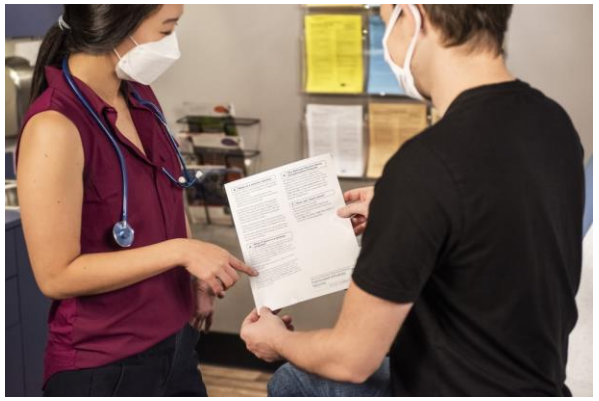
Pages 35-46

Interprofessional Collaboration

GOOD PRACTICE STATEMENT 3.0:

It is good practice that members of the interprofessional team collaborate to develop a transition plan that supports the unique needs of persons and their support network.

- Transition plans promote continuity of care and ensure necessary services, supports and resources have been arranged
- When providers collaborate to develop a transition plan and contribute their combined skills and knowledge, a more comprehensive transition plan can be developed
- Effectively developing a transition plan is contingent on good communication and collaboration



Note: While this statements focuses on collaboration among health and social service providers, it is essential that the interprofessional team also collaborate with persons and their support network when developing the transition plan (refer to good practice statement 1.0).

Pages 47-51

Interprofessional Collaboration

RECOMMENDATION 3.1:

The expert panel suggests that health and social service organizations collaborate to implement a formal interprofessional cross-sectoral approach* to support persons encountering transitions in care.

Strength of the recommendation: Conditional

Certainty of the evidence of effects: Very low

**Refers to a collaborative approach where two or more health or social service providers from different disciplines who work in different sectors work together in a formal way to ensure persons and their support network experience a safe transition in care.*

Discussion of evidence:

- Evidence suggest that formal interprofessional cross-sectoral approaches may increase follow-up visits with a health or social service provider, increase patient satisfaction, improve quality of life, and reduce hospital readmissions within 30 days. However, the evidence is very uncertain.
- No harms were reported.

Pages 52-57

Review of Medication History

GOOD PRACTICE STATEMENT 4.0:

In order to ensure medication safety, it is good practice for health providers to conduct the following in collaboration with the person encountering a transition and their support network:

- obtain a best possible medication history; and
- perform medication reconciliation at all transition points.

- During transitions in care, medications are frequently stopped, adjusted or newly prescribed
- Communication and care processes can break down leading to unintended medication discrepancies including omission of medication, prescribing errors or failures to communicate changes in medications
- Obtaining a best possible medication history and conducting medication reconciliation can help improve medication safety during transitions in care

Pages 59-62

Navigation Support

GOOD PRACTICE STATEMENT 5.0:

It is good practice for health and social service providers to provide persons and their support network with information and support to manage their needs during and after transitions in care.

- When health and social service providers share information and provide support to persons and their support network, it:
  - Provides persons with a means to understand the benefits, harms and outcomes of potential care needs and treatments
  - Empowers people in their care
  - Increases self-efficacy navigating the health-care system, and self confidence to manage health conditions

Pages 63-65

Navigation Support

RECOMMENDATION 5.1:

The expert panel suggests that navigation support be provided by health or social service providers for persons with complex care needs encountering a transition in care. This support includes regular follow-up by the provider(s) to assess and respond to the person's current and evolving health and social care needs.

Strength of the recommendation: Conditional

Certainty of the evidence of effects: Very low

Discussion of evidence:

- Evidence suggests that providing navigation support to persons with complex care needs during a transition in care may increase follow-up visits, reduce hospital readmissions within 30 days of a transition, and may increase patient satisfaction. However, there were some inconsistencies in the results, and the evidence is very uncertain.
- May be especially beneficial for people with complex care needs to help overcome barriers to care.
- No harms were reported in the studies.

Pages 66-73

Navigation Support

RECOMMENDATION 5.2:

The expert panel suggests that peer workers with lived experience offer support to persons with mental health needs who are encountering a transition in care.

Strength of the recommendation: Conditional

Certainty of the evidence of effects: Very low

Discussion of evidence:

- Evidence suggests that offering peer support may increase patient satisfaction and improve quality of life, however the evidence is very uncertain.
- Participants in the studies highly valued support from peer workers.
- No harms were reported.

Pages 74-80

Questions?

