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Transitions in Care and Services

Second Edition



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Declaration of Conflict of Interest

In the context of RNAO best practice guideline development, the term "conflict of interest" (COI) refers to situations in which an RNAO staff member or expert panel member's financial, professional, intellectual, personal, organizational or other relationships may compromise their ability to conduct panel work independently. Declarations of COI that might be construed as constituting a perceived and/or actual conflict were made by all members of the RNAO expert panel prior to their participation in guideline development work using a standard form. Expert panel members also updated their COI at the beginning of each expert panel meeting and prior to guideline publication. Any COI declared by an expert panel member was reviewed by the RNAO best practice guideline development and research team and expert panel co-chairs. No limiting conflicts were identified by members of the expert panel. See the [Declarations of Conflicts of Interest Summary](#) online.

Land Acknowledgement

We recognize that our work and the work of our members takes place on traditional Indigenous territories across Ontario. We also wish to acknowledge that the RNAO head office is located on the traditional and unceded territory of the Huron-Wendat, Haudenosaunee and the territory of the Mississaugas of the Credit. This territory was the subject of the Dish With One Spoon Wampum Belt Covenant, which is an agreement between the Iroquois Confederacy and the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes. We also acknowledge that Toronto is covered by Treaty 13 under the Toronto Purchase Agreement with the Mississaugas of the Credit. Today, this land is still the home to many First Nations, Inuit and Métis peoples from across Turtle Island and we are grateful to have the opportunity to work on this territory. By personally making a land acknowledgement, you are taking part in an act of reconciliation, honouring the land and Indigenous heritage which dates back more than 10,000 years. We encourage you to learn about the land you reside on and the treaties that are attached to it. Land acknowledgements are an act of reconciliation and we must all do our part.

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Transitions in Care and Services

Second Edition

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario



The Registered Nurses' Association of Ontario (RNAO) is delighted to present the second edition of the *Transitions in Care and Services* best practice guideline (BPG). We are grateful to the many partners central in developing this important guideline—from panel members with lived experience to [Best Practice Spotlight Organizations](#)[®] (BPSO), Ontario Health Teams and other stakeholders. RNAO is proud to partner with the Government of Ontario that has funded this program since its inception in 1999.

We offer our heartfelt thanks to the many stakeholders who made this BPG a reality. We are especially grateful to the expert panel co-chairs for their invaluable stewardship:

- Rhonda Crocker Ellacott, President and Chief Executive Officer, Thunder Bay Regional Health Sciences Centre and Chief Executive Officer, Thunder Bay Regional Health Research Institute.
- Shirlee Sharkey, former President and Chief Executive Officer, SE Health.

Special thanks to the expert panel for generously providing their time, diverse knowledge and perspectives to deliver a meaningful and relevant resource that will guide the education and practice of thousands of health and social service providers. We couldn't have done it without you!

Gratitude to RNAO staff Lyndsay Howitt and Greeshma Jacob (guideline development co-leads), Glynis Gittens (guideline development project coordinator), Nafsin Nizum (associate director, guideline development and research) and the rest of the RNAO best practice guideline development and research team for their intense and expert work in the production of this BPG.

Successful uptake of BPGs requires a concerted effort from educators, clinicians, employers, policy-makers, researchers and funders. Nursing and health communities, with their unwavering commitment and passion for excellence in care, provide the expertise and countless hours of voluntary work needed to develop new and next-edition BPGs. Employers have responded enthusiastically by becoming BPSOs, joining more than 1,500 service and academic institutions in Canada and abroad, committed to implementing RNAO's BPGs. They have sponsored best practice champions, now numbering more than 100,000 nurses, other health professionals and persons with lived experience – all eager to advance person-centred evidence-based care. BPSOs are also diligently evaluating the impact of BPG implementation on patients, organizations, and health system outcomes.

We invite you to share this BPG with nurses and all other team members, client navigators and advisors in the wider health systems and communities within which you work. We all have so much to learn from one another. Together, we must make sure that the public have access to and receive the best possible health and wellness services, always.

A handwritten signature in black ink that reads "Doris Grinspun". The signature is written in a cursive style with a long horizontal flourish extending to the right.

Doris Grinspun, RN, BS&N, MSN, PhD, LLD (hon), Dr (hc), DHC, FAAN, FCAN, O.ONT.
Chief Executive Officer and Founder of the Best Practices Guidelines Program
Registered Nurses' Association of Ontario

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How to Use This Document

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

This **best practice guideline^G** (BPG) is a comprehensive document that provides guidance and resources for **evidence-based practice^G**. It is not intended to be a manual or “how-to” guide; rather, it is a tool to guide best practices and enhance decision making for **nurses^G**, the **interprofessional team^G**, educators, **health and social service organizations^G**, academic institutions, and **persons^G** and their **support network^G**. This BPG should be reviewed and applied in accordance with the needs of individual health and social service organizations, academic institutions or other practice settings, and with the preferences of persons and their support network. This document provides evidence-based **recommendations^G** and **good practice statements^G** and descriptions of: (a) practice and organizational policy; (b) benefits and harms; (c) values and preferences; and (d) health equity considerations.

Nurses, members of the interprofessional team, educators and administrators who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols and educational programs to support service delivery. Nurses and members of the interprofessional team in direct care will benefit from reviewing the recommendations and supporting evidence.

If your organization is adopting this BPG, the Registered Nurses’ Association of Ontario (RNAO) recommends organizations establish change teams whose responsibilities include, but are not limited to, the following:

1. Conduct a gap/opportunity analysis: assess your existing policies, procedures, protocols and educational programs in relation to the recommendations, good practice statements and supporting discussions of evidence in this BPG, and identify any strengths, needs or gaps.
2. Note the recommendations and good practice statements that are applicable to your setting and that can be used to address your organization’s existing priorities, needs or gaps.
3. Develop a plan for implementing recommendations and good practice statements, sustaining best practices and evaluating **outcomes^G** by applying the Social Movement Action Framework (1,2) and/or the Knowledge-to-Action Framework (3).

Implementation science^G resources, including the *Leading Change Toolkit*, are available [online](#) (4). A description of the *Leading Change Toolkit* can be found in [Appendix M](#). For more information, see **Implementation Strategies** on page 82.

All [RNAO BPGs](#) are available for download, free of charge, from the RNAO website. To locate a particular BPG, search by keyword or browse by topic.

We are interested in hearing your feedback on this BPG and how you have implemented it. [Please share your story with us.](#)

The two-decade journey of RNAO BPGs is documented in: [Grinspun D, Bajnok I, editors. Transforming nursing through knowledge: best practices for guideline development, implementation science, and evaluation. Indianapolis \(IN\): Sigma Theta Tau International; 2018.](#)

Purpose and Scope

Purpose

RNAO's BPGs are systematically developed, evidence-based documents that include recommendations on specific clinical, healthy work environment and health system topics. They are intended for nurses, members of the interprofessional team in direct care positions, educators, administrators and executives, policy-makers, researchers, and **persons with lived experience**^G in health and social service organizations and academic institutions. BPGs promote consistency and excellence in clinical care, administrative policies, procedures and education, with the aim of achieving optimal health outcomes for people, communities, and the health system as a whole.

This BPG replaces the RNAO BPG *Care Transitions* published in 2014 (5). The purpose of the *Transitions in Care and Services* BPG is 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**^G for pediatric (17 years and younger) and adult (18 years and older) persons and their support network. This BPG recognizes that persons and their support network who are encountering a transition in care are experts in their health and decision-making. Collaboration among the interprofessional team, the person receiving care and their support network is therefore essential to achieving improved health outcomes.

In March 2021, RNAO convened an expert panel to determine the scope of this second edition BPG and to develop **recommendation questions**^G to inform the **systematic reviews**^G. The RNAO expert panel included persons with lived experience and was interprofessional in composition. It comprised individuals with knowledge and experience in clinical practice, education, research and policy across a range of health and social service organizations, academic institutions, practice areas and sectors. These experts shared their insights on supporting and caring for persons and their support network when encountering transitions within and across settings, including (but not limited to): primary care; **home**^G and community care; mental health and substance use health settings; acute care; rehabilitation; long-term care (LTC); correctional facilities; and shelters.

The expert panel also included representatives from **Best Practice Spotlight Organization**[®] **Ontario Health Teams**^G (BPSO OHT). The launch of OHTs in 2019 represented a milestone in the journey towards integrated care in Ontario (6). RNAO has entered into formal partnerships with OHTs to support them in advancing the **Quadruple Aim**^G and the United Nations **Sustainable Development Goals**^G (SDG) by addressing population health, supporting **underserved populations**^G and promoting health equity (7). This second edition BPG was developed through co-creation with BPSO OHTs to ensure the recommendations meet the needs of persons and their support network, organizations and the health system. Within OHTs, **health and social service providers**^G work as one coordinated team, no matter where care is provided.

To determine the scope and priority recommendation questions for this BPG, a comprehensive review and analysis were completed by the RNAO best practice guideline development and research team and the expert panel (see [Appendix C](#)).

Scope

To determine the scope of this BPG, the RNAO best practice guideline development and research team conducted the following steps:

- reviewed the previously published RNAO BPG: *Care Transitions* (5);
- conducted an environmental scan of existing guidelines and standards on this topic;
- undertook a review of the literature to determine available evidence on interventions to support pediatric and adult persons and their support network encountering transitions in care;
- led 26 key informant interviews via virtual calls with persons with lived experience, health and social service providers, student nurses, administrators and researchers;
- held one discussion group with nine representatives from four BPSO OHTs; and
- consulted with the expert panel.

This BPG is to be used by nurses and members of the interprofessional team across the continuum of care (e.g., primary care, home and community care, mental health and substance use health settings, acute care, rehabilitation, LTC, correctional facilities and shelters), in all domains of practice (e.g., clinical care, administration, education, policy and research) supporting persons and their support network during transitions in care. It is also to be used by organizations that employ nurses and members of the interprofessional team, including health and social service organizations and academic institutions.

Topics Outside the Scope of this Best Practice Guideline

The following populations and settings are not covered within the scope of this BPG:

- persons transitioning from pediatric to adult services;
- mothers and infants transitioning from hospital to home after birth;
- infants transitioning from neonatal intensive care units (NICU) to home;
- micro-level transitions (i.e., transfer of care between health providers during shift change); and
- transitions to and from diagnostic units within a hospital.

Key Concepts Used in this Best Practice Guideline

Transition in care: A significant point 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 (8). A transition in care occurs when a person moves from one setting or sector where care or services are provided to another setting or sector, including (but not limited to): primary care; home and community care; mental health and substance use health settings; acute care; rehabilitation; LTC; correctional facilities; and shelters. Examples include transitions from home to LTC, or hospital to hospice. A transition can also occur within the same organization, such as when a person moves from an intensive care unit to a general ward in a hospital. During their care trajectory, a person may also experience multiple transitions in care, such as a transition from hospital to a rehabilitation facility, and then to home. Although the term “transition in care” is used throughout this BPG, the guideline title reflects how a transition may occur between any settings where care or services are provided.

Best Practice Spotlight Organization[®] Ontario Health Teams (BPSO OHT): OHTs are groups of providers and organizations that are accountable for delivering a full and coordinated continuum of care to an attributed population in Ontario, Canada (9). The BPSO model for OHTs offers a tailored program to scale up and spread RNAO BPGs within **integrated systems of care[®]**. The BPSO OHT model helps OHTs advance all four elements of the Quadruple Aim as well as the United Nations SDGs by addressing population health, supporting underserved populations and promoting health equity. BPSO OHTs are actively supported by RNAO to systematically implement evidence-based BPGs by mobilizing teams towards their collective goals and evaluating outcomes. The BPSO OHT program is nested within the OHT, and program deliverables are designed to advance OHT goals.

Health and social service providers: Refers to both regulated health and social service providers (e.g., nurses, physicians, pharmacists, social workers, occupational therapists and paramedics) and unregulated health and social service providers (e.g., personal support workers, **peer workers with lived experience[®]**) who are part of the interprofessional team.

Regulated health and social service providers: In Ontario, the *Regulated Health Professional Act, 1991* (RHPA) provides a framework for regulating 26 health professions, outlining the scope of practice and the profession-specific controlled or authorized acts that each regulated professional is authorized to perform when providing health care and services (10). The regulations for social workers and social service professionals are outlined in the *Social Work and Social Service Work Act, 1998* (11). In this BPG, nurses, physicians, occupational therapists and pharmacists are examples of regulated health providers, and social workers are an example of a regulated social service provider.

Unregulated health and social service providers: Unregulated health and social service providers fulfill a variety of roles in areas that are not subject to the RHPA. They are accountable to their employers but not to an external regulating professional body (such as the College of Nurses of Ontario). Unregulated health and social service providers fulfill a variety of roles and perform tasks that are determined by their employer and employment setting. Unregulated health and social service providers only have the authority to perform a controlled act as set out in the RHPA if the procedure falls under one of the exemptions set out in the Act (12).

Interprofessional team: A team composed of multiple health and social service providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health services to persons within, between and across health and social care settings (13). Key interprofessional team members supporting pediatric and adult persons and their support network during transitions in care include, but are not limited to: nurses; physicians; pharmacists; social workers; occupational therapists; and paramedics. It is important to emphasize that persons and their support network who are encountering a transition in care are at the centre of the interprofessional team as active participants. The composition of the team will depend on the nature of the transition, the needs of the person experiencing the transition, and the types of care or services provided. If both health and social service providers are providing care to a person during a transition, it is expected that they would collaborate to help plan for the transition.

Interprofessional cross-sectoral approach[®]: 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.

Navigation support[®]: Refers to individualized and coordinated support provided by health or social service providers to help persons and their support network overcome challenges navigating the health and social care system during

transitions in care. In this BPG, navigation support involves regular follow-up by a health or social service provider who attends to a person’s individual needs and connects them with the right services and supports. This can include providing persons with the information and resources they need to achieve their goals of care, connecting persons with other health and social service providers, helping reduce barriers that prevent persons from accessing timely care, providing social and emotional support, and improving access to **culturally safe care**^G.

Peer worker with lived experience: A person who has lived through similar experiences to their peers, such as a mental health challenge or illness, and who is trained to support others in their journey by providing practical and emotional support (14). They often have experience navigating services similar to those used by their peers. In this BPG, peer workers with lived experience are also referred to as “peer workers.” These workers are non-regulated.

Support network: Individuals identified by a person as being significant in their life. The network can include individuals who are related (biologically, emotionally or legally) and/or those with close bonds (friendships, commitments, shared household and child-rearing responsibilities, and romantic attachment) (15). In this BPG, this term includes family, friends and **caregivers**^G providing support during a transition in care.

RNAO Best Practice Guidelines and Other Resources that Align with this Guideline

Other RNAO BPGs and evidence-based resources may support implementation of this BPG. See [Appendix B](#) for RNAO BPGs and other evidence-based resources on the following related topics:

- 2SLGBTQI+ health equity
- a palliative approach to care in the last 12 months of life
- implementation science, implementation frameworks and resources
- interprofessional collaboration
- person- and family-centred care
- **social determinants of health**^G

Good Practice Statements and Recommendations

This BPG includes both good practice statements and graded recommendations.

Good practice statements are actionable statements that should be done in practice (16). These statements are believed to be so beneficial that summarizing the evidence would be a poor use of the expert panel’s time and resources (16). Moreover, researchers may no longer be conducting studies on the topic, or the alternative to the action may be unethical or studying them may go against human rights (16,17). Given the high level of certainty that the benefits derived from good practice statements outweigh the harms, they are not based on a systematic review of the evidence. They also do not receive a rating of the certainty in their evidence or a strength (i.e., a rating of conditional or strong, which is further discussed below) (18). This does not diminish certainty in the evidence: while they may be supported by indirect evidence, there is a well-documented clear and explicit rationale connecting the indirect evidence to the statement (16). As such, good practice statements should be interpreted as strong recommendations, as there is an underlying assumption that there is high certainty in the benefits of implementing the action (16). It is important to note that good practice statements are not made due to a lack of evidence, nor are they based on expert opinion.

RNAO BPGs are developed using the **Grading of Recommendations Assessment, Development and Evaluation^G** (GRADE) methods. For more information about the guideline development process, including the use of GRADE methods, refer to [Appendix C](#).

Graded recommendations are also actionable statements; however, the recommendation statements are formed based on a direct or indirect link to a body of evidence found through the systematic review process (17). Recommendations are formulated as *strong* or *conditional* by considering the *certainty in evidence*, the *values and preferences* of persons who are impacted by the recommendation, and *health equity* (see **Interpretation of Evidence and Recommendation Statements** on page 14).