RNAO

RNAO

Kickstarting Your Implementation

Develop compelling messages

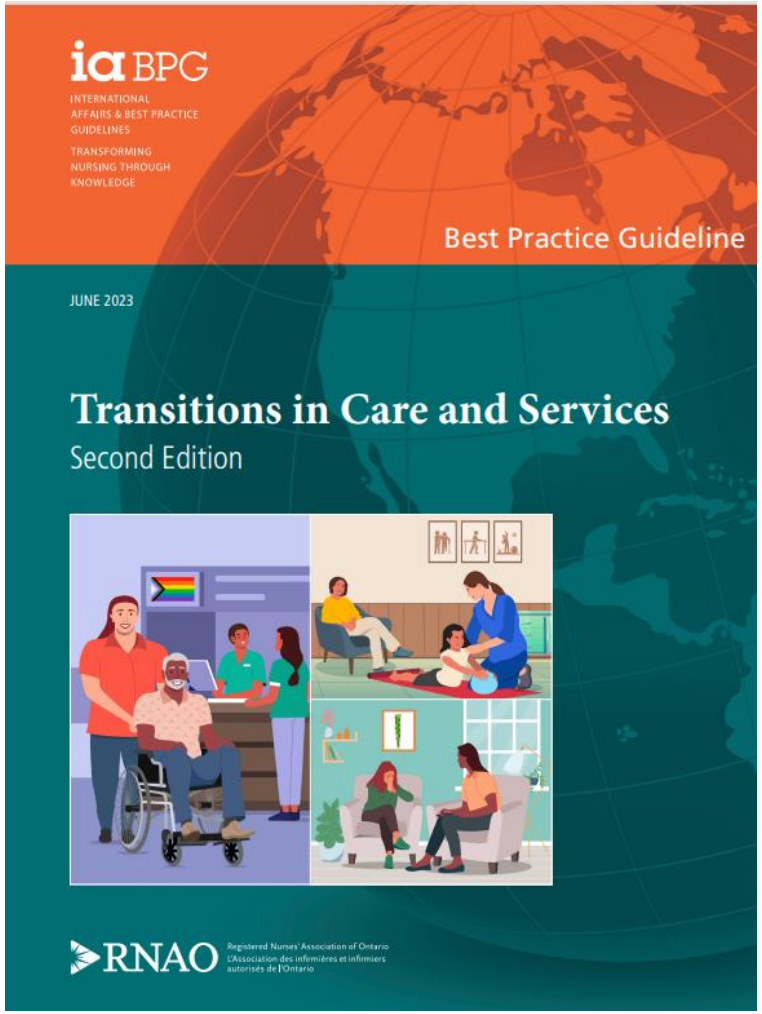
Integrate principles of equity

Establish a change team

Build capacity

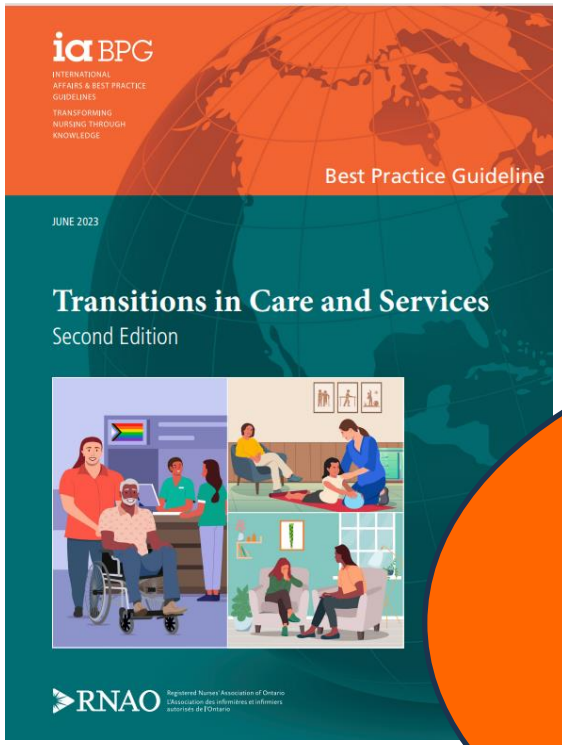
Develop Compelling Messages – The Impact and Implementability of this BPG

What is the impact of this BPG? What are the benefits?



Are the BPG's recommendation or good practice statements implementable?

Impact, as Told by Stories and by Evidence



Create meaning by engaging both the head and the heart

School for Change Agents

Impact, as Defined by the Evidence (Background)
Focus: Health Professionals and Services

A significant point in health care provision

Includes various providers, teams and/or settings

Occurs one or multiple times

Involves a transfer of information and care needs

Impact, as Defined by the Evidence (Background)
Focus: Persons and their families

Represents a major life event

- Home to LTC home or palliative care
- Hospital to home with life changing health status

Possible safety risk or adverse event(s)

- Medication errors, unnecessary tests, underdiagnosis of new health conditions
- Frustration, emotional distress, worsening symptoms, lack of trust of health professionals and the broader health system

Impact, as Defined by the Numbers (Background)

~30% Canadians have had poor care coordination

~200,000 Canadians annually have unplanned hospital readmission

1/11 leave hospital and are readmitted within 30 days of a care transition

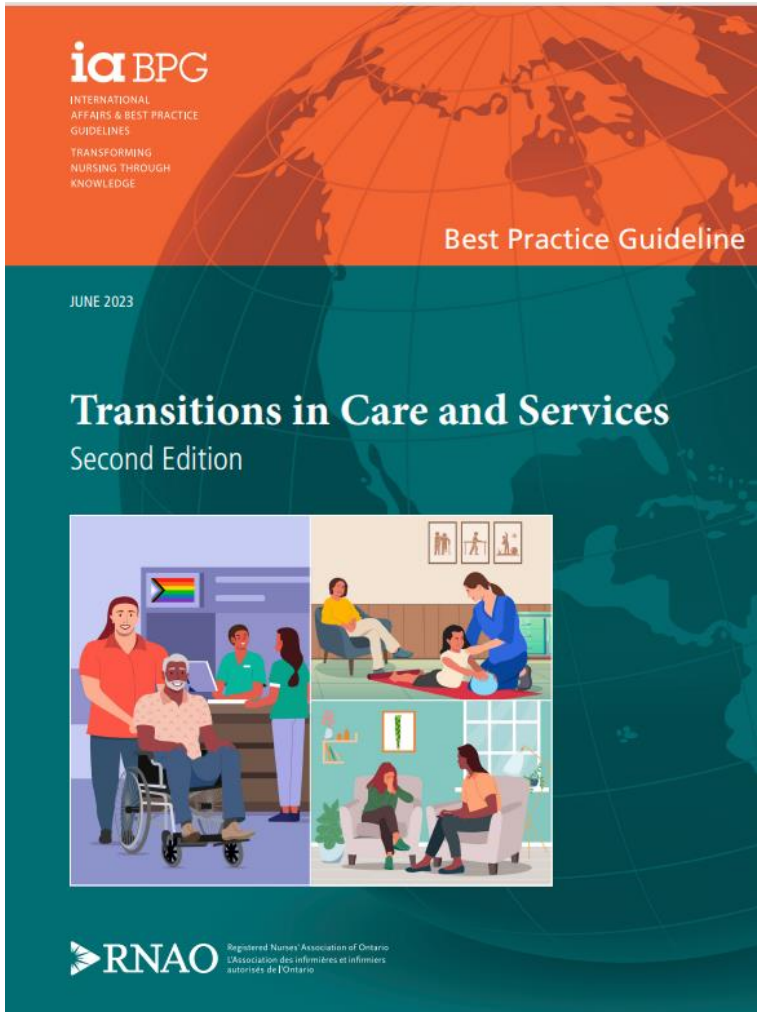
>$2.3 Billion

for unplanned hospital readmissions

25% of unplanned hospital readmissions are preventable

BPG Implementation – Emphasizing Implementability

What is the impact of this BPG?



Are the BPG's recommendation or good practice statements implementable? Are they workable /achievable?

COLLABORATION WITH PERSONS AND THEIR SUPPORT NETWORK

GOOD PRACTICE STATEMENT 1.0:

It is good practice that health and social service providers collaborate with persons and their support network before, during and after a transition in care in order to ensure a safe and effective transition.

This good practice statement is an overarching statement that is foundational to implementing all other recommendations and good practice statements.

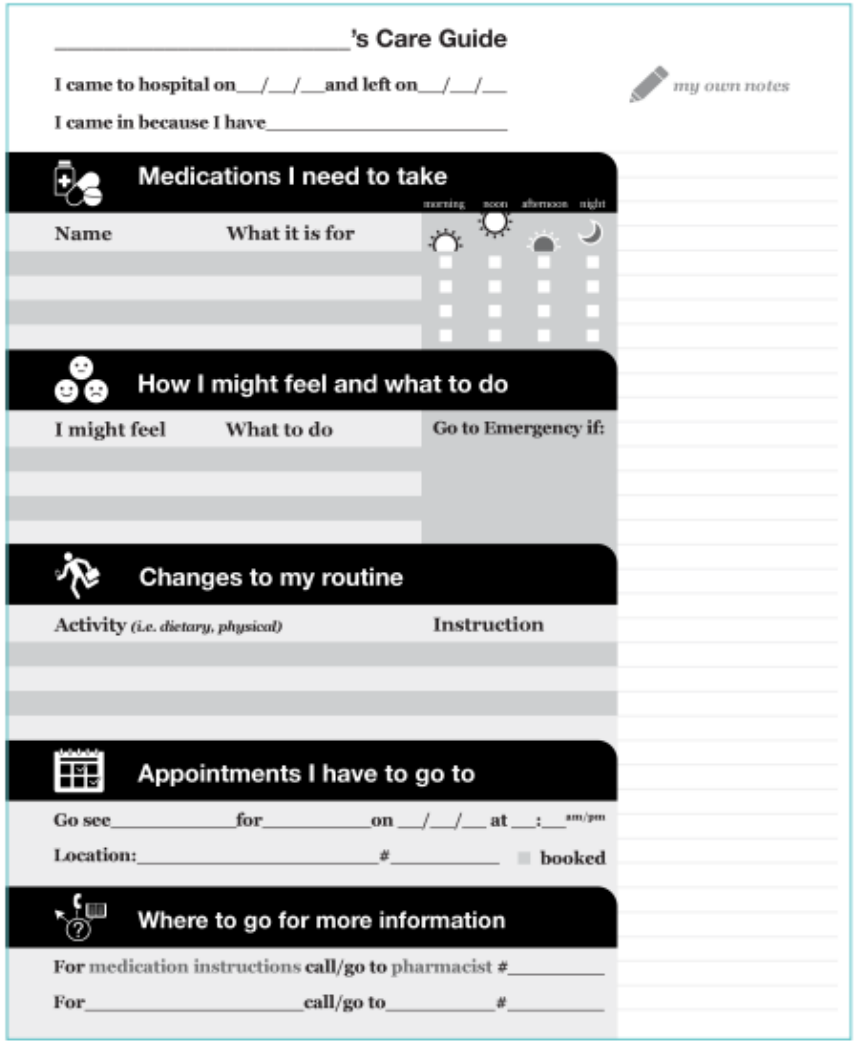
BPG Resources to Support Implementation

Implementation Tips

Implementation Tips from the Expert Panel

- When supporting persons and their support network who are encountering a transition in care, it is important for health and social service providers to ask open-ended questions to ensure the person's voice and concerns are heard and that care is customized to their individual needs, wishes and preferences. Examples of questions include:
  - What are your goals of care and how can we help you achieve them?
  - What can we do to best support you during the transition?
  - Is there anything else about your health or care preference you want to tell me that I haven't asked about?
- Engagement and trust building: when collaborating with persons to plan for a transition, health and social service providers are to do the following:
  - First reflect on the own biases and perceptions that they bring to the relationship.
  - Establish a trusting relationship with the person by being clear about their role, why they are asking certain questions, who the information will be shared with, and how the information gathered will support the plan of care.
  - Identify members of a person's support network who will be involved during the transition in care. This should be done prior to a transition in care or service occurring, and it should be documented within their transition plan.
  - Ask permission prior to asking questions and ensure confidentiality is maintained. A non-judgmental and empathetic approach can help persons and their support network feel supported and safe when discussing their concerns.
  - Ensure persons and their support network are involved in conversations early on when planning for a transition.
  - Ensure persons and their support network have an active voice and are truly engaged in the discussion. Signs of engagement may include asking questions, requesting information, and sharing observations and/or concerns.
  - Hold a meeting to plan for the transition at a time that works well for the person receiving care and their support network. The meeting should be held, whenever possible, at least a few days prior to the transition to allow the person receiving care and their support network time to adjust to the transition, digest information and ask questions.
  - Focus on what interventions best suit the person's goals of care.

Figure 4: Patient Oriented Discharge Summary (PODS)



_____'s Care Guide

I came to hospital on__/__/__and left on__/__/__

I came in because I have_____

my own notes

Medications I need to take

Name	What it is for	morning	noon	afternoon	night

How I might feel and what to do

I might feel	What to do	Go to Emergency if:

Changes to my routine

Activity *(i.e. dietary, physical)*	Instruction

Appointments I have to go to

Go see_____for_____on __/__/__ at __:__am/pm

Location:_____#_____ booked

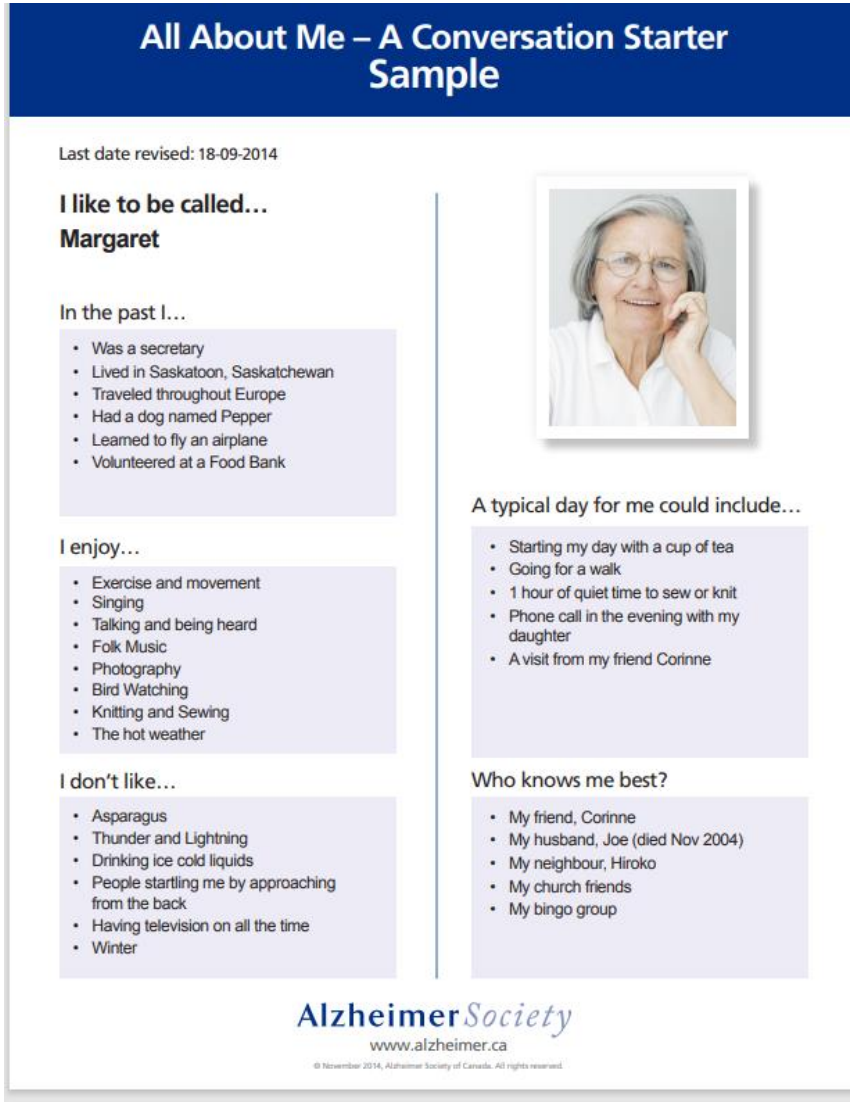
Where to go for more information

For medication instructions call/go to pharmacist #_____

For_____call/go to_____#_____

Source: Reprinted with permission from: Patient Oriented Discharge Summary (PODS). In: Open Lab [Internet]. Toronto (ON): Open Lab; 2019. Available from: http://uhnopenlab.ca/project/pods/.