Despite the fact that good practice statements and recommendation are developed differently, both provide comprehensive guidance on an action/intervention that should (or should not) be done (17). Therefore, both good practice statements and recommendations should follow the same process for implementation (see **Implementation Strategies** on page 82).

The recommendations and good practice statements in this BPG address unique and overlapping areas to support safe and effective transitions in care for persons and their support network. Specifically, the BPG focuses on the following areas:

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

The recommendations and good practice statements in this BPG are applicable to all practice settings where persons and their support network encountering a transition are accessing care or services.

Recommendation Questions

Recommendation questions are priority areas of care identified by the expert panel that require a synthesis of the evidence to answer. These recommendation questions inform the **PICO research questions^G** (population, intervention, comparison, outcomes) that guide the systematic reviews and subsequently inform recommendations. Potential outcomes were brainstormed and prioritized by the expert panel for each recommendation question, and an individual systematic review was conducted for each recommendation question, in alignment with GRADE methods (19).

The following were the priority recommendation questions and outcomes developed by the expert panel that informed the development of the recommendations in this BPG. The outcomes are presented in the order of importance, as rated by the expert panel.

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

Outcomes: Patient quality of life, emergency department visits (within 30 days of a transition in care), **follow-up visit with a health or social service provider^G**, patient satisfaction and readmission rates (within 30 days of 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?

Outcomes: Follow-up visit with a health or social service provider, emergency department visits (within 30 days of a transition in care), patient quality of life, patient satisfaction, readmission rates (within 30 days of a transition in care).

Note: These priority recommendation questions are condensed versions of the more comprehensive PICO research questions developed by the expert panel to guide the systematic reviews and development of this BPG. For more on the PICO research questions and the detailed process of how the expert panel determined the priority recommendation questions and outcomes, please see [Appendix C](#).

No recommendation questions were identified that addressed the core education and training strategies required for curricula—or the ongoing education and professional development of nurses or the interprofessional team—in order to support persons and their support network encountering transitions in care. Please refer to [Appendix D](#) for **education statements**^G that educators, managers, administrators, and academic and professional institutions can use to support the uptake of this BPG.



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	
<p>Good Practice Statement 1.0:</p> <p>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.</p> <p><i>This good practice statement is an overarching statement that is foundational to implementing all other recommendations and good practice statements.</i></p>	<p>This is a good practice statement that does not require application of the GRADE system.</p>
Assessing care needs and readiness for a transition	
<p>Good Practice Statement 2.0:</p> <p>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.</p>	<p>This is a good practice statement that does not require application of the GRADE system.</p>
Interprofessional collaboration	
<p>Good Practice Statement 3.0:</p> <p>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.</p>	<p>This is a good practice statement that does not require application of the GRADE system.</p>
<p>Recommendation 3.1:</p> <p>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.</p>	<p>Conditional</p>

RECOMMENDATIONS AND GOOD PRACTICE STATEMENTS	STRENGTH OF THE RECOMMENDATION
Review of medication history	
<p>Good Practice Statement 4.0:</p> <p>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:</p> <ul style="list-style-type: none"> ■ obtain a best possible medication history; and ■ perform medication reconciliation at all transition points. 	<p>This is a good practice statement that does not require application of the GRADE system.</p>
Navigation support	
<p>Good Practice Statement 5.0:</p> <p>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.</p>	<p>This is a good practice statement that does not require application of the GRADE system.</p>
<p>Recommendation 5.1:</p> <p>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.</p>	<p>Conditional</p>
<p>Recommendation 5.2:</p> <p>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.</p>	<p>Conditional</p>

Interpretation of Evidence and Recommendation Statements

GRADE provides a transparent framework and a systematic approach for rating the certainty of evidence and determining the strength of recommendations (19).

Certainty of Evidence

The certainty of evidence (i.e., the level of confidence we have that an estimate of effect is true) for **quantitative research**^G is determined using GRADE methods (19). After synthesizing the evidence for each prioritized outcome, the certainty of evidence is assessed. The overall certainty of evidence is determined by considering the certainty of evidence across all prioritized outcomes per recommendation. GRADE categorizes the overall certainty of evidence as *high*, *moderate*, *low* or *very low* (see **Table 1** for the definition of these categories).

Table 1: Certainty of Evidence

CERTAINTY OF EVIDENCE	DEFINITION
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very Low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Source: Reprinted with permission from: The GRADE Working Group. Quality of evidence. In: Schunemann H, 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 [cited 2018 Aug 31]. Table 5.1, Quality of evidence grades. Available from: <https://gdt.gradeapro.org/app/handbook/handbook.html#h.wsfivfhuxv4r>

Note: The assigned certainty of evidence can be found directly below each recommendation statement. For more information on the process of determining the certainty of the evidence and the documented decisions made by RNAO guideline development methodologists, please see **Appendix C**.

Strength of Recommendations

Recommendations are formulated as *strong* or *conditional* by considering the *certainty in evidence* and the following key criteria (see **Discussion of Evidence** for definitions):

- balance of benefits and harms
- values and preferences
- health equity

According to Schunemann et al., “a strong recommendation reflects the expert panel’s confidence that the desirable effects of an intervention outweigh its undesirable effects (strong recommendation *for* an intervention) or that the undesirable effects of an intervention outweigh its desirable effects (strong recommendation *against* an intervention)” (19). In contrast, “a conditional recommendation reflects the expert panel’s confidence that the desirable effects probably outweigh the undesirable effects (conditional recommendation for an intervention) or undesirable effects probably outweigh desirable effects (conditional recommendation against an intervention), but some uncertainty exists” (19).

When the overall certainty of the evidence is high or moderate, expert panel members can be confident that the evidence is credible and thus will support a strong recommendation. In addition, expert panel members need to ensure that the benefits outweigh the harms, and that there is reasonable confidence and limited variability in the values and preferences of persons (20). However, when the overall certainty of the evidence is low or very low, there is uncertainty regarding the impact of the intervention of interest, and expert panel members should expect conditional recommendations (20).

Table 2 outlines the implications of strong and conditional recommendations.

Table 2: Implications of Strong and Conditional Recommendations

IMPLICATIONS OF STRONG AND CONDITIONAL RECOMMENDATIONS		
POPULATION	STRONG RECOMMENDATION	CONDITIONAL RECOMMENDATION
For health and social service providers	<ul style="list-style-type: none"> ■ The benefits of a recommended action outweigh the harms. Therefore, most persons should receive the recommended course of action. ■ There is little variability in values and preferences among persons in this situation. ■ There is a need to consider the person’s circumstances, preferences and values. 	<ul style="list-style-type: none"> ■ The benefits of a recommended course of action probably outweigh the harms. Therefore, the majority of persons could receive the recommended course of action. ■ There is greater variability in values and preferences, or there is uncertainty about typical values and preferences among persons in this situation. ■ There is a need to consider the person’s circumstances, preferences and values more carefully than usual.

IMPLICATIONS OF STRONG AND CONDITIONAL RECOMMENDATIONS		
POPULATION	STRONG RECOMMENDATION	CONDITIONAL RECOMMENDATION
For persons receiving care	<ul style="list-style-type: none"> Most persons would want the recommended course of action and a small portion would not. 	<ul style="list-style-type: none"> The majority of persons in this situation would want the suggested course of action, but many would not.
For policy-makers	<ul style="list-style-type: none"> The recommendation can be adapted as policy in most situations. 	<ul style="list-style-type: none"> Policy-making will require substantial debate and involvement of many stakeholders. Policies are also more likely to vary between regions.

Source: Adapted with permission from: The GRADE Working Group. Quality of evidence. In: Schunemann H, 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 [cited 2020 May 11]. Table 6.1, Implications of strong and weak recommendations for different users of guidelines. Available from: <https://gdt.gradeapro.org/app/handbook/handbook.html#h.wsfvfhuxv4r>

Note: The strength of each recommendation statement is detailed directly beside it and in the **Summary of Recommendations and Good Practice Statements**. For more information on the process used by the expert panel to determine the strength of each recommendation, please see **Appendix C**.

Discussion of Evidence

The Discussion of Evidence that follows each recommendation includes the following main sections.

- Benefits and Harms:** Identifies the potential desirable and undesirable outcomes reported in the literature when the recommended practice is used. Content in this section includes only research from the systematic reviews.
- Values and Preferences:** Denotes the relative importance or worth placed on health outcomes derived from following a particular clinical action from a **person-centred^G** perspective. Content for this section may include research from the systematic reviews and, when applicable, observations and/or considerations from the expert panel.
- Health Equity:** Identifies the potential impact that the recommended practice could have on health across different populations or settings and/or the barriers to implementing the recommended practice in particular settings. This section may include research from the systematic reviews and, when applicable, observations and/or considerations from the expert panel.
- Expert Panel Justification of Recommendation:** Provides a rationale for why the expert panel made the decision to determine a recommendation as strong or conditional.
- Implementation Tips:** Highlights practical information for nurses and members of the interprofessional team to support implementation in practice. This section may include supporting evidence from the systematic reviews and/or from other sources (e.g., the expert panel).
- Supporting Resources:** Includes a list of relevant resources (e.g., websites, books and organizations) that support the recommendations. Content listed in this section was assessed based on five criteria: relevancy, credibility, quality, accessibility and timeliness of publication (published within the last 10 years). Further details about this process and the five criteria are outlined in **Appendix C**. The list is not exhaustive and the inclusion of a resource in one of these lists does not imply an endorsement from RNAO. Some recommendations may not have any identified supporting resources.

Best Practice Guideline Evaluation

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

The Donabedian model, which informs the development of indicators for evaluating quality health care, includes three categories: structure, process and outcome (21).

Structure describes the required attributes of the health system or health service organization to ensure quality care. It includes physical resources, human resources, and information and financial resources.

Process examines the health-care activities being provided to, for and with persons or populations as part of the provision of quality care.

Outcome analyzes the effect of quality care on the health status of persons and populations, health workforce, health service organizations or health systems (21).

For more details, see the **Monitor Knowledge Use** and **Evaluate Outcomes** sections in the [Leading Change Toolkit](#) (4).

The following indicators have been developed to support evaluation and quality improvement. Consider **Tables 3** and **4**, which provide a list of process and outcome indicators to assess the impact of BPG implementation and are derived from both BPG recommendations and good practice statements. Each table also identifies if the indicator aligns with other indicators in local, provincial, national and/or international data repositories and/or instruments. Alignment with data repositories/instruments is determined by comparing the following criteria with the developed indicators: the operational definition; if the indicator is nursing sensitive; and the inclusion/exclusion criteria. Depending upon the level of alignment, an indicator may be described to have full, partial or no alignment with external data repositories/instruments. Indicators may be adopted from external data repositories/instruments.

The following indicators will support quality improvement and evaluation. Select the indicators most relevant to the changes being made in practice, education and/or policy, based on BPG recommendations and good practice statements that are prioritized for implementation.

Table 3 supports the evaluation of practice changes during implementation. The indicators are directly associated with specific recommendation and good practice statements and support process improvement.

Table 3: Process Indicators

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

RECOMMENDATION OR GOOD PRACTICE STATEMENT	PROCESS INDICATORS	ALIGNMENT WITH INDICATORS IN DATA REPOSITORIES/ INSTRUMENTS
<p>Good Practice Statement 4.0</p>	<p>Percentage of persons who had a best possible medication history completed at all transition points, during the measurement period</p> <p><i>Numerator: Number of persons who had a best possible medication history completed at all transition points, during the measurement period</i></p> <p><i>Denominator: Total number of persons who experienced a transition in care, during the measurement period</i></p>	<p>Partial Alignment with Accreditation Canada, Better Outcomes Registry & Network (BORN), Institute for Clinical Evaluative Sciences (ICES), National Quality Forum (NQF), Ontario Health and Resident Assessment Instrument-Minimum Data Set (RAI-MDS)</p> <p>Full Alignment with Healthcare Excellence Canada</p>
<p>Good Practice Statement 4.0</p>	<p>Percentage of persons who had medication reconciliation completed at all transition points, during the measurement period</p> <p><i>Numerator: Number of persons who had medication reconciliation completed at all transition points, during the measurement period</i></p> <p><i>Denominator: Total number of persons who experienced a transition in care, during the measurement period</i></p>	<p>Partial Alignment with BORN, ICES, Ontario Health and RAI-MDS</p> <p>Full Alignment with Accreditation Canada, Healthcare Excellence Canada and NQF</p>
<p>Recommendation 5.1</p>	<p>Percentage of persons with complex care needs who received navigation support during their transition in care, during the measurement period</p> <p><i>Numerator: Number of persons with complex care needs who received navigation support during their transition in care, during the measurement period</i></p> <p><i>Denominator: Total number of persons with complex care needs who experienced a transition in care, during the measurement period</i></p>	<p>Partial Alignment with NQF</p>

Table 4 provides outcome indicators to assess the impact of implementing evidence-based practice changes.

Table 4: Outcome Indicators

OUTCOME INDICATORS	ALIGNMENT WITH INDICATORS IN DATA REPOSITORIES/INSTRUMENTS
<p>Percentage of new publicly funded home care clients, of all ages, who had an unplanned emergency department visit in 30 days after leaving hospital</p> <p>Numerator: <i>Number of unscheduled emergency department visits by home care clients newly referred to home care services within 30 days of initial hospital discharge</i></p> <p>Denominator: <i>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</i></p>	<p>Adopted from Ontario Health (22)</p> <p>Partial Alignment with Canadian Institute for Health Information (CIHI), Institute for Clinical Evaluative Sciences (ICES), National Quality Forum (NQF) and Public Health Ontario (PHO)</p>
<p>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</p> <p>Numerator: <i>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</i></p> <p>Denominator: <i>All unscheduled emergency department visits for mental health conditions in the reporting period</i></p>	<p>Adopted from Ontario Health (22)</p> <p>Partial Alignment with CIHI, ICES, NQF and PHO</p>
<p>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</p> <p>Numerator: <i>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</i></p> <p>Denominator: <i>Number of hospital discharges for which timely (within 48 hours) notification was received</i></p>	<p>Adopted from Ontario Health (22)</p> <p>Partial Alignment with ICES and NQF</p>

OUTCOME INDICATORS	ALIGNMENT WITH INDICATORS IN DATA REPOSITORIES/INSTRUMENTS
<p>Percentage of psychiatric (mental health or addiction [substance use*]) discharges that had a follow-up visit to either a primary care physician or psychiatrist, within 7 days of discharge</p> <p>Numerator: Number of patients who within 7 days of discharge following index hospitalization had at least one psychiatrist or primary care physician mental health visit</p> <p>Denominator: Number of acute care discharges from episode of care in which a mental health and addiction (substance use*) condition is diagnosed and is coded as most responsible diagnosis</p>	<p>Adopted from Ontario Health (22)</p> <p>Partial Alignment with Institute for Clinical Evaluative Sciences (ICES) and National Quality Forum (NQF)</p>
<p>Percentage of persons who received follow-up care within 30 days of their transition as part of their transition plan, during the measurement period</p> <p>Numerator: Number of persons who received follow-up care within 30 days of their transition as part of their transition plan, during the measurement period</p> <p>Denominator: Total number of persons who experienced a transition in care, during the measurement period</p>	<p>Partial Alignment with ICES, NQF and Ontario Health</p>
<p>Percentage of persons who were satisfied with their transition in care, during the measurement period</p> <p>Numerator: Number of persons who were satisfied with their transition in care, during the measurement period</p> <p>Denominator: Total number of persons who experienced a transition in care, during the measurement period</p>	<p>Partial Alignment with ICES, NQF, Ontario Health and Statistics Canada</p>

OUTCOME INDICATORS	ALIGNMENT WITH INDICATORS IN DATA REPOSITORIES/INSTRUMENTS
<p>Rate of un-planned hospital readmissions within 30 days of discharge after hospitalization for any of the following conditions: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, heart attack and other cardiac conditions (selected HBAM Inpatient Grouper (HIG) conditions)</p> <p>Numerator: <i>Number of subsequent non-elective (all-cause) readmissions to an acute care hospital within 30 days of discharge after hospitalization for any of the following conditions: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, heart attack and other cardiac conditions (selected HBAM Inpatient Grouper (HIG) conditions)</i></p> <p>Denominator: <i>Total number of hospital discharges after hospitalization for any of the following conditions: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, heart attack and other cardiac conditions (selected HBAM Inpatient Grouper (HIG) conditions)</i></p>	<p>Adopted from Ontario Health (22)</p> <p>Partial Alignment with Canadian Institute for Health Information (CIHI), Institute for Clinical Evaluative Sciences (ICES), National Database of Nursing Quality Indicators (NDNQI), National Quality Forum (NQF), Public Health Ontario (PHO) and Statistics Canada</p>
<p>Percentage of psychiatric (mental health or addiction [substance use*]) discharges that are followed within 30 days by another mental health or addiction (substance use*) hospital admission</p> <p>Numerator: <i>Number of individuals with any mental health or addictions (substance use*) hospital readmissions within (\leq) 30 days following the incident hospital discharge</i></p> <p>Denominator: <i>Total number of incident mental health or addictions (substance use*) hospital discharges between calendar years of interest</i></p>	<p>Adopted from Ontario Health (22)</p> <p>Partial Alignment with CIHI, ICES, NDNQI, NQF, PHO and Statistics Canada</p>

OUTCOME INDICATORS	ALIGNMENT WITH INDICATORS IN DATA REPOSITORIES/INSTRUMENTS
<p>Rate, per 100 patient discharges, of unplanned returns to a hospital within 30 days of discharge</p> <p><i>Numerator: Number of episodes of care for medical and surgical patients with an urgent readmission within 30 days of previous discharge</i></p> <p><i>Denominator: Number of episodes of care discharged between April 1 and March 1 of the fiscal year for surgical and medical patients</i></p>	<p>Adopted from Ontario Health (22)</p> <p>Partial Alignment with Canadian Institute for Health Information (CIHI), Institute for Clinical Evaluative Sciences (ICES), National Database of Nursing Quality Indicators (NDNQI), National Quality Forum (NQF), Public Health Ontario (PHO) and Statistics Canada</p>

*RNAO uses the terminology “mental health and substance use” (23).

Other RNAO resources for the evaluation and monitoring of BPGs:

- [Nursing Quality Indicators for Reporting and Evaluation](#)[®] (NQuIRE[®]), a unique international data system housed in the International Affairs and Best Practice Guidelines Centre, allows BPSOs[®] to measure the impact of BPG implementation. The NQuIRE data system collects, compares and reports data on human resource structure indicators as well as guideline-specific, nursing-sensitive structure, process and outcome indicators. NQuIRE indicator definitions are aligned with available administrative data and existing performance measures wherever possible, adhering to a “collect once, use many times” principle. By complementing other established and emerging performance measurement systems, NQuIRE strives to leverage reliable and valid measures, minimize reporting burden and align evaluation measures to enable comparative analyses. The international NQuIRE data system was launched in August 2012 to create and sustain evidence-based practice cultures, optimize safety of persons, improve health outcomes and engage staff in identifying relationships between practice and outcomes to advance quality and advocate for resources and policy that support best practice changes (24).
- [BPG Order Sets](#)[™] embedded within electronic records are technology-enabled implementation tools that provide a mechanism for electronic data capture of process and outcome measures. The ability to link structure and process measures with specific client outcome measures helps determine the impact of BPG implementation on specific health outcomes. In LTC, BPG Order Sets have evolved into [RNAO Clinical Pathways](#)^{™ G} with the support of senior nurses with extensive expertise in this setting. RNAO Clinical Pathways have been embedded within a commonly used **electronic health record**^G system and are accessible to all Canadian LTC homes.

Background Context

Transitions in Care

A transition in care is a significant point in the provision of health care during which a person's information and care needs are transferred between health and social service providers, interprofessional teams and settings (8). A transition in care occurs when a person moves from one setting or sector to another setting or sector where care or services are provided, including (but not limited to): primary care; home and community care; mental health and substance use health settings; acute care; rehabilitation; LTC; correctional facilities; and shelters. Examples include transitions from home to LTC, or from a hospital to a rehabilitation facility. Transitions can also occur within the same organization, such as when a person moves from an intensive care unit to a general ward in a hospital. A transition in care may also represent a major life event. This can be especially true for persons transitioning to a LTC home that becomes their permanent residence. It is important to note that transitions are not always straightforward; instead, non-linear transitions can occur, with persons moving through various areas of the care system. For example, a person can transition to home after a lengthy hospital stay, only to be readmitted to the hospital after a few days. Transitions in care require thoughtful attention and compassion from health and social service providers and a strong emphasis on safety.

Within an integrated health system, persons and their support network are cared for by various health and social service providers within the system: they are never “discharged” from a health or social service organization, but they instead transition from one setting or sector to another. To reflect this, the term “transition” has been intentionally used in this guideline instead of “discharge,” whenever possible.



Challenges for Persons and their Support Network During Transitions in Care

The transition process is complicated in instances where care is delivered in different settings by multiple health and social service providers with varying levels of accountability (25). It is estimated that in Canada, 30 per cent of persons experience a gap in coordination during transitions in care, such as lack of sharing of information or receiving conflicting information from health providers (26). Communication and care processes can unfortunately break down at several points during a transition in care, including: when preparing persons and their support network for the next stage of the transition; when communicating the person's care plan to the team receiving care; during **medication reconciliation**^G; or when assessing care needs, arranging for transportation and coordinating follow-up care (25). These breakdowns can subsequently lead to safety risks and adverse events, such as:

- a lack of information to manage care needs;
- unnecessary diagnostic testing or treatments;
- delays and cancellations of medical screenings, procedures and surgeries;
- medication errors;
- injury;
- delayed or poor-quality care;
- health and social service providers not receiving test results and reports required for follow-up care;
- underdiagnosis of new health conditions; and
- frustration among persons and their support network and health and social service providers (8,25,27,28).

Furthermore, inefficiencies can contribute to emotional distress, worsening of symptoms and negative experiences for persons and their support network during transitions in care (8,25,29).

Unplanned hospital readmissions, emergency department visits and increased health-care costs are other consequences that result from poor coordination in care (25). In fact, unplanned hospital readmissions following a transition from hospital are a major burden nationwide and affect almost 200,000 Canadians every year (30). Approximately 1 in 11 persons leaving hospital are readmitted within 30 days of a transition in Canada (31). Particularly in Ontario, approximately 20 per cent of people with serious chronic conditions are readmitted to hospital within 30 days of a transition from hospital (25). This has significant financial consequences, as readmissions cost more than \$2.3 billion annually in Canada (31). While not all readmissions can be prevented, about 25 per cent of unplanned hospital readmissions are retrospectively determined to be preventable (30).

Readmission rates can be reduced through better follow-up and care coordination after transitions (31). Many people with serious chronic conditions are discharged from hospital without a scheduled follow-up appointment with a primary care provider within seven days of a transition from hospital (25). Furthermore, as many as 44 per cent of persons in Ontario do not attend follow-up appointments after a transition from hospital due to low **health literacy**^G, financial barriers and a lack of social support (25). There are also many people in Ontario who do not have a primary care provider to provide follow-up care (32).

Barriers Related to Social Determinants of Health and Health Equity Concerns

Access to health care is generally defined as an opportunity for persons to obtain needed health services and care (33). A health inequity is defined as differences that occur in one's health and wellness status that are systemic, avoidable and identified as unfair and unjust (34). Research suggests that barriers related to the social determinants of health such as unstable housing, lack of transportation, insufficient social support, cost of care to the person (e.g., affording prescriptions, medical equipment and transportation), low health literacy, lack of basic necessities, unemployment and financial strains, lack of affordable childcare and insurance status complicate transitions in care and negatively impact access to health services and health outcomes (35–38). Additional barriers can include a lack of timely access to primary care and specialists, particularly for people in rural and remote communities (25).

There are many populations that are particularly vulnerable and experience barriers to care, and pre-existing socio-economic disparities further complicate access and health inequities (36,39). A non-exhaustive list of these populations include: individuals residing in rural communities; persons with sexual or gender diversity; persons who are inadequately housed; children and youth with complex medical conditions; persons with disabilities; new immigrants and refugees to the country; persons who use substances; and persons who experience socio-economic, cultural and language barriers (25,40). People of colour who face historic and systemic racism, such as **Indigenous^G** peoples (First Nations, Inuit and Métis) may face additional barriers during transitions in care, including lack of access to culturally safe care (25,28). The Canadian health system has been called upon to close gaps in health outcomes for Indigenous peoples and to provide access to culturally safe health services (41).

Streamlining Support throughout Transitions in Care

To ensure care decisions respect the unique needs, values and preferences of persons and their support network—and to ensure a smooth, safe, coordinated and successful transition in care—health and social service providers need to collaborate with persons and their support network (25,27), as they are the experts on their own circumstances (42). A collaborative interprofessional team approach will facilitate the identification of the person's physical, emotional, social and spiritual needs, the development of a **transition plan^G**, and coordination of referrals and essential services. For persons without a support network, additional considerations should be made to ensure they are adequately supported during the transition.

It is important to ensure that all persons experiencing a transition in care receive information and support to manage their health and social care needs following a transition (25). This involves health education, information about medications, follow-up appointments, community-based resources and who to contact if questions or concerns arise (25). Adequate supports should also be provided to caregivers and other members of a person's support network, such as information about family support groups or respite care (25). Persons with complex care needs may benefit from additional support to help them navigate the health and social care system, such as routine follow-up from a health or social service provider who can assess and address barriers to care and attend to evolving care needs (43,44).

Co-creation with Ontario Health Teams

In the province of Ontario, the launch of OHTs in 2019 represented a milestone in the journey towards integrated care (6). OHTs are groups of health and social service providers and organizations that work together to deliver a continuum of coordinated care to their attributed population (9). OHTs are changing how care is delivered in Ontario, and as such, these teams are well positioned to improve the delivery of health services through intersectoral collaboration and to help ensure that persons experience seamless transitions in care (9).

The BPSO[®] model for OHTs was established to respond to health system transformation in Ontario by offering a tailored approach to scale up and spread best practices within integrated systems of care. The program provides structure and uses approaches to mobilize teams from different disciplines and sectors towards their collective goals and evaluate outcomes. RNAO has formal partnerships with OHTs across the province to support them in advancing the Quadruple Aim and the United Nations SDGs by addressing population health, supporting underserved populations and promoting health equity (see **Figure 1**). The quadruple aim is an internationally-recognized framework for the delivery of health care that is centred around four overarching goals: (1) enhanced experiences for persons receiving care; (2) enhanced experiences for health and social care providers delivering care; (3) improved health outcomes; and (4) reduced health-care costs (45). The United Nations SDGs were launched in 2015 as a universal call to action to end poverty, protect the planet, and ensure peace and prosperity for all persons (46).

BPSO OHTs are supported by RNAO to systematically and collectively implement evidence-based BPGs across the care continuum, using a population health approach. BPSO OHTs will be implementing the *Transitions in Care and Services* BPG, and this BPG was developed through co-creation with BPSO OHTs to ensure the recommendations align with the needs of persons and their support network, organizations, and the health system. The expert panel for this BPG included health and social service providers and persons with lived experience from four BPSO OHTs. Additional BPSO OHTs provided feedback on the BPG during the **stakeholder^G** review stage.

Figure 1: The BPSO Program Supports Achievement of the Quadruple Aim and the Sustainable Development Goals



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Conclusion

This BPG provides evidence-based recommendations for nurses, members of the interprofessional team, organizations and the health system to support safe and effective transitions in care for pediatric and adult persons along with their support networks. In collaboration with persons with lived experience and a wide array of expert panel members, including representatives from BPSO OHTs, this BPG was developed to ensure that the recommendations support integrated care across settings and sectors, and that they ultimately improve health outcomes and health equity for persons encountering transitions in care and services.

Recommendations and Good Practice Statements

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 (18). Actively collaborating with persons when developing a care plan—and identifying their goals, wishes and preferences—is a standard of professional practice (47–50): not collaborating with them would be unethical. As such, collaborating with persons and their support network before, during and after a transition in care is good clinical practice.

During a transition in care, a person's health information and care needs are transferred between health and social service providers, interprofessional teams and settings (8). To achieve the best outcomes during a transition in care, it is imperative for health and social service providers to use an informed, shared decision-making process (38,51,52). Shared decision-making is a collaborative process that involves a person and their health or social service provider working together to reach a mutual decision about their current or future care (53). Shared-decision making is more than conveying knowledge to persons and their support network; it also involves determining and integrating a person's wishes and preferences (53). Research suggests that when persons receive information they understand and can act upon—and when support is customized to meet their needs—they are better equipped to manage their health following the transition in care (51).

When preparing for a transition in care, persons should have opportunities to engage in meaningful discussions with health and social service providers. These discussions should, with the person's consent, also involve the person's support network, as they play an essential role in the person's transition (25,38). For example, the person's support network can provide relevant information about the person's health condition and physical and psychosocial needs (25). They can also be directly involved in their care (e.g., administering medication, performing wound care, helping with daily activities, arranging transportation to follow-up appointments, monitoring worrisome signs and symptoms, and advocating on the person's behalf) (25,54). Despite the essential role that caregivers and other members of a person's support network play during transitions in care, they are often not involved in the planning process (55,56).

When the perspectives of both persons and their support network are overlooked, it can result in frustration, power imbalances, non-adherence with the plan of care or inappropriate care plans (51,57–59). Persons and their support networks have also reported feeling abandoned, lacking confidence when it comes to navigating the health system, and feeling anxious due to a lack of readiness for the transition and/or a lack of resources to self-manage their

condition (60). It is important that health and social service providers listen to the needs of persons and their support network and genuinely consider their preferences. When recommendations are made that do not reflect a person's wishes or preferences, it is vital to explain why different clinical treatments/activities were recommended (51). A collaborative practice that respects the needs, wishes and capacities of persons and their support network is of utmost importance to ensure a safe, smooth, coordinated and successful transition in care (8,27,51).

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.
 - Use a **strength-based approach**^G, which involves recognizing existing knowledge, capabilities and connections of persons that can help them achieve their goals of care.
 - Uphold respect for each person's autonomy and understand that persons have the right to make decisions that health and social service providers may not agree with.
 - Provide a copy of the transition plan to the person receiving care and their support network.

- Considerations are to be made when communicating with persons with disabilities, persons who have cognitive impairments or mental health challenges, or when language barriers exist. Health and social service providers are to minimize medical jargon and ensure print material is written in plain language at a Grade 5 or 6 level. When needed, translation and interpreter services are to be arranged.
- Care is to be provided in a culturally safe, psychologically safe, respectful and **trauma-informed**^G manner. Safe, trusting therapeutic relationships are developed when health and social service providers understand how a person's lived experience—including how the impact of trauma or previous negative experiences within the health system—can impact a person's health behaviours.
- Health and social service providers are to explore socio-economic realities, concerns and cultural sensitivities to ensure that persons and their support network have the resources and services needed to optimize the transition.
- Identifying barriers to care: health and social service providers are to explore what barriers persons may experience when encountering a transition in care and which barriers can be overcome. Health and social service providers are to consider if the person:
 - has a support network available to assist during the transition;
 - has access to health-care resources, including access to navigation support;
 - has a history of trauma related to accessing health services;
 - has physical limitations or cognitive impairment;
 - can read and comprehend written documents and instructions;
 - can afford the treatments, equipment or medications being proposed;
 - has access to a phone to book appointments or to the Internet to attend virtual appointments;
 - has access to transportation to attend in-person appointments;
 - faces barriers to attending appointments due to work requirements (e.g., no flexible work hours or paid leave or benefits);
 - has stable housing and a safe living situation; and
 - can afford food and other necessities.
- Health and social service providers are to collaborate with persons to assess the quality of the transition and to evaluate how well services are meeting the person's needs.
- If the transition does not occur as planned, ensure that the person and their support network know who to contact and when.

Supporting Resources

RESOURCE	DESCRIPTION
RESOURCES FOR PERSONS AND THEIR SUPPORT NETWORK	
Alzheimer Society of Canada. All about me – a conversation starter [Internet]. Vaughan (ON): Alzheimer Society of Canada; c2014. Available from: https://alzheimer.ca/sites/default/files/documents/all_about_me_a_conversation_starter_e.pdf	<ul style="list-style-type: none"> ■ Document that outlines information persons would like health and social service providers to know. ■ Examples include: “I like to be called ...” and “A typical day for me could include”
PODS (Patient Oriented Discharge Summary). In: OpenLab [Internet]. Toronto (ON): OpenLab; 2019. Available from: http://uhnopenlab.ca/project/pods/	<ul style="list-style-type: none"> ■ The Patient Oriented Discharge Summary (PODS) is an easy-to-use discharge summary^G designed for persons transitioning from hospital to home. It is not meant to replace a traditional discharge summary sent to a primary care provider. ■ PODS contains useful information that persons should know, including information about medications, changes to diet and activities, follow-up appointments and symptoms to watch for after a transition. ■ See Appendix G for the PODS template.
RESOURCES FOR HEALTH AND SOCIAL SERVICE PROVIDERS	
Adams S, Nicholas D, Mahant S, et al. Care maps for children with medical complexity. <i>Developmental Medicine & Child Neurology</i> [Internet]. 2017;59(12):1299-306. Available from: https://onlinelibrary.wiley.com/doi/epdf/10.1111/dmcn.13576	<ul style="list-style-type: none"> ■ This research study explores the meaning of care maps for families. ■ A care map is a diagram that visually maps the complex web of services that children with medical complexities and their families require. The map is patient/family created.