Appendix G



All About Me – A Conversation Starter Sample

Last date revised: 18-09-2014

I like to be called…
Margaret

In the past I…

- Was a secretary
- Lived in Saskatoon, Saskatchewan
- Traveled throughout Europe
- Had a dog named Pepper
- Learned to fly an airplane
- Volunteered at a Food Bank

I enjoy…

- Exercise and movement
- Singing
- Talking and being heard
- Folk Music
- Photography
- Bird Watching
- Knitting and Sewing
- The hot weather

I don't like…

- Asparagus
- Thunder and Lightning
- Drinking ice cold liquids
- People startling me by approaching from the back
- Having television on all the time
- Winter

A typical day for me could include…

- Starting my day with a cup of tea
- Going for a walk
- 1 hour of quiet time to sew or knit
- Phone call in the evening with my daughter
- A visit from my friend Corinne

Who knows me best?

- My friend, Corinne
- My husband, Joe (died Nov 2004)
- My neighbour, Hiroko
- My church friends
- My bingo group

Alzheimer Society
www.alzheimer.ca

Supporting resources

INTERPROFESSIONAL COLLABORATION

GOOD PRACTICE STATEMENT 3.0:

It is good practice that members of the interprofessional team collaborate to develop a transition plan that supports the unique needs of persons and their support network.

BPG Resources to Support Implementation

Implementation Tips

Implementation Tips from the Expert Panel

- Consider which health and social service providers are to be involved in developing the transition plan to best support the needs of the person and their support network:
  - Health and social service providers who closely understand a community or a person's experiences—such as Indigenous navigators, harm reduction workers or peer workers with lived experience—can offer valuable insight during transition planning.
  - If the person is exhibiting responsive behaviours associated with dementia, complex mental health, substance use or neurological conditions, involving appropriate health and social service providers to develop a behavioural support plan can help reduce the incidence of responsive behaviours during the transition in care.
- Each member of the interprofessional team should be aware of their role in developing the transition plan.
- It is beneficial to have one designated health or social service provider lead the team and coordinate care.
- Underserved populations may face challenges related to language barriers, literacy or systemic racism when it comes to participating in decision making. Interprofessional collaboration—using a trauma-informed and culturally safe approach to care—must be the standard to support underserved populations to express and manage their care needs. A strong emphasis must be placed on providing psychosocial and pragmatic support when developing the transition plan.
- As part of developing a transition plan, providers should collaborate to ensure a "no fail" system is set up so that persons have access to basic necessities such as housing, medications and food, as well as knowledge about local social services in their area and how to access them.
- Transition plans are to be informed by assessments that identify a person's current and evolving care needs. This could include, but is not limited to, information about allergies, code status, medications, diagnostic tests, lab results and special requests made by persons and/or their support network. For information on what factors are to be considered when developing a transition plan, see **Good Practice Statement 2.0**.
- Developing a transition plan also requires collaboration among health and social service providers in both the sending and receiving settings, and an understanding of the resources available in each sector. For further information on developing an interprofessional cross-sectoral approach to support transitions in care, see

Table 6: Implementation Tips from the Evidence

DETAILS FROM THE EVIDENCE
The studies below describe examples of interprofessional teams collaborating to develop a transition plan. They were identified through a literature review conducted on the topic.
Baldwin et al., 2018 ▪ Participants were seen in an interprofessional discharge clinic affiliated with a hospital. ▪ The interprofessional team consisted of a nurse practitioner, clinical pharmacist, nurse case manager and a social worker. ▪ The team discussed the recent hospitalization, reviewed lab and imaging results, and developed an individualized care plan. They placed orders for medical equipment, coordinated referrals and appointments with specialists, reviewed medications and performed a psychosocial assessment. The social worker provided persons with resources related to caregiver support, long-term placement, financial assistance, transportation services and meal assistance, as needed (79).
Otsuka et al., 2019 ▪ Participants were seen in an interprofessional post-acute care clinic in a large academic medical centre. ▪ The interprofessional team consisted of a registered nurse, medical assistant, clinical pharmacist, resident physician, attending physician and social worker who met with each participant to conduct medication reconciliation, develop a plan to optimize medication management, establish referrals, and arrange services and follow-up (74).
Reidt et al., 2016 ▪ Participants were transitioning from a short-term rehabilitation facility to home. ▪ The model involved a geriatrician, nurse practitioner and pharmacist who cared for persons at the rehabilitation facility. ▪ Before the transition, the pharmacist reviewed medications and collaborated with the nurse practitioner to determine the medication regimen. The pharmacist followed-up with the participant in-home or over the telephone one week after the transition, focusing on reviewing medications and assessing adherence. The nurse practitioner recommended items for the pharmacist to address at follow-up, such as monitoring for specific medication side effects and reminding persons of follow-up appointments (80).

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario
brainXchange

Name:
DOB *(dd/mm/yyyy)*:
HCN:
Other ID:

My Transitional Care Plan©

1. My Support System Leading Up to and on the Day of My Move:	
Substitute Decision Maker:	**Phone #:**
Transitional Support Lead - Current Location:	**Phone #:**
Transitional Support Lead - New Location:	**Phone #:**
Healthcare Providers/Teams Available to Support My Move:	
Current Location: ☐ Hospital ☐ Retirement Home ☐ Private Dwelling ☐ Other: **Details:**	
Destination:	**Date & Time of Move:**
Transportation Plan:	**Arrival Plan:** ☐ Arriving alone ☐ Arriving with others
My Room Setup:	
Who will set up my room: ☐ In advance ☐ On the day of the move	**Favourite items to make my room feel like home:**
My Personhood Highlights *(e.g. social/ cultural background)* :	**My Typical Daily Routine** *(e.g., sleep, meals, personal care)*:
	My Smoking/Alcohol/Substance Use Plan:
Section 1 completed by:	
2. My Functional Status:	
My Assistive Devices *(check all that apply and include details pertaining to their use)*:	
☐ Mobility Aids ☐ Communication/Cognition Aids ☐ Hearing/Vision/Dental Aids ☐ Other: **Details:**	
I May Need Help/Reminders for the Following Tasks:	
Hygiene/Personal Care: ☐ Independent ☐ Set Up Only ☐ Some Assistance ☐ Full Assistance **Details:**	
Elimination Care: ☐ Independent ☐ Reminder/Routine ☐ Incontinent **Details:**	
Ambulation/Transfers: ☐ Independent ☐ Supervision ☐ Full Assistance **Details:**	
Nutrition/Eating: ☐ Independent ☐ Set Up Only ☐ Full Assistance **Details:**	
Medication Administration: ☐ Whole ☐ Crushed **Details & Recent Changes:**	
Section 2 completed by:	

Adapted by: The Behavioural Support Integrated Teams (BSIT) Collaborative (Version 1.1 October 2022)
From: North East BSO/Seniors' Mental Health Regional Consultation Service (2020, Apr). My Transitional Care Plan. *North Bay Regional Health Centre.*

Page 1

Appendix H

Care Transitions from Hospital to Home: IDEAL Discharge Planning

Implementation Handbook

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Guide to Patient and Family Engagement

Supporting Resources

REVIEW OF MEDICATION HISTORY

GOOD PRACTICE STATEMENT 4.0:

In order to ensure medication safety, it is good practice for health providers to conduct the following in collaboration with the person encountering a transition and their support network:

- obtain a best possible medication history; and
- perform medication reconciliation at all transition points.