RESOURCE	DESCRIPTION
<p>Agency for Healthcare Research (AHRQ). AHRQ health literacy universal precautions toolkit. 2nd ed. [Internet]. Rockville (MD): AHRQ; 2020. Tool 5: use the teach-back method. Available from: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2_tool5.pdf</p>	<ul style="list-style-type: none"> ■ Provides facts, instructions and helpful tips on how to learn and subsequently use the teach-back method with persons and their support network. ■ This helps ensure health education is explained in a way persons and their support network understand.
<p>Building Rapport with Patients: OARS Communication Skills. In: Agency for Healthcare Research and Quality (AHRQ) [Internet]. Rockville (MD): AHRQ; 2016. Available from https://www.ahrq.gov/evidencenow/tools/oars-model.html</p>	<ul style="list-style-type: none"> ■ Outlines the Open-ended Questions, Affirming, Reflective Listening and Summarizing (OARS) approach, a set of verbal and non-verbal communication skills that health and social service providers can use to build rapport with persons and their support network and to elicit their goals of care.
<p>Engaging Patients and Families in Their Health Care. In: Agency for Healthcare Research and Quality (AHRQ) [Internet]. Rockville (MD): AHRQ; 2022. Available from: https://www.ahrq.gov/patient-safety/patients-families/index.html</p>	<ul style="list-style-type: none"> ■ Includes tools and resources to improve engagement with persons and their support network during health-care visits in various settings, including hospital, primary care and LTC.
<p>Engaging persons with lived experience. In: Registered Nurses' Association of Ontario (RNAO) [Internet]. Toronto (ON): RNAO; 2021. Available from: https://RNAO.ca/leading-change-toolkit/engaging-persons</p>	<ul style="list-style-type: none"> ■ A section of the <i>Leading Change Toolkit</i> that focuses on engaging persons with lived experience in change initiatives to support lasting improvements through knowledge uptake and sustainability. ■ Provides guidance on how change agents and change teams can collaborate with persons, families and/or communities to plan, deliver and evaluate change initiatives.
<p>Healthcare Excellence Canada (HEC). Engagement capable environments: organizational self-assessment tool [Internet]. Ottawa (ON): HEC; 2022. Available from: https://healthcareexcellence.ca/media/0n0hfkwj/20220321_ece_organizationalselfassessmenttool_en.pdf</p>	<ul style="list-style-type: none"> ■ This tool helps identify characteristics of organizations that support purposeful and meaningful engagement with persons with lived experience.

RESOURCE	DESCRIPTION
<p>Essential Together. In: Healthcare Excellence Canada (HEC) [Internet]. Ottawa (ON): HEC; 2023. Available from: https://www.healthcareexcellence.ca/en/what-we-do/all-programs/essential-together</p>	<ul style="list-style-type: none"> ■ Program designed to support the integration of essential caregivers into health and social service organizations. ■ Webpage includes links to a variety of resources, including an organizational self-assessment.
<p>Healthcare Excellence Canada (HEC). How safe is your care? Measurement and monitoring of safety through the eyes of patients and their care partners [Internet]. Ottawa (ON): HEC; 2022. Available from: https://www.healthcareexcellence.ca/media/dnrgw10m/20220525_howsafeisyourcare_final_en.pdf</p>	<ul style="list-style-type: none"> ■ Report that provides an approach to understand how persons and their support network experience safety in the health-care system, and how this knowledge can be used to influence health-care practice.
<p>Patient, Family and Caregiver Declaration of Values for Ontario. In: Government of Ontario [Internet]. Toronto (ON): Government of Ontario; 2021. Available from: https://www.ontario.ca/page/patient-family-caregiver-declaration-values-ontario</p>	<ul style="list-style-type: none"> ■ The purpose of this Patient, Family and Caregiver Declaration of Values, drafted by the Minister's Patient and Family Advisory Council in consultation with Ontarians, is to articulate patient, family and caregiver expectations of Ontario's health-care system. ■ The Declaration serves as a compass for persons and organizations involved in health care and reflects a summary of the principles and values that persons, families and caregivers say are important to them. ■ See Appendix F for the Patient, Family and Caregiver Declaration of Values for Ontario.
<p>Registered Nurses' Association of Ontario (RNAO). Person- and family-centred care [Internet]. Toronto (ON): RNAO; 2015. Available from: RNAO.ca/bpg/guidelines/person-and-family-centred-care</p>	<ul style="list-style-type: none"> ■ RNAO BPG. ■ Outlines best practice recommendations for nurses and members of the interprofessional team to enhance the quality of partnerships with persons accessing care.

RESOURCE	DESCRIPTION
<p>RNAO Clinical Pathways for long-term care homes. In: Registered Nurses' Association of Ontario (RNAO) [Internet]. Toronto (ON): RNAO; c2023. Available from: https://RNAO.ca/bpg/implementation/clinicalpathways</p>	<ul style="list-style-type: none"> ■ RNAO Clinical Pathways™ are a digitized version of RNAO's BPGs that can be embedded in an electronic health record system to promote evidence-based care. ■ The RNAO Clinical Pathways that are currently available have been contextualized to the LTC sector in Ontario. RNAO Clinical Pathways are available for the Person- and Family-centred Care BPG. ■ Note: this is a resource for which there is a fee.
<p>About The Canadian Quality & Patient Safety Framework for Health Services. In: Healthcare Excellence Canada (HEC) [Internet]. Ottawa (ON): HEC; c2023. Available from: https://www.patientsafetyinstitute.ca/en/toolsResources/Canadian-Quality-and-Patient-Safety-Framework-for-Health-and-Social-Services/Pages/About-the-Framework.aspx</p>	<ul style="list-style-type: none"> ■ Framework that provides guidance for organizations on safety and quality with five overarching goals (person-centred care, safe care, accessible care, appropriate care and integrated care). ■ The second goal states that persons using health services are to be equal partners in planning, developing and monitoring care.

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 (18). Conducting an initial assessment before developing a plan of care or implementing any intervention is a standard of professional practice (61). It is unethical if it is not completed. As such, completing an assessment to identify care and determine readiness for the transition is good clinical practice and a pre-requisite for developing a transition plan.

Assessing readiness for a transition is a central component of transition planning (62). Readiness assessments are based on clinical criteria, such as: medical stability; functional ability to manage self-care; and having the knowledge, skills, confidence and supports necessary to manage the transition and cope with common challenges that may arise (62). When readiness assessments are not made, persons experiencing a transition in care and members of their support network frequently report feeling unprepared to self-manage care or to assume caregiving responsibilities following the transition (63,64). When transitions are rushed, persons and caregivers are left feeling scared, unsafe and unprepared for the transition (38,64). Low levels of readiness for a transition have also been associated with difficulties coping following the transition and a higher likelihood of hospital readmission (65,66). Importantly, perceptions of readiness may differ between health and social service providers and persons experiencing a transition (67). It is therefore crucial that health and social service providers determine the person's perception of their readiness for the transition.

In addition to helping to identify when a person is ready for a transition, assessments can also help identify the type of care and assistance required during and following a transition (63). This is especially important for persons with complex needs. Assessments play a key role in detecting barriers that may prevent a smooth transition and in identifying appropriate interventions, resources and supports that can guide the plan and coordination of care. In the pursuit of health equity and population health, it is imperative that providers seek to understand the social determinants of health that affect the person when conducting assessments, such as income, housing and social inclusion (68). **Underserved populations**^G are at higher risk of poor clinical outcomes during transitions in care due to factors that impact their health and access to health services and resources (36). Understanding the impact of these factors can help health and social service providers tailor transition plans to the unique needs of persons.

Although there are many factors to consider when conducting an assessment, it is fundamental that the assessment focuses on the needs that are identified by the person and their support network, as they are experts on their own circumstances (42). Information gathered during the assessment can serve as a foundation for: collaboratively developing a transition plan; educating the person and their support network about the transition; and tailoring information to their needs and stage of care. This approach may involve: sharing information about **self-management**^G strategies; offering information and providing access to services and supports; and providing education about medication changes.



The expert panel highlighted that while assessments are critical to prepare for a transition in care, health and social service providers should avoid repeating assessments unnecessarily. It can be frustrating for people to repeat their story multiple times to different health or social service providers, as this can make them feel unheard and can lead to mistrust in the health system. The expert panel further noted that harm can occur when assessments are repeated due to communication breakdown and health and social service providers working in silos. There is a risk of information being lost or not reviewed by providers involved in the person's care.

To avoid repeating assessments unnecessarily, health and social service providers should review previous assessments and highlight similarities and changes when new assessments are conducted. Health and social services providers should also receive education regarding the appropriate use of assessment tools, including whose role it is to perform and document the assessment and when the assessment should be conducted.

When assessments must be repeated, health and social service providers are to explain to the person and their support network why the assessment is important to complete.

See **Table 5** under “Implementation Tips” (below) for further details from the expert panel on: who should perform the assessment; what should be assessed; where, when and how the assessment should take place; and what health equity considerations health and social service providers should be mindful of when completing an assessment. Please note that these factors will depend on the type of transition and the needs of the person and their support network encountering the transition.

Implementation Tips

Table 5: Implementation Tips from the Expert Panel

COMPONENTS OF THE ASSESSMENT	DETAILS OF THE ASSESSMENT
<p>Who should perform the assessment</p>	<ul style="list-style-type: none"> ■ The assessment is to be performed in collaboration with the person experiencing the transition and their support network. ■ The assessment is to involve collaboration between health and social service providers in the settings the person is transitioning to and from. ■ Members of the interprofessional team involved in performing an assessment can include (but are not limited to): nurses; physicians (both family doctors and specialists); social workers; care coordinators; pharmacists; physiotherapists; occupational therapists; speech language pathologists; respiratory therapists; dietitians; psychologists; mental health and substance use service providers; behavioural support staff; Indigenous navigators; harm reduction workers; case managers; case workers; peer workers with lived experience; and spiritual care staff. ■ The name and contact details of the health or social service provider(s) performing the assessment are to be clearly documented to ensure they can be reached for follow-up, as needed. ■ For persons with complex needs, it is beneficial for an interprofessional team to be involved in completing the assessment to ensure a comprehensive picture of the person is gathered and that the person’s needs are well addressed. ■ Having one health or social service provider conduct a main assessment in collaboration with other team members can help ensure that the same questions are not asked multiple times. It also allows for consistency in the information gathered, ensures greater accountability, reduces delay in the collection of relevant information and minimizes the communication errors that can result when multiple individuals are involved. ■ Health and social service providers are to assess their own competency and ensure they have the appropriate knowledge, skill and judgement before conducting the assessment.

COMPONENTS OF THE ASSESSMENT	DETAILS OF THE ASSESSMENT
<p>What factors should be assessed</p>	<ul style="list-style-type: none"> ■ The assessment is to be tailored to the care priorities that are relevant to the transition process and the person’s desired outcomes and care goals following the transition. ■ The list below is not intended to be exhaustive. Health and social service providers familiar with the services they provide are to add to this list based on the needs of the person they are supporting. Information to consider includes (but is not limited to): <ul style="list-style-type: none"> □ The goals of the person and their support network, including what a good transition in care looks like for them and what outcomes are important. □ The person’s physical, cognitive and mental health status, including presenting concerns and other co-morbidities that may impact function and recovery. □ Functional ability, including the ability to care for personal health needs, perform activities of daily living (e.g., feeding, bathing, dressing and toileting) and instrumental activities of daily living (e.g., managing finances, housekeeping and medications). □ Resources, services and supports the person has and needs (e.g., home care services, meal delivery, transportation to and from appointments, or medical equipment), and the person’s insurance coverage or ability to afford these services and resources. □ Safety and appropriateness of the home environment or destination to which the person is transitioning (e.g., whether the LTC home can meet the person’s rehabilitation needs or whether a person transitioning home may be at risk for falls or elder abuse). □ Health literacy and health education that is needed to promote self-management. □ Medications (including the person’s awareness of new medications and potential side effects), what the person is prescribed versus actually taking and what medications the person can afford or has coverage for (for further details, refer to Good Practice Statement 4.0). □ The person’s understanding of the care plan and their ability to engage in care/follow through with appointments. □ Social support that is available, including caregiver commitment and capacity to provide support, and information and resources that caregivers require to provide care.

COMPONENTS OF THE ASSESSMENT	DETAILS OF THE ASSESSMENT
<p>What factors should be assessed, cont.</p>	<ul style="list-style-type: none"> □ Factors that may make the transition more complex (e.g., language barriers, inadequate housing, cognitive impairment, responsive behaviours^G, poverty, self-harm, palliative or end-of-life care needs, lack of access to health insurance and so on). □ Contact information for the person experiencing the transition, or the name and contact information of someone who knows where they are if the person does not have a phone, email or home/ mailing address. □ Contact information for individuals the person trusts and provides consent to share information with, and any substitute decision makers appointed under a Power of Attorney for Personal Care. □ Contact information for the person’s primary care provider (if they have one) to ensure they receive an update on the person’s health status and/or care received. □ Aspects related to personhood, such as values, routines, diet and life history, that can help providers gain a detailed picture of the person and their unique preferences. ■ At the end of the assessment, health and social service providers are to ask if there is anything further the person and their support network wishes to discuss that would be helpful for the interprofessional team to know.

COMPONENTS OF THE ASSESSMENT	DETAILS OF THE ASSESSMENT
<p>How to conduct an assessment</p>	<ul style="list-style-type: none"> ■ Health and social service providers are to use a strength-based approach when conducting assessments. This involves recognizing the existing knowledge, capabilities and connections of the person and their support network that can help them achieve their care goals. ■ Standardized approaches and tools for conducting assessments can be useful because they provide a consistent way of completing assessments and can help ensure care needs are not missed. However, standardized assessments must be balanced with conversations with the person and their support network using open-ended questions to ensure that the person’s voice and concerns are heard, information is not missed and care is customized to their needs. ■ Assessments are to be clearly documented. Some standardized assessments are long, and it can be helpful to include a one-page, high-level summary so that health and social service providers can quickly review the main content of the assessment. ■ A good assessment should not feel like the health or social service provider is “checking boxes,” because this can erode trust between the person receiving care and the provider. The person and their support network are to be engaged and have an active part in the discussion. ■ Initiating an assessment requires establishing a trusting relationship between the person and the health or social service provider. It is important for providers to: <ul style="list-style-type: none"> □ Be 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. □ Ask permission prior to asking questions and ensure confidentiality is maintained. □ Use a non-judgmental and empathetic approach to help persons and their support network feel supported and safe discussing their concerns and asking questions. ■ The documented assessment is to contain accurate and up-to-date information. This will help to ensure that health and social service providers in the setting to which the person is transitioning will have the resources and capacity to appropriately care for the person (e.g., information about responsive behaviours). ■ Health and social service providers are to share a copy of the assessment with the person and their support network.

COMPONENTS OF THE ASSESSMENT	DETAILS OF THE ASSESSMENT
<p>How to conduct an assessment, cont.</p>	<ul style="list-style-type: none"> ■ When assessment tools are implemented, programs and organizations are to: <ul style="list-style-type: none"> □ Work with the interprofessional team to determine processes for conducting assessments, which includes clearly identifying the purpose of each assessment and the recommended frequency. These decisions are to be based on an understanding of how persons transition throughout the health system. □ Evaluate the appropriateness of assessment tools (e.g., their reception and usefulness) based on direct feedback from persons receiving care and health and social service providers. □ Evaluate the effectiveness of assessment tools.
<p>Setting and timing of the assessment</p>	<ul style="list-style-type: none"> ■ Assessments are to be performed at a time that allows the person receiving care and their support network to participate. This ensures they can have an active role in the assessment. Health and social service providers are to allow time and space for persons and their support network to ask questions and/or raise concerns. ■ An assessment is to be performed before and after a transition in care and in response to any changes in the person's health status or care needs. There may also be instances when the person or their support network asks for an additional assessment. ■ An assessment is to be conducted, or a previously conducted assessment is to be reviewed, 48–72 hours prior to a transition. This will ensure that information is up to date. ■ After the person has transitioned to a new setting, a follow-up assessment is to be done to ensure the person's needs are being met and the appropriate services are being provided. This assessment is to be done as soon as possible in order to avoid delaying care after the transition. Ongoing re-assessments are to be conducted, as needed. ■ Some aspects of the assessment may only need to be completed once, such as collecting information about personhood. Other assessments, however—such as those related to behaviour change—may need to take place more frequently. ■ Re-assessments should be a continuation of the initial assessment, focused on identifying changes from the previous assessment. ■ In some circumstances, it is appropriate to take a stepped-care approach, where a brief assessment is initially conducted and a more comprehensive assessment is later performed, if needed, based on the person's care needs.