BPG Resources to Support Implementation

Implementation Tips

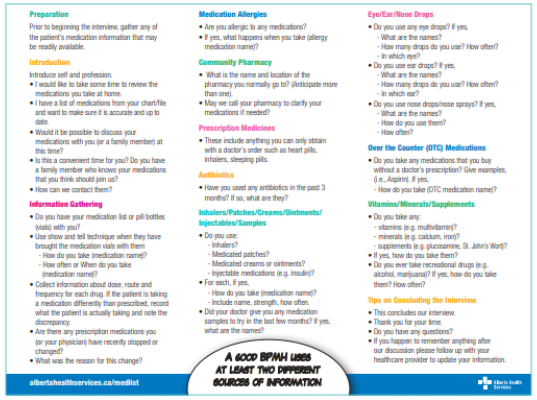
Implementation Tips from the Expert Panel

- A BPMH is to be completed prior to medication reconciliation occurring. When possible, it is helpful for the BPMH to be completed prior to a transition in care as it allows medication reconciliation to occur much more easily and quickly following the transition. If it is not possible to complete a BPMH prior to a transition, it should be conducted following a transition in care prior to medication reconciliation occurring.
- When conducting a BPMH with the person and their support network, medical jargon should not be used. The medication history should include prescribed drugs, over-the-counter medications, herbal supplements and/or other health products, eye drops and topical creams. Culturally safe care involves acknowledging traditional medicines that may be used for medicinal, spiritual, sacred and ceremonial purposes to promote healing.
- Health providers obtaining a health history and conducting medication reconciliation are to carefully consider the interactions, side effects and contraindications of new medications before prescribing them. This is especially important for persons with complex or chronic health conditions.
- Medication reconciliation is a shared responsibility of health providers in collaboration with persons and their support network in all settings where transitions in care occur.
- It is crucial that persons and their support network are informed and given printed material notifying them of changes made to their medications and why these changes were made. A lack of understanding about medication changes can result in polypharmacy and persons continuing to take medications that are no longer needed or medications that have a changed dosage after the transition. In the receiving setting, it is important for persons to have access to a pharmacist who can answer questions about their medications.

Appendix I: Best Possible Medication History Interview Guide

This interview guide from Alberta Health Services provides a list of questions health providers can ask when conducting a best possible medication history.

Figure 6: Best Possible Medication History Interview Guide



Preparation

Prior to beginning the interview, gather any of the patient's medication information that may be readily available.

Introduction

Introduce self and profession.

- I would like to take some time to review the medications you take at home.
- I have a list of medications from your chart/file and want to make sure it is accurate and up to date.
- Would it be possible to discuss your medications with you (or a family member) at this time?
- Is this a convenient time for you? Do you have a family member who knows your medications that you think should join us?
- How can we contact them?

Information Gathering

- Do you have your medication list or pill bottles (vials) with you?
- Use show and tell technique when they have brought the medication vials with them
  - How do you take (medication name)?
  - How often or When do you take (medication name)?
- Collect information about dose, route and frequency for each drug. If the patient is taking a medication differently than prescribed, record what the patient is actually taking and note the discrepancy.
- Are there any prescription medications you (or your physician) have recently stopped or changed?
- What was the reason for this change?

Medication Allergies

- Are you allergic to any medications?
- If yes, what happens when you take (allergy medication name)?

Community Pharmacy

- What is the name and location of the pharmacy you normally go to? (Anticipate more than one).
- May we call your pharmacy to clarify your medications if needed?

Prescription Medicines

- These include anything you can only obtain with a doctor's order such as heart pills, inhalers, sleeping pills.

Antibiotics

- Have you used any antibiotics in the past 3 months? If so, what are they?

Inhalers/Patches/Creams/Ointments/Injectables/Samples

- Do you use:
  - Inhalers?
  - Medicated patches?
  - Medicated creams or ointments?
  - Injectable medications (e.g. insulin)?
- For each, if yes,
  - How do you take (medication name)?
  - Include name, strength, how often.
- Did your doctor give you any medication samples to try in the last few months? If yes, what are the names?

Eye/Ear/Nose Drops

- Do you use any eye drops? If yes,
  - What are the names?
  - How many drops do you use? How often?
  - In which eye?
- Do you use ear drops? If yes,
  - What are the names?
  - How many drops do you use? How often?
  - In which ear?
- Do you use nose drops/nose sprays? If yes,
  - What are the names?
  - How do you use them?
  - How often?

Over the Counter (OTC) Medications

- Do you take any medications that you buy without a doctor's prescription? Give examples, (i.e., Aspirin). If yes,
  - How do you take (OTC medication name)?

Vitamins/Minerals/Supplements

- Do you take any:
  - vitamins (e.g. multivitamin)?
  - minerals (e.g. calcium, iron)?
  - supplements (e.g. glucosamine, St. John's Wort)?
- If yes, how do you take them?
- Do you ever take recreational drugs (e.g. alcohol, marijuana)? If yes, how do you take them? How often?

Tips on Concluding the Interview

- This concludes our interview.
- Thank you for your time.
- Do you have any questions?
- If you happen to remember anything after our discussion please follow up with your healthcare provider to update your information.

A GOOD BPMH USES AT LEAST TWO DIFFERENT SOURCES OF INFORMATION

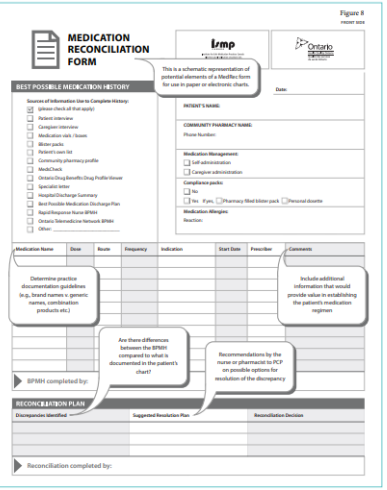
albertahealthservices.ca/medlist

Source: Reprinted with permission from: Alberta Health Services (AHS). Best possible medication history (BPMH) interview guide [Internet]. Edmonton (AB): AHS; 2014. Available from: https://www.albertahealthservices.ca/assets/info/hp/medrec/if-hp-medrec-provider_interview_brochure.pdf

Appendix J: Sample Medication Reconciliation Form

The Ontario Primary Care Medication Reconciliation Guide provides quality improvement strategies for implementing, sustaining and measuring medication reconciliation in primary care settings in Ontario (167). A sample medication reconciliation form can be found on pages 43 and 44 of the guide. The Ontario Primary Care Medication Reconciliation Guide is also available in French.