COMPONENTS OF THE ASSESSMENT	DETAILS OF THE ASSESSMENT
<p>Health equity considerations when conducting an assessment</p>	<ul style="list-style-type: none"> ■ Health and social service providers are to consider the best way to communicate with persons and their support network to ensure they can actively participate in the assessment. Considerations are to be made when communicating with persons who are deaf, blind or have low health literacy, or when language barriers exist. Health and social service providers are to use plain language and minimize medical jargon. When needed, translation services are to be arranged. ■ Safe, trusting therapeutic relationships are developed when health and social service providers understand how a person’s lived experience, including trauma or previous negative experiences within the health system, can impact a person’s health behaviours. Care is to be provided in a culturally safe, psychologically safe, respectful and trauma-informed way. ■ For caregivers and members of a person’s support network, there can be a financial burden associated with needing to take time off of work to provide support and answer questions when assessments are performed, especially if they must travel long distances. Reducing the number of unnecessary assessments can help reduce this burden. Many assessments can be facilitated remotely to decrease burden around travel. Organizations are to consider creative and hybrid ways to collaborate and conduct assessments during transitions in care. ■ Health and social service providers are to explore what barriers persons may experience when encountering a transition in care, and which barriers can be overcome. Health and social service providers are to consider if the person: <ul style="list-style-type: none"> □ has a support network available to assist during the transition; □ has access to health care resources, including access to navigation support; □ has a history of trauma related to accessing health services; □ has physical limitations or cognitive impairment; □ can read and comprehend written documents and instructions; □ can afford the treatments, equipment or medications being proposed; □ has access to a phone to book appointments or the Internet to attend virtual appointments;

COMPONENTS OF THE ASSESSMENT	DETAILS OF THE ASSESSMENT
<p>Health equity considerations when conducting an assessment, cont.</p>	<ul style="list-style-type: none"> □ has access to transportation to attend appointments; □ faces barriers to attending appointments due to work requirements (e.g., no flexible work hours, paid leave or benefits); □ has stable housing and a safe living situation; and □ can afford food and other necessities. <ul style="list-style-type: none"> ■ For persons who have experienced racism, discrimination or a traumatic experience within the health system, it is important for a person they trust to be present when assessments are being performed. ■ Assessments are to focus on what interventions best suit the person’s goals of care. Health and social service providers must uphold respect for each person’s autonomy and understand that persons have the right to make decisions that providers may not agree with.

Supporting Resources

RESOURCE	DESCRIPTION
<p>Behavioural Supports Ontario (BSO). Making connections: recommendations to enhance the use of personhood tools to improve person-centered care delivery across sectors. [Internet]. [place unknown]: BSO; 2018. Available from: https://brainxchange.ca/Public/Special-Pages/BSO/Files/Personhood-Tools/Making-Connections-BSO-Lived-Experience-Advisory-A.aspx</p>	<ul style="list-style-type: none"> ■ Resource from Behavioural Supports Ontario. ■ Lists tools that can be used to assess personhood during a transition in care.
<p>Comprehensive Assessment Instruments. In: inteRAI [Internet]. [place unknown]: inteRAI; [date unknown]. Available from: https://interrai.org/instrument-category/comprehensive-assessment-instruments/</p>	<ul style="list-style-type: none"> ■ Comprehensive assessments to help health providers identify, assess and prioritize common physical, cognitive and psychosocial issues. ■ Assessments are available for acute care and rehabilitation, adult and older adult care, children and youth, and mental health. ■ Note: this is a resource for which there is a fee.

RESOURCE	DESCRIPTION
<p>Health Quality Ontario (HQO). Transitions between hospital and home: care for people of all ages [Internet]. Toronto (ON): HQO; 2020. Available from: https://www.hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-transitions-between-hospital-and-home-quality-standard-en.pdf</p>	<ul style="list-style-type: none"> ■ Quality Standard from Health Quality Ontario. ■ Addresses care for people of all ages who are transitioning between hospital and home. ■ Includes a detailed section on how to conduct a comprehensive assessment of a person’s health and social care needs.
<p>Inquest into the death of Bradley Chapman. Verdict of Coroner’s Jury [Internet]. Office of the Chief Coroner. [place unknown]: Ministry of the Solicitor General (Ontario); 2018. Available from: https://www.toronto.ca/legdocs/mmis/2019/ec/bgrd/backgroundfile-136740.pdf</p>	<ul style="list-style-type: none"> ■ Outlines the jury’s recommendations following a coroner’s inquest into a death from an opiate overdose. ■ Recommends conducting a timely assessment when planning for a transition from a correctional facility. Refer to Recommendation 34.
<p>Kessler D, Provencher V, MacLeod H. The Living with Risk: Decision Support Approach Research Project [Internet]. [place unknown: publisher unknown; date unknown]. Available from: https://lwrdsa-vivreaveclesrisques.recherche.usherbrooke.ca/?lang=en</p>	<ul style="list-style-type: none"> ■ A tool developed to help providers assess older adults’ risk status associated with remaining at home or returning home after they have been hospitalized. ■ Website includes a range of resources, including a risk analysis fillable worksheet. ■ Also available in French.
<p>National Institute for Health and Care Excellence (NICE). Transition between inpatient hospital settings and community or care home settings for adults with social care needs. [Internet]. London (UK): NICE; 2015 Dec 01. Available from: https://www.nice.org.uk/guidance/ng27</p>	<ul style="list-style-type: none"> ■ Guideline from the National Institute for Health and Care Excellence. ■ Contains recommendations related to assessment and care planning during transitions in care (Recommendations 1.3.9 and 1.3.10).

RESOURCE	DESCRIPTION
<p>PATH-s is a freely accessible, evidence-based tool designed to assess caregiver's preparedness to transition stroke patients home. In: Association of Rehabilitation Nurses (ARN) [Internet]. Chicago (IL): ARN; [date unknown]. Available from: https://rehabnurse.org/advance-your-practice/practice-tools/path-s-instrument</p>	<ul style="list-style-type: none"> ■ Instrument designed to assess caregiver readiness prior to a stroke survivor's transition from an inpatient rehabilitation facility to home.
<p>Readiness for Hospital Discharge Scale (RHDS). In: Marquette University, College of Nursing [Internet]. Milwaukee (WI): Marquette University, College of Nursing; c2022. Available from: https://www.marquette.edu/nursing/readiness-hospital-discharge-scale.php</p>	<ul style="list-style-type: none"> ■ Tools developed to measure readiness to return home from the hospital. ■ Versions are available for both the person experiencing the transition and the nurse to complete.
<p>RNAO Clinical Pathways for long-term care homes. In: Registered Nurses' Association of Ontario (RNAO) [Internet]. Toronto (ON): RNAO; 2022. Available from: https://RNAO.ca/bpg/implementation/clinicalpathways</p>	<ul style="list-style-type: none"> ■ RNAO Clinical Pathways™ are a digitized version of RNAO's BPGs that can be embedded in an electronic health record system to promote evidence-based care and help guide assessments. ■ The RNAO Clinical Pathways that are currently available have been contextualized to the LTC sector in Ontario. ■ Note: this is a resource for which there is a fee.

RESOURCE	DESCRIPTION
<p>The Family Caregiver Activation in Transitions® (FCAT®) tool. In: The Care Transitions Program® (CTP®) [Internet]. [place unknown]: CTP®; 2015. Available from: https://secureservercdn.net/72.167.242.33/253.582.myftpupload.com/wp-content/uploads/2019/09/Family-Caregiver-Activation-in-Transitions-FCAT-tool.pdf</p>	<ul style="list-style-type: none"> ■ Tool developed to guide the interprofessional team in understanding person and family needs prior to a transition in care.
<p>Toronto Paramedic Services. In case of emergency information sheet [Internet]. Toronto (ON): Toronto Paramedic Services; 2016. Available from: https://www.toronto.ca/wp-content/uploads/2017/10/903f-ICE-Sheet2016-1.pdf</p>	<ul style="list-style-type: none"> ■ Allows persons and their support network to provide important details for paramedics and hospital staff, such as emergency contact details, relevant medical history, medications, allergies, mobility and pet care contacts. ■ Available in a range of languages, including English, French, Chinese, Farsi, Polish, Spanish and Tamil.

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 (18). Interprofessional collaboration occurs when health or social service providers from different professional backgrounds assume complementary roles, share responsibility for decision-making and work together to provide high quality care (69). Collaborating with other members of the health-care team is a standard of professional practice (48,50,61,70). As such, collaborating with the interprofessional team to develop a transition plan that supports the unique needs of persons and their support network is good clinical practice. While this good practice statement 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 (see **Good Practice Statement 1.0**).

Transition plans are necessary to promote **continuity of care**^G and ensure that the necessary services, supports and resources have been arranged for the person encountering the transition (71). When health and social service providers come together to share professional perspectives and understanding, a more comprehensive transition plan can be created (72). It can be especially beneficial to have health and social service providers from different disciplines contribute to developing the transition plan, as their combined skills and knowledge can help ensure a person's needs are well addressed (73). Team rounds and interprofessional discharge clinics are two examples where interprofessional teams gather to coordinate a plan of care (72,74).

Effectively developing a transition plan is contingent on good communication and collaboration between the interprofessional team (75). Evidence suggests that when health and social service providers lack clarity about the roles and responsibilities of other providers, strain can occur when developing a transition plan (71,76). Limited opportunities for meaningful interaction and decision making, perceived power differentials and professional hierarchies, and inadequate respect for the expertise of other team members can further prevent collaboration from occurring (72,73,76,77). Furthermore when members of the interprofessional team communicate contradictory information to persons and their support network and do not collaborate, this can create confusion among persons and a lack of trust in the team (78). Many practices can be implemented however to promote interprofessional collaboration when developing a transition plan. Organizations can establish a culture that supports the equal value of all team members involved in transition planning (78), and health and social service providers can strive to communicate effectively and demonstrate trust and respect for other team members and their roles (71,76). These practices foster safe, collaborative spaces where interprofessional team members feel comfortable contributing to team discussions and decision making.

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 **Recommendation 3.1**.
- Education should be provided to health and social service providers and students to develop the skills required for effective coordination during transitions in care. Education is to include content about team roles, interprofessional communication and the process of developing a transition plan to ensure that the contributions of each profession are incorporated.

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).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Agency for Healthcare Research and Quality (AHRQ). Care transitions from hospital to home: IDEAL discharge planning implementation handbook. Rockville (MD): AHRQ; 2017. Available from: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Implement_Hndbook_508_v2.pdf</p>	<ul style="list-style-type: none"> ■ An implementation toolkit that highlights key elements required to engage persons and their support network in the discharge process to ensure a successful transfer of information.
<p>Interprofessional Education Collaborative (IPEC). Core competencies for interprofessional collaborative practice: 2016 update [Internet]. Washington (DC): IPEC; 2016. Available from: https://ipec.memberclicks.net/assets/2016-Update.pdf</p>	<ul style="list-style-type: none"> ■ Outlines the Interprofessional Education Collaborative's (IPEC) four core competencies of interprofessional collaborative practice that can be used to guide curriculum development across health profession schools.
<p>Registered Nurses' Association of Ontario (RNAO). Developing and sustaining interprofessional health care: optimizing patients/clients, organizational and system outcomes. Toronto (ON): RNAO; 2013. Available from: https://RNAO.ca/sites/rnao-ca/files/DevelopingAndSustainingBPG.pdf</p>	<ul style="list-style-type: none"> ■ RNAO BPG. ■ Outlines best practice recommendations at the system, organization and individual levels for developing and sustaining interprofessional collaboration in health care.
<p>TeamSTEPPS Canada Essentials Course. In: Healthcare Excellence Canada (HEC). [Internet]. Ottawa (ON): HEC; 2023. Available from: https://www.healthcareexcellence.ca/en/what-we-do/all-programs/teamstepps-canada-essentials-course/</p> <p>Pocket Guide: TeamSTEPPS. Team Strategies & Tools to Enhance Performance and Patient Safety. In: Agency for Healthcare Research and Quality (AHRQ). [Internet]. Rockville (MD): AHRQ; [created January 2014; revised January 2020]. Available from: https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html</p>	<ul style="list-style-type: none"> ■ TeamSTEPPS is an evidence-based framework to optimize team communication and collaboration across the health system. ■ Healthcare Excellence Canada is the TeamSTEPPS Canada educational lead. The TeamSTEPPS Canada Essential Course is a free, 20-minute, e-learning course. ■ The pocket guide from ARHQ contains strategies and tools to enhance team performance and safety.

RESOURCE	DESCRIPTION
<p>My Transitional Care Plan®: Tool Download & Permissions. In: Behavioural Supports Ontario (BSO) [Internet]. [place unknown]: BSO Collaborative; [date unknown]. Available from: https://brainxchange.ca/Public/Special-Pages/BSO/Clinical-Tools-and-Resources/My-Transitional-Care-Plan/My-Transitional-Care-Plan%C2%A9-Tool-Download-Permis</p>	<ul style="list-style-type: none"> ■ My Transitional Care Plan® summarizes information to facilitate successful transitions in care for older adults presenting with or at risk of responsive behaviours or complex mental health, substance use or neurological conditions. ■ See Appendix H for a template. The form can also be built within an electronic health record 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.

Strength of the recommendation: Conditional

Certainty of the evidence of effects: Very low

Discussion of Evidence:**Benefits and Harms**

For the purposes of this BPG, an interprofessional cross-sectoral approach refers to a collaborative approach where two or more health or social service providers from different disciplines and in different sectors work together in a formal way to ensure that persons and their support network experience a safe transition in care. The studies looked at cross-sectoral collaboration among providers who were supporting adults transitioning from hospital to home (81–84) or from hospital to a rehabilitation facility (85,86) when compared to standard care. Standard care included discharge to home or a rehabilitation facility with a discharge summary and a scheduled follow-up appointment with a primary care provider or specialist (81) and/or a lack of formal communication and follow-up between providers from different sectors (82–86).

The members of the interprofessional team that engaged in a formal cross-sectoral approach to support persons encountering a transition varied across studies. Interprofessional team members included, but were not limited to: nurses; social workers; pharmacists; general practitioners; psychologists; rehabilitation specialists; and physical therapists (81–86). The types of formal interprofessional cross-sectoral approaches also varied across studies. Examples included: video conference sessions attended by providers in hospital and rehabilitation facilities to discuss the plan of care for persons experiencing a transition (86); and a program where a nurse practitioner assessed persons prior to hospital discharge and post-discharge in a rehabilitation facility and then discussed the assessment directly with the rehabilitation staff (85). For further details on the types of formal interprofessional cross-sectoral approaches studied, please refer to the “Implementation Tips” below.

Evidence suggests that formal interprofessional cross-sectoral approaches may increase follow-up visits with a health or social service provider (81), and that they may reduce readmission rates within 30 days of discharge from hospital (81–86). One study reported more outpatient specialist clinic visits in the intervention group, which received transitional care through an integrated practice unit (81). Out of six studies that reported on readmission rates (81–86), four reported lower readmission rates (81,82,84,86), one study reported a slight increase in readmission rates (85), and one study reported no important differences when a formal interprofessional cross-sectoral approach was implemented to support persons during transitions in care (83). Two studies assessed the effect of formal interprofessional cross-sectoral approaches on emergency department visits within 30 days of discharge from hospital (81,84). However there were some inconsistencies in the results, with one study reporting a 40 per cent reduction in emergency department visits in the intervention group compared to the control group (81), and one study reporting no important differences (84).

The expert panel noted that quality of life and patient satisfaction were critical outcomes that the systematic reviews should focus on; however, there was a lack of direct evidence related to these outcomes. As a result, these outcomes were measured using a survey that systematically gathered the expert panel's experiences and observations related to formal interprofessional cross-sectoral approaches being implemented to support persons during transitions in care. The data from the survey capturing systematic observations was collated and the quality appraised. Thirteen out of 20 expert panel members responded to the survey, the majority of whom reported observations from their experiences working in hospitals where a formal process was in place to support transitions in care. In terms of the impact of formal interprofessional cross-sectoral approaches on patient quality of life, nine expert panel members (69.2 per cent) reported that formal interprofessional cross-sectoral approaches improve patient quality of life, two expert panel members (15.4 per cent) reported no change in quality of life and one expert panel member (7.7 per cent) reported a reduction in quality of life. One panel member (7.7 per cent) could not provide information on this outcome.

In terms of the effects of formal interprofessional cross-sectoral approaches on patient satisfaction, eight expert panel members (61.6 per cent) reported that formal interprofessional cross-sectoral approaches improve patient satisfaction, and two expert panel members (15.4 per cent) reported a reduction in patient satisfaction. Three panel members (23.1 per cent) could not provide information on this outcome.

No harms related to the use of formal interprofessional cross-sectoral approaches were reported in the evidence or noted by the expert panel.

The evidence was of very low certainty due to limitations in how the studies were conducted, inconsistency in the use of measurement tools and study results, and a small number of study participants or few events.

For more detailed information about the impact on the prioritized outcomes resulting from formal interprofessional cross-sectoral approaches being implemented to support persons during transitions in care, refer to the [evidence profiles](#).

Values and Preferences

From the Systematic Review Evidence

No evidence was identified in the systematic review that directly assessed the values and preferences of persons with respect to formal interprofessional cross-sectoral approaches being implemented during transitions in care.

From the Expert Panel (Systematic Observation)

Expert panel members reported that persons valued the use of formal interprofessional cross-sectoral approaches during transitions in care, as these approaches may:

- ensure continuity of care and care coordination;
- increase safety and reduce medication errors, miscommunication and readmissions;
- support person and family involvement in regular care and decision-making activities; and
- give persons a sense of security and confidence in the health system.

Health Equity

From the Systematic Review Evidence

No evidence was identified in the systematic review that directly assessed the impact of formal interprofessional cross-sectoral approaches on health equity.

From the Expert Panel (Systematic Observation)

A few expert panel members emphasized that formal interprofessional cross-sectoral approaches should be the norm and not the exception during transitions in care, especially for underserved populations. If communication among health and social service providers breaks down and information is not accurately shared during transitions across settings, it may result in significant harm, especially for persons who are inadequately housed, older adults, persons with cognitive impairment, persons with mental health challenges, persons who use substances, and persons who face historic and systemic racism, such as Indigenous peoples. An expert panel member noted that interprofessional teams should collaborate to provide psychosocial and pragmatic support for underserved populations during a transition, along with the contact information of an interprofessional team member so that persons and their support network can reach out when questions or challenges arise after a transition in care.

Expert Panel Justification of Recommendation

The expert panel noted that there may be benefits in implementing a formal interprofessional cross-sectoral approach to support transitions in care, such as increased follow-up visits with health or social service providers, increased patient satisfaction, improved quality of life and a reduction in hospital readmissions within 30 days of a transition. No harms were reported in the literature. However, the certainty in the evidence is very low; therefore, the expert panel determined the strength of the recommendation to be conditional.

Implementation Tips

Implementation Tips from the Expert Panel

- Although the evidence focused on a formal interprofessional cross-sectoral approach to support transitions from hospital to home or hospital to rehabilitation, the expert panel emphasized that this recommendation should be inclusive to all settings where persons and their support network encounter a transition in care.
- Health and social service organizations are to ensure that providers are aware of who is part of the interprofessional team and their respective roles and responsibilities. This will help to ensure a clear path of communication among all members involved.
- It is beneficial to have one designated health or social service provider lead the team and coordinate care. Such collaboration has the potential to promote effective communication and information transfer, reduce duplication of services, and ultimately ensure a smooth transition for persons and their support network. It is useful for this designated provider to operate within the organization where the person will have the longest involvement (e.g., home care or LTC).
- It is beneficial for providers in both settings (i.e., the setting from which the person is transitioning and the new setting) to directly communicate by phone or videoconference to discuss the plan of care and ensure the person's care needs are understood. This is especially important for persons with complex needs. For example, when persons are transitioning between the hospital and a LTC home, it is beneficial for the most responsible provider in the hospital (i.e., a physician or nurse practitioner) to directly communicate with the physician or nurse practitioner in the LTC home.

- Persons are to be made aware that interprofessional team members—from whom persons have consented to receive treatment—will be discussing their care together. This means that information will be shared with the receiving interprofessional team as a component of transition planning.
- Health and social service organizations are to establish systems for communicating pertinent information about the person and/or their support network during transitions in care in order to meet all privacy, security and legislated regulatory requirements.
- Health and social service organizations are to use standardized documentation tools and communication strategies for the clear and timely exchange of information pertaining to the person and their support network before, during and after transitions in care.
- To ensure the quality and safety of transitions, organizations are to establish transitions in care as a strategic priority. This will allow system-wide approaches to be developed and will encourage the development of improved processes and care pathways.

Table 7: Implementation Tips from the Evidence**DETAILS FROM THE EVIDENCE**

The types of formal interprofessional cross-sectoral approaches implemented to support persons during transitions in care varied across studies.

Enzinger et al., 2021

- In the study, participants were transitioning from an acute medicine unit in a hospital to home.
- The hospitalist contacted the person's primary care physician by telephone within 72 hours prior to discharge, making a maximum of three call attempts. During the phone call, health providers discussed the reason and duration of hospitalization, medical care provided, medication changes, relevant social care considerations, date of discharge, and all information required to provide follow-up care after the transition (83).

Krol et al., 2019

- Health Optimization Program for Elders (HOPE) is a program for higher risk older adults transitioning from a hospital to a rehabilitation facility.
- The HOPE team at the hospital included a nurse practitioner (who leads the program), a geriatrician, hospitalists, geriatrics fellows, nursing leadership, case management, hospital leadership representatives and an administrative leader.
- The rehabilitation team included nursing staff, medical providers, rehabilitation therapists, social workers and transportation coordinators.
- The type of support provided included a one-time inpatient consultation by the HOPE team and an evaluation approximately 72 hours after the transition by the nurse practitioner, who communicated with rehabilitation staff by phone or in-person about the person's hospital stay, medications, rehab progress, outpatient follow-up appointments and goals of care (85).

DETAILS FROM THE EVIDENCE

Low et al., 2017

- Intervention group participants received pre-discharge transitional care through an integrated practice unit, which comprised an inpatient care team and an outpatient virtual ward team.
- The inpatient team included the attending family physician, a medical officer, a nurse case manager, a pharmacist and a social worker.
- The outpatient virtual ward team included the attending family physician, two nurse case managers and a social worker. At the time of the transition, care was handed over to the outpatient virtual ward team.
- The type of supports provided by the inpatient team included: discharge planning; medication reconciliation; self-management coaching; scheduling follow-ups; and sharing contact info for the virtual ward nurse.
- The virtual ward team closely monitored persons for three months and conducted a telephone review within 72 hours of the transition, home assessment and regular telephone reviews to identify early complications (81).

Moore et al., 2017

- The Extension for Community Healthcare Outcomes Care Transitions (ECHO-CT) video conference sessions focus on older adults transitioning from hospital to a rehabilitation facility.
- The hospital-based team included a pharmacist, social worker, hospitalist facilitator and project manager.
- The rehabilitation facility staff included nurses, doctors, and occasionally physical therapists and trainees.
- The ECHO-CT video conference sessions were conducted weekly for 1.5 hours and consisted of discrete 15-minute face-to-face discussions between the hospital and rehabilitation care teams using secure video communication technology.
- The video conference sessions included a discussion about the person's hospital stay, current medical condition, medications and concerns/questions related to their care plan (86).

Paolini et al., 2022

- The Careggi Re-Engineered Discharge (CaRED) intervention is designed to support adults transitioning home from a high complexity medicine ward in a teaching hospital.
- CaRED is a restructured discharge protocol, that involves direct communication between hospitals and general practitioners in primary care.
- General practitioners received an email informing them that one of their patients was hospitalized. The email authorized the general practitioner to access the hospital electronic health record throughout the patient's hospitalization. General practitioners were also able to directly contact and discuss health data and health-care decisions with hospital staff. At discharge, general practitioners received an e-mail with the discharge letter, directly alerting them of the discharge (84).

DETAILS FROM THE EVIDENCE

Schubert et al., 2016

- The Geriatric Resources for Assessment and Care of Elders (GRACE) is an intervention for veterans 65 and older transitioning home after hospitalization.
- A nurse practitioner and social worker (the GRACE team) performed an assessment at home one week after the older adult was discharged from hospital. The visit focused on identifying post-discharge concerns related to medications, follow-up appointments and so on.
- The GRACE team then connected with an expanded team (the GRACE interdisciplinary panel)—which was comprised of a geriatrician, pharmacist, and psychologist or mental health liaison—to relay the findings of the assessment and put together a detailed care plan. The GRACE team then connected with the person and their primary care provider to review, modify and implement the plan of care to ensure it aligned with the person’s goals and preferences.
- Once the plan was finalized, the GRACE team conducted follow-up home visits on a monthly basis, or as needed, in order to continue its participation in the veteran’s care (face-to-face or by phone) (82).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Provincial Geriatrics Leadership Ontario (PGLO). Designing integrated care for older adults living with complex and chronic health needs: a scoping review. [place unknown]: PGLO; 2020. Available from: https://rgps.on.ca/wp-content/uploads/2020/11/PGLO-Scoping-Review-FINAL.pdf</p>	<ul style="list-style-type: none"> ■ Literature examining design elements to help planners, policy-makers, health leaders and clinicians design ways to integrate systems of care for older adults with complex health concerns.
<p>Registered Nurses' Association of Ontario (RNAO). Developing and sustaining interprofessional health care: optimizing patients/clients, organizational and system outcomes. Toronto (ON): RNAO; 2013. Available from: https://RNAO.ca/sites/rnao-ca/files/DevelopingAndSustainingBPG.pdf</p>	<ul style="list-style-type: none"> ■ RNAO BPG. ■ Outlines best practice recommendations at the system, organization and individual levels for developing and sustaining interprofessional collaboration in health care.
<p>SBAR Tool: Situation-Background-Assessment-Recommendation. In: Institute for Healthcare Improvement (IHI) [Internet]. Boston (MA): IHI; 2013. Available from: https://www.ihl.org/resources/Pages/Tools/sbartoolkit.aspx</p>	<ul style="list-style-type: none"> ■ SBAR (Situation-Background-Assessment-Recommendation) is a tool for framing conversations about a person's condition between members of the interprofessional team. ■ Encourages clear and concise sharing of information.
<p>TeamSTEPPS Canada Essentials Course. In: Healthcare Excellence Canada (HEC). [Internet]. Ottawa (ON): HEC; 2023. Available from: https://www.healthcareexcellence.ca/en/what-we-do/all-programs/teamstepps-canada-essentials-course/</p> <p>Pocket Guide: TeamSTEPPS. Team Strategies & Tools to Enhance Performance and Patient Safety. In: Agency for Healthcare Research and Quality (AHRQ) [Internet]. Rockville (MD): AHRQ; [created January 2014; revised January 2020]. Available from: https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html</p>	<ul style="list-style-type: none"> ■ TeamSTEPPS is an evidence-based framework to optimize team communication and collaboration across the health system. ■ Healthcare Excellence Canada is the TeamSTEPPS Canada educational lead. The TeamSTEPPS Canada Essential Course is a free, 20-minute, e-learning course. ■ The pocket guide from ARHQ contains strategies and tools to enhance team performance and safety.

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.

This is a good practice statement that does not require application of the GRADE system (18). Transitions in care include transfer of a person's information and care across different settings, health and social service providers, and interprofessional teams (8,87). During these transitions, medications are frequently stopped, adjusted or newly prescribed. Communication and care processes can break down at various points during a transition in care, resulting in unintended medication errors or discrepancies (88). As such, medication safety is a professional standard of practice (89), and it is good clinical practice for health providers to collaborate with persons and their support network to implement strategies that ensure medication safety during transitions in care.

The common types of medication discrepancies that occur during transitions in care include omission of medication, prescribing errors and failure to communicate changes in medications (88). While it is difficult to estimate the prevalence of medication discrepancies during transitions in care due to the various methods of defining and classifying discrepancies, a 2018 Cochrane review reported that 559 out of 1000 people are at risk of having one or more medication discrepancies during a transition in care (88,90). A considerable portion of medication discrepancies result in **medication-related harm**^G, including a preventable adverse drug event (e.g., harm due to a medication error) or a non-preventable adverse drug event (e.g., an adverse reaction) (88). Health Quality Ontario reports that the following populations in Ontario are at greater risk of experiencing a medication-related harm: children and youth; older adults; persons taking multiple medications (polypharmacy); persons with mental health conditions; persons with dementia or mild cognitive impairment; persons whose first language is not English; persons with low literacy or low health literacy; persons with disabilities; persons with low socio-economic status; and those without an insurance drug plan (91).

According to the World Health Organization (WHO) (2019), the following key strategies can help improve medication safety during transitions in care (88):

1. Implementing a structured process for medication reconciliation at each stage of the transition by:
 - a) Obtaining a **best possible medication history (BPMH)**^G, which includes interviewing the person or a member of their support network and verifying the medication history with at least one other reliable source of information to gather a complete and accurate list of medications used at the time of transition. For a list of questions health providers can ask when conducting a BPMH, see [Appendix I](#).
 - b) Reconciling and updating the medication list, which includes comparing the BPMH with prescribed medications, identifying and resolving any discrepancies, documenting changes and updating the medication list. This is done in partnership with persons to ensure the complete and accurate transfer of medication information at each stage of the transition.

- c) Communicating the current list of medications and reasons for any changes to medications to the person, their support network and the health providers to whom care is being transferred (88).

For a sample medication reconciliation form that health providers can use, see [Appendix J](#).

2. Collaborating with persons and their support network to ensure persons can manage their medications safely, which includes understanding what their medications do and how each medication should be taken.

Education and medication literacy are crucial to prevent medication-related harms and improve medication safety during transitions in care. Collaboration between persons, their support network and health providers is desirable to inform and empower persons to self-manage medications and improve health outcomes and safety. It is important to provide persons with information about their medications and how to use them safely. Providing information leaflets and offering advice or counselling can aid with this. Medication safety can also be improved by providing medication instructions, follow-up care after the transition and a contact number that persons can call when they have questions or issues related to their medications (88).

For a list of questions that persons should ask about their medications prior to a transition, see [Appendices K and L](#).

3. Providing enhanced support for persons at high risk of medication-related harm before and after transitions in care.
4. Improving the quality and availability of information about medications during transitions of care.

It is important to identify the most reliable information sources for verifying medication histories at the time of transitions of care. The person's knowledge and understanding of their medications can be supported by the use of a patient-held medication list. This may be in the form of paper (e.g., a medication card or medication passport) or an electronic form (e.g., a mobile application) to help persons keep track of medications and share information with health providers when needed (88).

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.

- When a transition is occurring, a report listing current and past medication(s) is to be sent to providers in the receiving setting that notifies them of changes made to the person's medications. When possible, this report is to be electronically transferred. When persons are transitioning from hospital to LTC, it is beneficial for the most responsible provider in the hospital (i.e., the physician or nurse practitioner) to communicate this information directly with the receiving physician or nurse practitioner in the LTC home.
- Health providers are to consider whether persons can access and afford medication prescribed and equipment (e.g., insulin and syringes), and whether medications are covered under provincial, territorial or federal drug programs. Health providers are to be aware that certain medications are only covered in specific settings (e.g., The Ontario Drug Benefit covers certain medications in hospital but not in LTC).
- Health providers are also to assess:
 - Whether persons have the capacity to follow through with instructions (e.g., someone is present to remind them to take medications, if necessary).
 - Whether persons are able to adhere to specific medication regimens based on their personal lifestyle, preferences and so on.
 - Whether or not persons understand the changes made to their medications. This includes understanding what the medication does and how it should be taken.
- Once medication reconciliation has been performed, a medication review can also occur. A medication review is a structured evaluation of the medications a person is taking with the aim of optimizing medication use (88). The risks and benefits of each medication are considered in light of the person's current health and living conditions, and decisions are made about future therapy. This can occur before or after a transition in care (88).
- Organizations are to develop standardized policies and structured processes to guide medication reconciliation during transitions in care. This ensures that complete and accurate information about medications are communicated during all transition points. This also aligns with Accreditation Canada's Required Organizational Practice to maintain an accurate medication list at care transitions (forthcoming, 2024 implementation) (92).