Figure 7: Medication Reconciliation Form



MEDICATION RECONCILIATION FORM

BEST POSSIBLE MEDICATION HISTORY

RECONCILIATION PLAN

Supporting Resources

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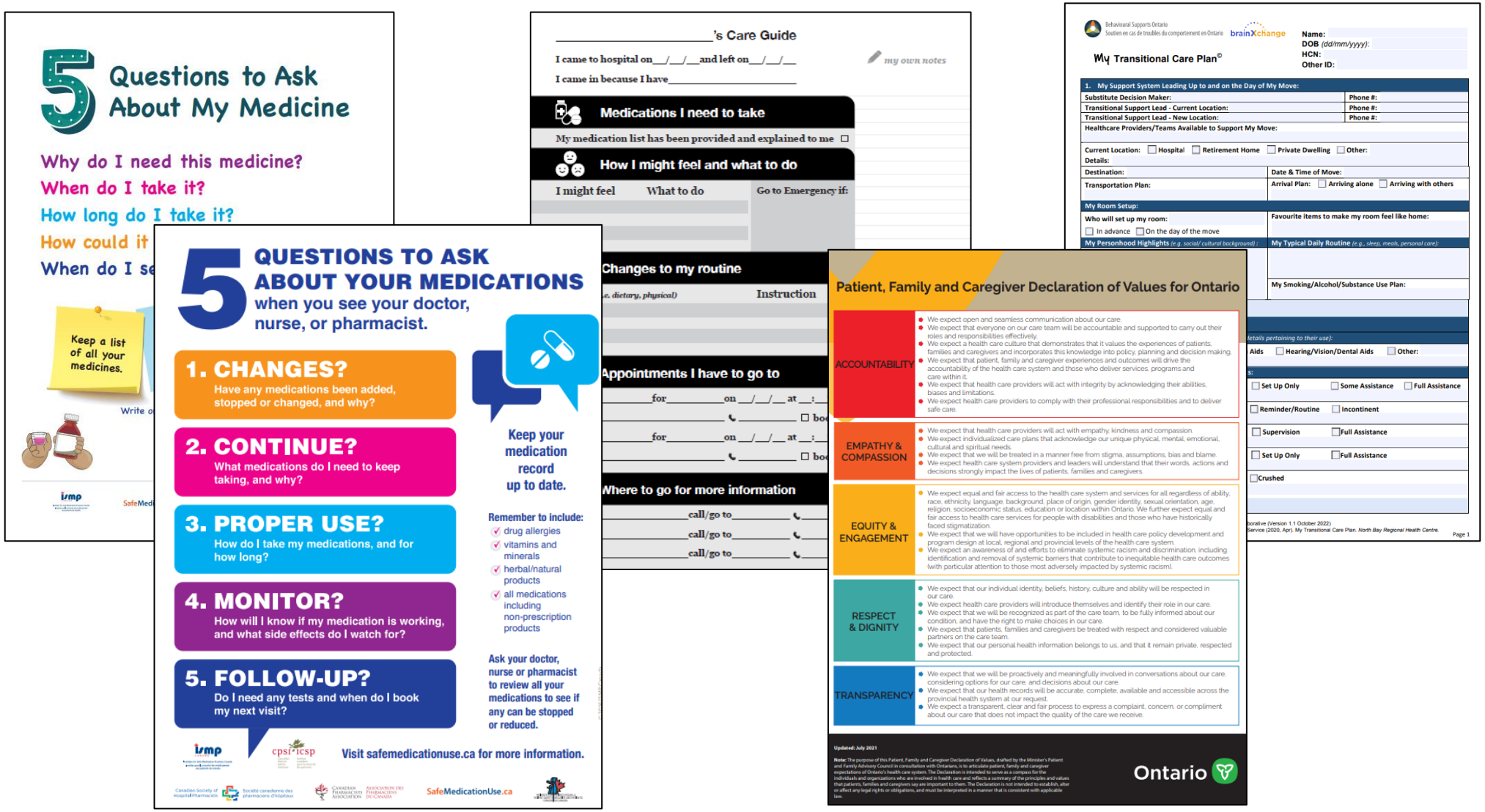
Appendices



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Considerations for Implementing Principles of Equity with this BPG

- To achieve and sustain best practices, we must also have - or, where absent, advocate for - equitable access to care and services
- Must recognize role of social determinants of health (SDOH) and how these determinants impact health outcomes in care transitions
- Actions are needed at the macro, meso and micro levels

Macro (System) Level Needs to Address Inequities and Barriers to Care Transitions

- ❑ Affordable and accessible housing
- ❑ Adequate financial resources for underserviced populations
- ❑ Service access across regions (versus centralized)
- ❑ Increased primary care services (e.g., NP-led clinics)

Micro (Point of Care) and Meso (Organization) Level Actions to Address Care Transition Barriers

- ❑ Current list of relevant resources (e.g., support groups, respite care)
- ❑ Accessible health education (i.e., plain language, visuals, online or print)
- ❑ On-site and written translation supports
- ❑ Training and integration of care principles that embrace cultural safety, anti-racism and equity
- ❑ Safe and effective staffing workloads

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SOCIAL MOVEMENT ACTION FRAMEWORK

FOR KNOWLEDGE UPTAKE AND SUSTAINABILITY

Grinspun, D., Wallace, K., Li, S.A., McNeill, S., & Squires, J. (2020, Spring). Leading change through social movement. *Registered Nurse Journal, 32*(1),15.
Grinspun, D., Wallace, K., Li, S. A., McNeill, S., Squires, J. E., Bujalance, J., ... & Zhao, J. (2022). Exploring social movement concepts and actions in a knowledge uptake and sustainability context: A concept analysis. *International Journal of Nursing Sciences, 9*(4), 411-421.

PRECONDITIONS

- Change is valued and necessary
- Receptivity to change
- Examples of social movements are recognized

KEY CHARACTERISTICS

- Urgent need to take action
- Framing
- Emerging leaders
- Intrinsic motivation
- Individual and collective action
- Public visibility
- Collective identity
- Momentum
- Networks of people and resources
- Core leadership structures

OUTCOMES

- Goals and outcomes are met
- Change is scaled up, out, or deep
- Capacity in leading change is increased