Supporting Resources

RESOURCE	DESCRIPTION
<p>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</p>	<ul style="list-style-type: none"> ■ Interview guide for conducting a BPMH. ■ Lists questions that health providers can ask to gain a complete and accurate list of medications taken at the time of transition.
<p>Hospital to Home – Facilitating Medication Safety at Transitions. A Toolkit and Checklist for Healthcare Providers. In: The Institute for Safe Medication Practices (ISMP) Canada [Internet]. Toronto (ON): ISMP Canada; [date unknown]. Available from: https://www.ismp-canada.org/transitions/</p>	<ul style="list-style-type: none"> ■ A toolkit to help health providers prevent medication errors during transitions from hospital to home. ■ Includes a checklist and sample fax form to facilitate communication with community pharmacists.
<p>The Institute for Safe Medication Practices Canada (ISMP). Medication reconciliation. Frequently asked questions [Internet]. Toronto (ON): ISMP Canada; [date unknown]. Available from: https://www.ismp-canada.org/download/MedRec/FAQ-RolesResponsibilitiesMedRec.pdf</p>	<ul style="list-style-type: none"> ■ Outlines which interprofessional team members should be involved in medication reconciliation and their roles and responsibilities. ■ Also outlines the role of persons and their support network in the medication reconciliation process.

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.

This is a good practice statement that does not require application of the GRADE system (18). Providing persons and their support network with information and support is a standard of professional practice (61), and it is part of the College of Nurses of Ontario's Code of Conduct (93). As such, when persons and their support network encounter a transition in care, it is good clinical practice and a pre-requisite for health and well-being that health and social service providers ensure that information and support are provided to them.

Health and social service providers need to provide persons and their support network with information that is clear and timely, involve and support them when making care decisions, and advocate and help them access the health care they require (93). The types of information and support that health and social service providers provide to persons and their families can vary, and may include the following: individualized health education or coaching to promote self-management (43,44,94–97); scheduling appointments, making referrals or providing guidance about services or community resources (43,44,94,96,98–104); helping persons to identify and respond to complications or warning signs (43,95,97); and addressing barriers to care (44,94,99). Health education should be tailored to the needs of the person and their support network, and their ability and readiness to manage care following the transition (25). Examples include education about wound care, medication administration and how to safely use medical equipment.

When health and social service providers share information with persons and their support network, it gives the person and their support network the means to appreciate the benefits, harms and outcomes of potential care needs and treatments; this, in turn, empowers people to make decisions about what is right for them and their care (105). For example, persons in one study reported that when they received accurate information and assistance from a health provider, they felt a sense of relief, and it enabled them to “[know their] rights a little bit more” (99). Feelings of self-efficacy to navigate the health-care system and self-confidence in managing health conditions were also noted by multiple persons (99).

It is critical that the needs of caregivers and members of a person's support network are not overlooked, as they are often the main source of support for the person following a transition (55). One systematic review that studied the needs of caregivers during transitions in care reported that there is often a lack of education and training for caregivers to allow them to provide optimal care for their loved ones following a transition (55). In addition, caregivers often report feeling emotionally and physically exhausted (55,106) and worried that they lack the skills or knowledge to care for the person experiencing a transition (107). Attention must be paid to providing adequate education, training and practical support for both persons and their support network.

Implementation Tips

Implementation Tips from the Expert Panel

- It is the responsibility of the health or social care provider to demonstrate their trustworthiness by clearly stating their roles and responsibilities, carefully listening to the person's concerns, appreciating the apprehension that people may feel and following through on their commitments. When a trusting relationship is developed between the person and the health or social service provider, persons are more likely to feel comfortable voicing their concerns and asking questions.
- Power imbalances are inherent in the delivery of health services, and health and social service providers can act as gatekeepers to services and treatments. Health and social service providers are to minimize power differences by actively listening, asking questions and offering options. Persons may not know what potentially beneficial supports are available; to address this, providers are to share the available resources and funded services for which persons are eligible.
- Not all services and supports may be available in rural and remote areas; whenever possible, health and social service providers are to work to reduce gaps in care and increase access to services. When this is not possible, providers are to be transparent about what services are available and clearly communicate this to persons and their support network.
- Health and social service providers are to ensure information is provided and understood, supports are in place and follow-up appointments have been scheduled and can be attended before the person transitions to the next setting.
- When providing health education, health and social service providers are to use plain language, minimize medical jargon and ensure print material is written at a Grade 5 or 6 level. To accommodate different learning styles, information is to be provided in a variety of ways, including verbal and written formats. Hands-on training can provide opportunities for persons to learn and practice new skills, such as dressing changes, prior to a transition.
- Health and social service providers should use the teach-back approach to ensure that persons and their support network understand education and instructions prior to the transition. Teach-back involves asking a person to share in their own words what was explained to them (108).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Agency for Healthcare Research (AHRQ). AHRQ Health Literacy Universal Precautions Toolkit. 2nd ed. [Internet]. Rockville (MD): AHRQ; 2020. Tool 5: use the teach-back method. Available from: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2_tool5.pdf</p>	<ul style="list-style-type: none"> ■ Provides facts, instructions and helpful tips on how to learn and subsequently use the teach-back method with persons and their support network. ■ This helps ensure health education is explained in a way persons and their support network understand.
<p>Health Quality Ontario (HQO). Transitions between hospital and home: care for people of all ages [Internet]. Toronto (ON): HQO; 2020. Available from: https://www.hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-transitions-between-hospital-and-home-quality-standard-en.pdf</p>	<ul style="list-style-type: none"> ■ Quality Standard from Health Quality Ontario. ■ Addresses care for people of all ages transitioning between hospital and home. ■ Includes a section on information, education and support that should be provided to persons and their support network during transitions in care.
<p>The Ontario Caregiver Helpline. In: Ontario Caregiver Organization (OCO) [Internet]. Toronto (ON): OCO; 2023. Available from: https://ontariocaregiver.ca/helpline/</p>	<ul style="list-style-type: none"> ■ Helpline where caregivers can speak to a community resource specialist to connect them to community-based services and supports across Ontario, based on their individual needs. ■ Interpretation services are available in over 150 languages.
<p>The Ontario Caregiver Organization (OCO). I am a caregiver toolkit [Internet]. Toronto (ON): OCO; 2023. Available from: https://ontariocaregiver.ca/wp-content/uploads/2023/04/OCO-starter-kit-March-24-2023-Web_FINAL-es.pdf</p>	<ul style="list-style-type: none"> ■ Toolkit from the Ontario Caregiver Organization. ■ Includes information and educational resources for caregivers supporting family members, partners or friends. ■ Helps caregivers identify and reflect on their own needs to make caregiving responsibilities more manageable.

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:**Benefits and Harms**

Navigation support refers to individualized and coordinated support provided by health or social service providers to help persons and their support network overcome challenges related to navigating the health and social care system during transitions in care. In this BPG, navigation support involves regular follow-up by a health or social service provider who attends to a person's individual needs and connects them with the right services and supports. This can include providing persons with the information and resources they need to achieve their goals of care, connecting persons with other health and social service providers, helping reduce barriers that prevent persons from accessing timely care, providing social and emotional support, and improving access to culturally safe care. In the included studies, the alternative to this type of care was usual care without support from a system navigator. Usual care typically involved standard post-discharge instructions, referrals and outpatient follow-up appointments. Throughout the studies, navigation support was provided by both regulated health and social service providers (e.g., nurses and social workers) (98–100,104,109,110) and non-regulated health and social service providers (e.g., peer workers with lived experience and transition coaches) (43,44,60,94–96,99,101–103). This support was provided to persons with complex care needs who had a high number of previous inpatient admissions or emergency department visits within a specific time period (94,96,99,103,104,110), or persons who received a diagnosis associated with a high risk of admission or readmission to hospital (43,60,95,97,98,100–102,109,111).

Overall navigation support included follow-up with persons after a transition in care in order to assess their current and evolving health or social care needs. Regular check-ins allowed health and social service providers to determine if a person's circumstances, needs or goals had evolved, whether services provided met the person's needs, and whether new supports or services were required. Contact was mainly provided through in-person visits or phone calls, and the length of follow-up ranged from one month to one year. The majority of studies focused on providing support during transitions from hospital to home. Specific components of the intervention noted in the literature are outlined below under "Implementation Tips."

Evidence suggests that providing navigation support to persons with complex care needs during a transition in care may increase follow-up visits with a health or social service provider (44,60,96,103,109,110), may reduce readmissions within 30 days of a transition in care (43,44,94,96,104,109,111), and may increase patient satisfaction (95,97,99,100,102,103). However, there were some inconsistencies in the results, with some studies showing no important differences for follow-up visits (60), patient satisfaction (97,103) and readmissions within 30 days (111). In the studies, follow-up visits with a health or social service provider were defined as outpatient appointments to assess

a person's health status following a transition in care. No important differences were found in studies that assessed the effect of navigation support on quality of life (97,98,100,101) and emergency department visits within 30 days of a transition in care (44,96,109,111). Overall, the certainty in the evidence was very low across studies.

No harms were found in the literature related to providing navigation support for persons with complex care needs during transitions in care. In one study where navigation support was provided to adults transitioning from mental health crisis resolution teams, adverse events (readmission, attempted suicide, attempted murder and death) were assessed independently by a steering committee, and none were judged to be related to the study (95).

The certainty of evidence was very low due to limitations in how the studies were conducted, inconsistency in the use of measurement tools and study results, and imprecision related to the small number of study participants or few reported events. The evidence was also indirect, as many of the studies included a navigator as part of a multicomponent intervention, and different types of navigation support were provided in each study based on the needs of the participants. For more detailed information about the impact that providing navigation support during a transition in care has on the prioritized outcomes, refer to the [evidence profiles](#).

Values and Preferences

In four studies that reported on values and preferences, persons valued the navigation support they received from health and social service providers (43,99,101,102). In one study, persons described feeling relieved upon finally receiving the assistance they needed (99). Persons appreciated: being connected to community-based resources (102); receiving emotional and practical support, such as assistance with transportation (102); and having a health or social service provider follow up on their care needs (43) and health-care appointments (99). Participants also reported that navigation support helped bridge inpatient and outpatient services during the transition from psychiatric hospital to home (101). Some individuals felt that persons with complex mental health needs would benefit from follow-up support that lasted longer than six weeks (101). In one study (99), persons valued the continuity of care and individualized support, and they felt this was especially important for those without strong health-care networks.

Health Equity

From the Systematic Review Evidence

Mistrust of the health-care system is often high in underserved communities, which may result in a lower use of preventive health services and delays in seeking medical treatment (94). If providers understand the communities and experiences of the people they are supporting, this can help build trust between persons and the health system. From the systematic review, three studies addressed health equity: in two studies, interventions were designed to support frequent users of the health system in underserved communities who had complex medical and social needs (99,104); in one study, participants were children and caregivers from low-income families (43). After receiving navigation support, a reduction in 30-day readmissions was found in two studies (43,104), and participants in one study reported high satisfaction with the support received (99). One study also reported that receiving navigation support from bilingual health or social service providers was critical to the program's success, given the intervention was serving a primarily Spanish-speaking population (43).

From the Expert Panel

The expert panel noted that persons with complex needs are vulnerable to gaps in care coordination, which places them at increased risk of adverse events during transitions in care. Moreover, navigation support may be especially beneficial for persons from underserved communities who often experience greater health disparities and barriers when navigating a complex health system. In these communities, system navigators can work to advocate for and

connect persons and their support network with the health and social care services they require. They can also support the provision of both Traditional and Western health services by working alongside local communities to increase access to and coordination of Western and Traditional health services for Indigenous peoples. The expert panel also noted that structural barriers, such as systemic racism and discrimination within the health system, create further risks for persons navigating the health system. They referenced the cases of Brian Sinclair and Joyce Echaquan, Indigenous persons who died due to systemic racism while accessing health services in Canada (112,113).

Expert Panel Justification of Recommendation

Despite the evidence being very uncertain about the effects of providing navigation support on patient quality of life, emergency department visits, follow-up visits, patient satisfaction and readmission rates, persons who are provided with navigation support strongly value the support they receive. In addition, no harms were reported in the literature. Moreover, navigation support may be beneficial for vulnerable populations and those with complex care needs because it may help overcome barriers commonly faced in the health-care system. Therefore, the panel determined this recommendation to be conditional.

Implementation Tips

Implementation Tips from the Expert Panel

- The type of health or social service provider providing navigation support, as well as the type of support they provide, will vary based on the physical, mental and social needs of the person encountering a transition. It may be appropriate for navigation support to be provided by regulated or non-regulated health or social service providers.
- Existing role descriptions can be modified to include navigation support depending on the roles and expertise of current staff.
- There may be benefits to having the same health or social service provider provide navigation support during multiple transitions in care. Embedding this provider in primary care or the community sector can allow for an ongoing relationship to be developed between the person and provider. However, persons may also receive navigation support from organizations in the community who function to help persons navigate the system during transitions in care. These organizations may be staffed with multiple health or social service providers with whom the person could develop trusting relationships.
- No matter who is providing navigation support, there should be a clear understanding of their role and responsibilities.
- The length of follow-up support will depend on the needs of the person receiving care. For many persons, especially those requiring support for chronic conditions, a longer period of follow-up support may be needed.
- Although follow-up will often occur through in-person visits, virtual tools can also be useful to facilitate follow-up between persons and health and social service providers.
- Health and social service providers should assess and respond to social care needs when conducting follow-up visits. This is particularly important for persons from underserved populations, including persons who are inadequately housed. Health and social service providers are to be aware of and facilitate referrals to services that can support community members with food security and housing.
- It is helpful for the health or social service providers offering navigation support to understand the language, culture and worldview of the person they are supporting. It is critical that providers appreciate their own social position, values and views and how this may affect their relationships with others. It is also very important that health and social service providers learn and develop culturally safe practices and provide trauma-informed care.
- When providing navigation support, it is important for health or social service providers to understand what values, goals and supports are most important for the person and their support network.

- In addition to ensuring that navigation support is available for persons with complex needs, it is also important to consider the overall design of the health system to ensure that all persons accessing the system can easily navigate it. The need for navigation support is further amplified when there is fragmentation in the health system and gaps in service delivery. The development of OHTs offers a unique opportunity to co-design the health system in an integrated way so that persons and their support network can easily navigate the system during transitions in care.
- Feedback should be collected from persons and their support network with respect to how well supported they feel when receiving navigation support. This will give the person and their support network an opportunity to voice any concerns.

Table 8: Implementation Tips from the Evidence

COMPONENTS OF THE STUDIES	DETAILS FROM THE EVIDENCE
Persons receiving navigation support	<ul style="list-style-type: none"> ■ Across all studies, navigation support and follow-up were provided to persons with complex care needs who were encountering a transition in care. ■ In 16 studies, support was provided to adults (44,60,94–104,109–111), and in one study, support was provided to children and their caregivers (43). ■ Persons with complex care needs had either a high number of previous inpatient admissions or emergency department visits within a defined time period (94,96,99,103,104,110) or a diagnosis associated with a high risk of readmission (e.g., chronic obstructive pulmonary disease, stroke, sepsis, heart failure, pneumonia, myocardial infarction, sickle cell disease, mental illness or medical complexity) (43,60,95,97,98,100–102,109,111). ■ In one study, risk of readmission was based on a combination of factors related to age, previous hospital admission, length of stay and diagnosis (44).
Type of transition	<ul style="list-style-type: none"> ■ Most studies focused on transitions from hospital to home (43,60,94,97,99–102,104,109–111). ■ The other studies focused on transitions from hospital to home or a rehabilitation facility (44), hospital to home or a rehabilitation facility before returning home (96,98), or from the emergency department to home (103). ■ One study focused on transitions from a mental health crisis resolution team to the community (95). Crisis resolution teams provide intensive treatment at home during a mental health crisis and offer an alternative for persons who would otherwise require a psychiatric inpatient admission. ■ In one study, persons were transitioning home to receive palliative care (100).

COMPONENTS OF THE STUDIES	DETAILS FROM THE EVIDENCE
<p>Health and social service providers providing navigation support</p>	<ul style="list-style-type: none"> ■ Navigation support was provided by a variety of regulated and unregulated health and social service providers. ■ In nine studies, support was provided by unregulated health and social service providers described as peer workers with lived experience (60,95,101,102), patient navigators (44,103), community health workers (60,96), community navigators (94) and transition coaches (43). ■ In six studies, support was provided by regulated health and social service providers, including nurses (100,109,110), social workers (98,104) and mental health professionals (111). ■ In one study, support was provided by both a nurse navigator and a patient navigator (99). ■ In another study, the intervention was delivered by a case manager (97).
<p>Types of navigation support provided</p>	<ul style="list-style-type: none"> ■ The included studies described a variety of forms of navigation support that were provided to ensure persons had the information and support they needed to manage their health and social care needs. This included: <ul style="list-style-type: none"> □ providing individualized health education or coaching to promote self-management (43,44,60,94–97,109,111); □ scheduling appointments, making referrals or providing guidance about services or community resources (43,44,60,94,96,98–104,110,111); □ helping persons identify early warning signs and know how to respond to them (43,95,97); □ promoting medication adherence (43,44,98,103,111); □ addressing safety issues (98); □ sharing information with primary-care providers to support continuity of care (110,111); □ addressing barriers to care (44,60,94,99,110), such as transportation to and from appointments (44,103,110,111); and □ providing persons with required staple supplies (101).
<p>Support modality</p>	<ul style="list-style-type: none"> ■ Navigation and follow-up support was provided through in-person visits (94,95,101), phone calls (109–111), a combination of in-person visits and phone calls (43,44,60,97,99,100,102–104), or a combination of in-person visits, phone calls and text messages (96,98). ■ Health and social service providers often met with persons in hospital prior to the transition and then continued providing follow-up support after the transition (44,96,97,103,104,109).