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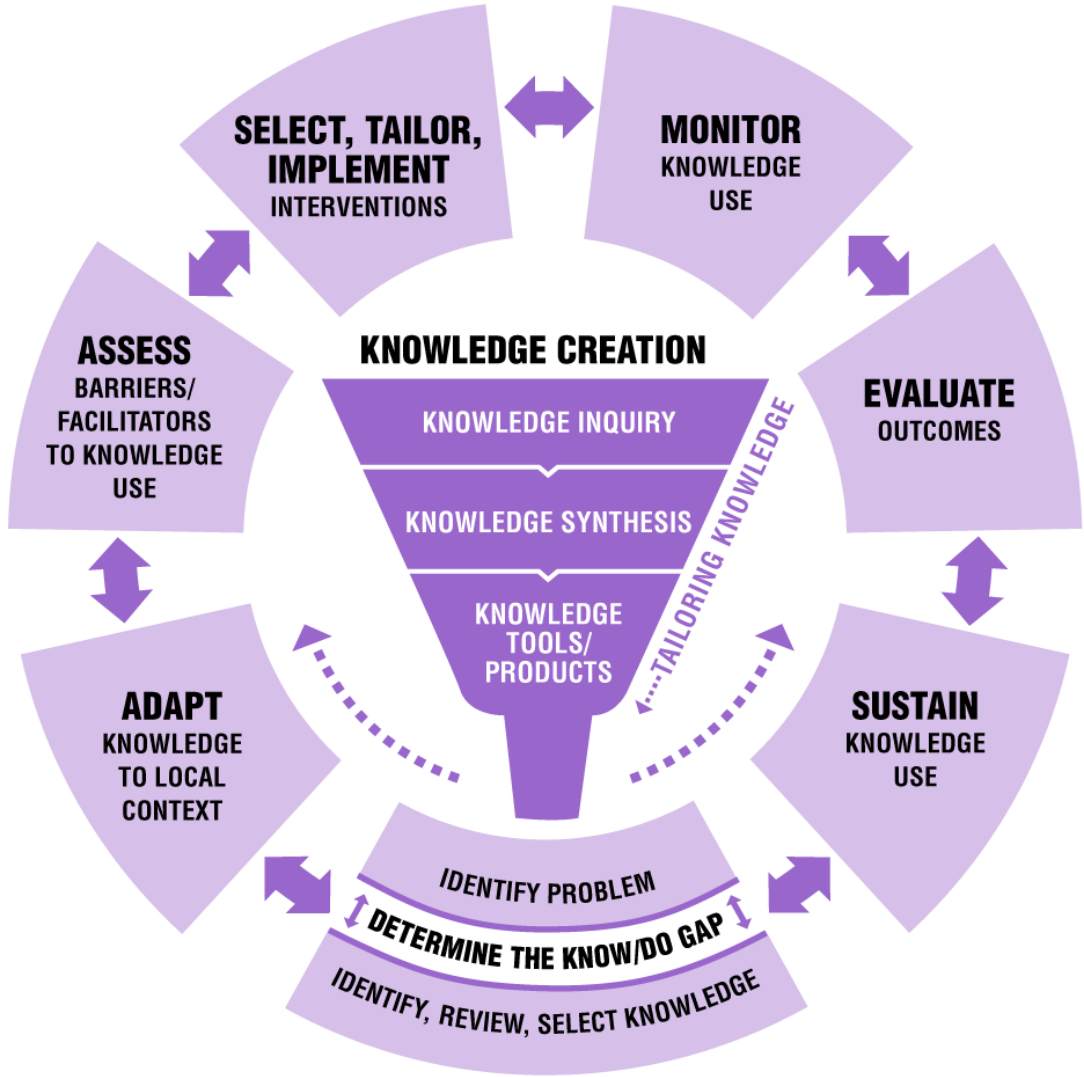
KNOWLEDGE-TO-ACTION FRAMEWORK

Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: time for a map? *Journal of Continuing Education in the Health Professions*, 26(1), 13-24. Used with permission.



Championing change by mobilized change agents

[Engaging persons with lived experience | RNAO.ca]

[Is your change team ready to engage persons with lived experience? | RNAO.ca]

[Considerations for getting started | RNAO.ca]

Practicing Completing a Gap Analysis

REVIEW OF MEDICATION HISTORY

GOOD PRACTICE STATEMENT 4.0:

In order to ensure medication safety, it is good practice for health providers to conduct the following in collaboration with the person encountering a transition and their support network:

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- perform medication reconciliation at all transition points.

Strengthening Capacity in BPG Implementation

RNAO's ADVANCED CLINICAL PRACTICE FELLOWSHIP PROGRAM

Best Practice Champions Network

Virtual Learning Series - Level 1

BPSO RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION

Clinical BPG Institute

Questions?

Evaluation and Monitoring

Evaluation and Monitoring Chart

Table 3: Process Indicators

RECOMMENDATION OR GOOD PRACTICE STATEMENT	PROCESS INDICATORS	ALIGNMENT WITH INDICATORS IN DATA REPOSITORIES/ INSTRUMENTS
Good Practice Statement 2.0	Percentage of persons who received an assessment to determine care needs and readiness for a transition prior to a transition in care, during the measurement period ***Numerator:*** *Number of persons who received an assessment to determine care needs and readiness for a transition prior to a transition in care, during the measurement period* ***Denominator:*** *Total number of persons who experienced a transition in care, during the measurement period*	Partial Alignment with National Quality Forum (NQF)
Good Practice Statement 3.0	Percentage of persons who had a transition plan developed prior to a transition in care, during the measurement period ***Numerator:*** *Number of persons who had a transition plan developed prior to a transition in care, during the measurement period* ***Denominator:*** *Total number of persons who experienced a transition in care, during the measurement period*	New

RNAO's Indicator Development Process

Practicing Completing a Gap Analysis

REVIEW OF MEDICATION HISTORY

GOOD PRACTICE STATEMENT 4.0:

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- perform medication reconciliation at all transition points.

Identify YOUR Evaluation Team

Selecting Indicators

Pre-implementation

- Identify the best practice guidelines (BPG)
- Conduct an opportunity (gap) analysis to identify practice recommendations to implement
- Consider feasibility, organizational priorities, and reporting requirements
- Select indicators that align with BPG recommendations
- Consider the level of implementation

RNAO's Data Quality and Management Guide (p.28-29)

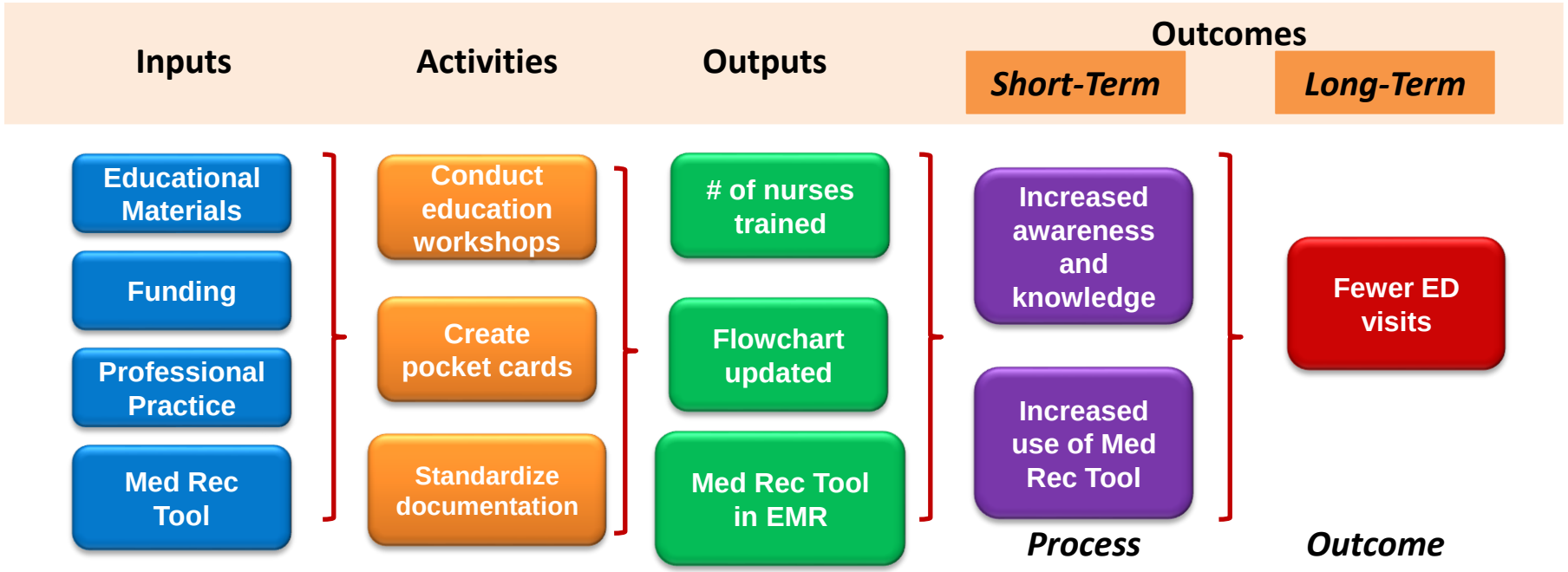
Alignment in other Data Repositories/Instruments

OUTCOME INDICATORS	ALIGNMENT WITH INDICATORS IN DATA REPOSITORIES/INSTRUMENTS
Percentage of new publicly funded home care clients, of all ages, who had an unplanned emergency department visit in 30 days after leaving hospital ***Numerator:*** *Number of unscheduled emergency department visits by home care clients newly referred to home care services within 30 days of initial hospital discharge* ***Denominator:*** *Number of clients referred to home care from hospital who were discharged from hospital and received their first home care service visit within the time period of interest*	Adopted from Ontario Health (22) Partial Alignment with Canadian Institute for Health Information (CIHI), Institute for Clinical Evaluative Sciences (ICES), National Quality Forum (NQF) and Public Health Ontario (PHO)
Proportion of unscheduled emergency department visits for care for mental health conditions with a second unscheduled emergency department visit for mental health or substance abuse (substance use*) within 30 days ***Numerator:*** *Presence of 1 or more unscheduled emergency department visits for mental health conditions or substance abuse (substance use*) within 30 days of the index visit* ***Denominator:*** *All unscheduled emergency department visits for mental health conditions in the reporting period*	Adopted from Ontario Health (22) Partial Alignment with CIHI, ICES, NQF and PHO
Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge ***Numerator:*** *Number of hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge* ***Denominator:*** *Number of hospital discharges for which timely (within 48 hours) notification was received*	Adopted from Ontario Health (22) Partial Alignment with ICES and NQF

Adhering to a collect once, report multiple times principle

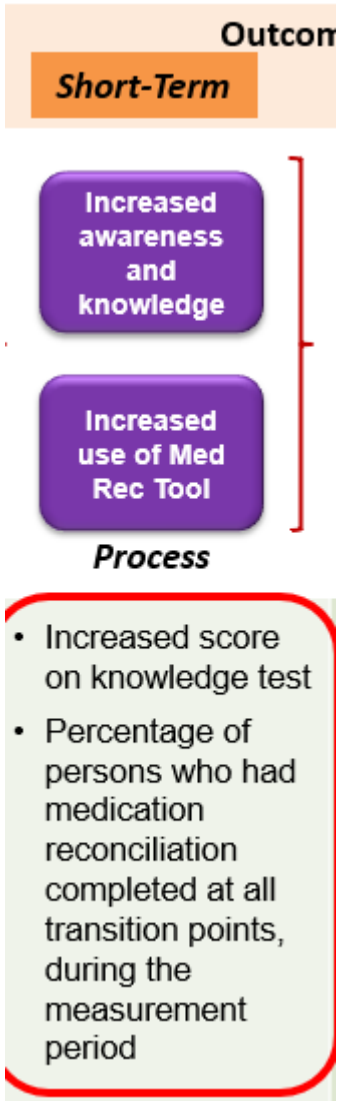
Create an Evaluation Plan

Pre-implementation



Good Practice Statement 4.0: It is good practice for health providers to conduct the following in collaboration with the person encountering a transition and their support network: □ obtain a best possible medication history; and □ perform medication reconciliation at all transition points.	• What are the activities that need to be carried out?	• How many nurses were trained? • How many educational workshops were conducted? • Participant feedback	• Increased score on knowledge test • Percentage of persons who had medication reconciliation completed at all transition points, during the measurement period	Percentage of newly publicly funded home care clients, of all ages, who had an unplanned emergency department visit in 30 days after leaving hospital

Monitor Knowledge Use



Implementation

Measure processes related to knowledge use

- Conceptual knowledge use (understanding)
- Instrumental knowledge use (applied)

Sharing your Quality Improvement Data

- Why is this important?
  - To understand the impact of evidence based practices on outcomes
  - To engage frontline workers and others making the change
  - Promote innovation and spread best practices
  - Continue to improve care

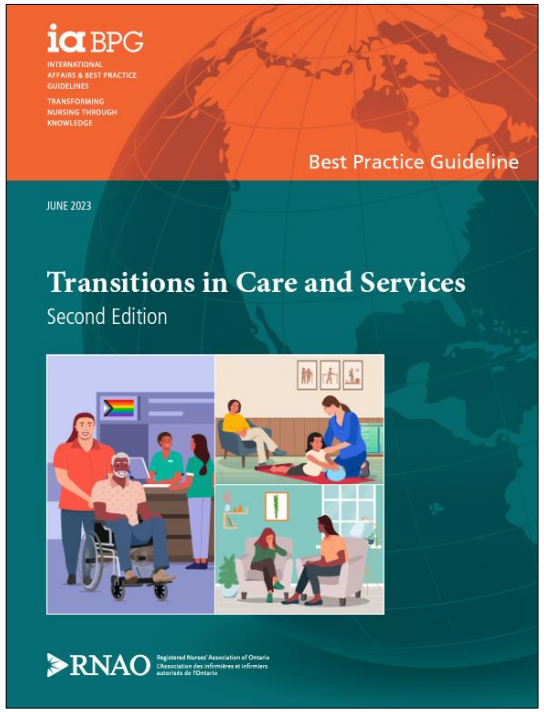
More to Come!

Monday, Aug. 14, 2023, 2-4 p.m. ET

New Guidance for OHTs: Transitions In Care and Services BPG

Register here

Questions?



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Download the BPG for free:
https://rnao.ca/bpg/guidelines/transitions-in-care

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Questions?

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Lotfi T, Hajizadeh A, Moja L, et al. A taxonomy and framework for identifying and developing actionable statements in guidelines suggests avoiding informal recommendations. J Clin Epidemiol. 2022 Jan 1;141:161– 71.

Schunemann HJ, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Available from: https://gdt.gradepro.org/app/handbook/handbook.html