COMPONENTS OF THE STUDIES	DETAILS FROM THE EVIDENCE
Duration and frequency of follow-up	<ul style="list-style-type: none"> ■ The length of follow-up varied, ranging between: <ul style="list-style-type: none"> □ one to two months (43,44,60,96,98,101,102,109,110); □ three to four months (95,100,111); □ six months (104); and □ one year (94,97,99,103). ■ Follow-up contact often occurred more frequently in the first weeks or months following a transition, becoming less frequent after that (97,99,100,104). ■ In three studies, the frequency of contact and length of follow-up were determined by the person’s needs (98,104,110).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Budde H, Williams GA, Scarpetti G et al., editors. Policy brief 44: what are patient navigators and how can they improve integration of care? [Internet]. Copenhagen: European Observatory on Health Systems and Policies; 2022. Available from: https://eurohealthobservatory.who.int/publications/i/what-are-patient-navigators-and-how-can-they-improve-integration-of-care</p>	<ul style="list-style-type: none"> ■ Policy brief that describes the roles performed by patient navigators and how they can contribute to improving integration of care.
<p>Carmichael C, Smith L, Aldasoro E, et al. Exploring the application of the navigation model with people experiencing homelessness: a scoping review. J Soc Distress Homeless [Internet]. 2022 Jan. Available from: https://www.tandfonline.com/doi/full/10.1080/10530789.2021.2021363</p>	<ul style="list-style-type: none"> ■ Scoping review that describes how navigation models have been used to support persons who are inadequately housed. ■ Describes barriers and facilitators to implementing navigation models.

RESOURCE	DESCRIPTION
<p>Carter N, Valaitis RK, Lam A, et al. Navigation delivery models and roles of navigators in primary care: a scoping literature review. <i>BMC Health Serv Res</i> [Internet]. 2018 Dec;18(96). Available from: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-2889-0</p>	<ul style="list-style-type: none"> ■ Scoping review describing the delivery of navigation services in primary care.
<p>Entité2. Report on lessons learned from French-language health system navigators [Internet]. Welland (ON): Entité2; 2019. Available from: http://www.entitesante2.ca/sante-en-francais/wp-content/uploads/2019/11/E2-Report-on-Lessons-Learned-Navigators-January-2019-FINAL.pdf</p>	<ul style="list-style-type: none"> ■ Report outlining how navigation support can improve access to health and social care services for the francophone population in Ontario. ■ Describes conditions necessary to establish navigation services.
<p>Funk LM. Relieving the burden of navigating health and social services for older adults and caregivers [Internet]. Montreal (QC): Institute for Research on Public Policy; 2019. Available from: https://cnpea.ca/images/irpp_study_no_73_fr.pdf</p>	<ul style="list-style-type: none"> ■ Proposes policy directions to alleviate the problems that older adults and caregivers face in navigating care.
<p>Inquest into the death of Bradley Chapman. Verdict of Coroner's Jury [Internet]. Office of the Chief Coroner. [place unknown]: Ministry of the Solicitor General (Ontario); 2018. Available from: https://www.toronto.ca/legdocs/mmis/2019/ec/bgrd/backgroundfile-136740.pdf</p>	<ul style="list-style-type: none"> ■ Outlines the jury's recommendations following a coroner's inquest into a death from an opiate overdose. ■ Recommends providing navigation support for persons who are incarcerated and have complex needs to ensure safe transitions from correctional facilities back to the community.
<p>Peart A, Lewis V, Brown T, et al. Patient navigators facilitating access to primary care: a scoping review. <i>BMJ Open</i> [Internet]. 2018 Mar;8(3):e019252. Available from: https://bmjopen.bmj.com/lookup/doi/10.1136/bmjopen-2017-019252</p>	<ul style="list-style-type: none"> ■ Scoping review that describes how navigation support has been used to facilitate access to primary care.

RESOURCE	DESCRIPTION
<p>Rankin A, Baumann A, Downey B, et al. The role of the Indigenous patient navigator: a scoping review. <i>Can J Nurs Res</i> [Internet]. 2022 Jul;54(2):199-210. Available from: http://journals.sagepub.com/doi/10.1177/08445621211066765</p>	<ul style="list-style-type: none"> ■ Scoping review that maps the role of Indigenous patient navigators within Canada, the United States, Australia and New Zealand.
<p>RISE: Rapid-Improvement Support and Exchange. RISE brief 6: population health management [Internet]. Hamilton (ON): RISE; [last updated 12 February 2020]. Available from: https://www.mcmasterforum.org/docs/default-source/rise-docs/oht-forum/4_rise_rb6_population-health-management.pdf?sfvrsn=8be657d5_3</p>	<ul style="list-style-type: none"> ■ Resource from Rapid-Improvement Support and Exchange (RISE) that provides support for rapid learning and improvement by OHTs. ■ Describes the population risk pyramid that can be used to divide a population into high-, medium-, and low-risk groups based on the complexity of their health and social care needs and their needs for care coordination.

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:**Benefits and Harms**

Peer workers with lived experience (hereafter referred to as “peer workers”) are non-regulated providers who have lived through experiences similar to those of their peers (e.g., a mental health challenge or illness) and are trained to support others in their journey by providing a consistent presence along with emotional and practical support (14). This type of support, which occurs between two people who share a common experience, is referred to as “peer support” (14). The included studies focused on either peer support provided to persons following a transition from a mental health hospital (101,102) or peer support to persons following transition from a mental health crisis resolution team (i.e., a team that provides intensive home treatment following a mental health crisis) (95). The comparator in these studies was no peer support provided or usual care.

The types of support provided by peer workers varied across the evidence. Support included: assessing needs prior to a transition (101); linking persons with community-based supports and resources (101,102); sharing coping strategies (95); and helping persons complete a personal recovery workbook (95). For further details on the support provided by peer workers, please refer to the “Implementation Tips” below.

Evidence suggests that peer support may improve patient satisfaction and quality of life for persons with mental health needs who are encountering a transition in care, but the evidence is very uncertain (95,101,102). One study reported an improvement in self-reported quality of life in the domains of “living situation” with a large effect size, and “social relationships” with a low to medium effect size, post intervention (101). Two studies reported improved satisfaction after persons with mental health needs received peer support (95,102). There were no studies found within the systematic review that assessed the effect of peer workers during care transitions on the following outcomes: emergency department visits (within 30 days of a transition in care); follow-up visits with a health or social service provider; or readmission rates (within 30 days of a transition in care).

No harms related to peer support were reported in the literature. In one study where peer support was provided to adults transitioning from a mental health crisis resolution team, adverse events (hospital readmission, attempted suicide, attempted murder and death) were assessed independently by a steering committee, and none were judged to be related to the study (95).

The evidence was of very low certainty due to limitations in how individual studies were conducted and the small number of study participants.

For more detailed information on the impact of peer support on the prioritized outcomes during transitions in care, please refer to the [evidence profiles](#).

Values and Preferences

The evidence indicates that persons valued the support received during the transition in care; persons noted that the lived experience of peer workers added credibility, helped them feel understood and offered them hope for the future (101,102). In one study, persons described peer workers as role models during a vulnerable transition period, and they appreciated how peer workers connected them to community-based resources and offered practical support (102). In another study, persons reported feeling less anxious and had an increased understanding of the recovery process after they received support from a peer worker (101). Peer workers helped bridge inpatient and outpatient services and helped persons feel less isolated as they transitioned from the hospital to the community, where there was less social support in place. Support was provided for six weeks in this study, and some participants wished support was available for a longer period of time (101).

Health Equity

One study reported that time and resources were required to train and supervise peer workers (95). However, more research is required on the impact of peer support on health equity during transitions in care.

Expert Panel Justification of Recommendation

There may be benefits when peer workers offer support to persons with mental health needs during a transition in care, including increased patient satisfaction and improved quality of life. No harms were identified in the included studies. However, the certainty of the evidence is very low. In addition, none of the studies assessed the effect of peer workers during care transitions on the following outcomes: emergency department visits (within 30 days of a transition in care); follow-up visits with a health or social service provider; or readmission rates (within 30 days of a transition in care). Participants in the studies highly valued support from peer workers.

The expert panel also noted that persons with mental health needs would value this support, as no one knows more about navigating the health system than persons who have transitioned through the system themselves. However, the expert panel noted that not all persons with mental health needs may want to receive support from a peer worker. Therefore, based on the benefits and harms reported in the evidence, the values and preferences reported by persons within the literature, and the very low certainty in the evidence, the expert panel determined the strength of this recommendation to be conditional.

Implementation Tips

Implementation Tips from the Expert Panel

- Although the evidence focused on peer workers providing support to persons after transitioning from a mental health hospital, this recommendation is inclusive of transitions between all settings to ensure that support is available to (and provided for) persons with mental health needs, regardless of the type of transition.
- Although the evidence was specific to persons with mental health needs, persons with other health needs may also benefit from peer support during transitions in care. See **Table 10** (on page 80) for research gaps and future implications.
- Persons are to be offered a choice about whether they would like to receive support from a peer worker during a transition in care.
- Peer workers are to meet specific qualifications and possess the appropriate skills and abilities in order to provide peer support. This includes the need to have appropriate representation to address intersectionality. See “Supporting Resources” for a description of peer worker competencies and training guidelines, and for information about peer support certification.

- Peer workers are to also understand the importance of confidentiality and privacy, and the consequences if breaches occur.
- While the evidence focused on peer support provided over a time period of six weeks to four months, persons living with mental illness may benefit from long-term peer support as they transition through the continuum of care.
- The contributions of peer workers are to be highly valued by members of the interprofessional team, as they often have a greater understanding of the experiences of the person going through a transition. Both paid and volunteer peer workers are to be valued equally by the organization.
- It is important to note that the value of peer support will be dependent on the person's readiness for a transition in care.

Table 9: Implementation Tips from the Evidence

COMPONENTS OF THE STUDIES	DETAILS FROM THE EVIDENCE
Type of transition	<ul style="list-style-type: none"> ■ In two studies, peer workers provided support to adults transitioning from mental health hospitals to community settings (101,102). ■ In one study, persons were transitioning from mental health crisis resolution teams to the community (95). Crisis resolution teams provide intensive treatment at home during a mental health crisis and aim to offer an alternative for people who would otherwise require a psychiatric inpatient admission.
Time frame	<ul style="list-style-type: none"> ■ The intervention time frame ranged from six weeks (101,102) to four months (95). More specifically, support was provided: <ul style="list-style-type: none"> □ for six to eight weeks following transition from hospital (102); □ over a period of six weeks (starting two weeks before transition from hospital and lasting until four weeks after the transition), occurring weekly (usually for two hours per session) (101); and □ over a period of four months, during 10 one-hour sessions (95).
Support modality	<ul style="list-style-type: none"> ■ Peer support was provided in person in two studies (95,101). ■ In one study, a mix of face-to-face contact and telephone contact was provided (102).

COMPONENTS OF THE STUDIES	DETAILS FROM THE EVIDENCE
Type of support provided	<ul style="list-style-type: none"> ■ The following types of support were provided by peer workers: <ul style="list-style-type: none"> □ Assessing needs prior to a transition (101). □ Linking persons with community-based supports and resources (101,102). □ Offering supportive listening and sharing coping strategies and skills (95). □ Helping persons complete a personal recovery workbook. This included setting personal recovery goals, making plans to re-establish a support network, identifying early warning signs, formulating an action plan to avoid relapse and identifying strategies to promote well-being (95). □ Providing persons with a basket of needed/desired items (e.g., staple supplies, coupons, comfort items and calendars) (101). □ Providing practical and emotional support (102).
Qualifications	<ul style="list-style-type: none"> ■ All peer workers had their own lived experience with mental illness and recovery (95,101,102). ■ In one study, peer workers received training focused on listening skills, cultural awareness, self-disclosure and confidentiality (95). They also received supervision by clinicians once every two weeks, and support from an experienced peer worker.

Supporting Resources

RESOURCE	DESCRIPTION
RESOURCES FOR PERSONS AND THEIR SUPPORT NETWORK	
Buddy up. In: Centre for Suicide Prevention. [Internet]. [place unknown]: Centre for Suicide Prevention; [date known]. Available from: https://www.buddyup.ca/	<ul style="list-style-type: none"> ■ A suicide prevention communications campaign for men by men. ■ Includes tools and resources to provide authentic conversations among men and their peers.
Connect with a community of support. In: Wellness Together Canada [Internet]. [place unknown]: Wellness Together Canada; 2022. Available from: https://www.wellnesstogether.ca/en-CA/service/connect	<ul style="list-style-type: none"> ■ Access to numerous communities of peer support for mental health and substance use.

RESOURCE	DESCRIPTION
Get help. In: Talk Suicide Canada [Internet]. [place unknown]: Talk Suicide Canada; 2023. Available from: https://talksuicide.ca/	<ul style="list-style-type: none"> ■ A list of resources for people who are thinking about suicide, including connections (via telephone and text) to crisis responders.
Mental Health Commission of Canada. Toolkit for people who have been impacted by a suicide attempt [Internet]. Toronto (ON): Mental Health Commission of Canada; 2018. Available from: https://mentalhealthcommission.ca/wp-content/uploads/2018/05/Toolkit-for-people-who-have-been-impacted-by-a-suicide-attempt.pdf	<ul style="list-style-type: none"> ■ Provides a summary of resources and tools for people who have attempted suicide and those who have lost someone to suicide. ■ Pages 5–6 specifically outline peer support groups (i.e., who is a peer support worker and their role), as well as where they can be found.
Welcome to the hope for wellness helpline. In: Hope for Wellness Helpline [Internet]. [place unknown]: Hope for Wellness Helpline; 2022. Available from: https://www.hopeforwellness.ca/	<ul style="list-style-type: none"> ■ A helpline available to all Indigenous people across Canada, providing telephone and online chat services in English, French, Cree, Ojibway and Inuktitut.
RESOURCES FOR HEALTH AND SOCIAL SERVICE PROVIDERS	
Canadian Mental Health Association North and West Vancouver (CMHA NWV). Reenergizing wellness: a resource for peer-led wellness programs in Indigenous communities [Internet]. North Vancouver (BC): CMHA NWV; 2021. Available from: https://northwestvancouver.cmha.bc.ca/wp-content/uploads/2021/05/ReenergizingWellness-TrainingManual-May2021.pdf	<ul style="list-style-type: none"> ■ Training manual from the Canadian Mental Health Association that highlights emerging definitions of peer support that are rooted in culture. ■ Provides a framework for creating or building upon existing peer work that is already happening in community settings.
Mental Health Commission of Canada (MHCC). Guidelines for the practice and training of peer support [Internet]. Calgary (AB): MHCC; 2013. Available from: https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/peer_support_guidelines.pdf.pdf	<ul style="list-style-type: none"> ■ Training guideline developed by peer workers across Canada. ■ The guideline outlines the core values, skills and abilities required for peer workers, and serves as the basis for peer support certification.

RESOURCE	DESCRIPTION
<p>National Institute for Health and Care Excellence (NICE). Transition between inpatient mental health settings and community or care home settings [Internet]. London (UK): NICE; 2016 Aug 30. Available from: https://www.nice.org.uk/guidance/ng53</p>	<ul style="list-style-type: none"> ■ Guideline from the National Institute for Health and Care Excellence. ■ Contains two recommendations related to peer support during transitions in care (1.5.13 and 1.5.14).
<p>Peer Support Accreditation and Certification (Canada) (PSACC). National certification handbook [Internet]. Version 3. [place unknown]: PSACC; 2016. Available from: https://peersupportcanada.ca/wp-content/uploads/2019/06/Certification_Handbook_v3-ENG.pdf</p>	<ul style="list-style-type: none"> ■ Handbook from Peer Support Accreditation and Certification Canada that outlines the experience, skills and knowledge that make up the Standards of Practice and the Peer Support Certification process.
<p>Peer Support Canada. Peer supporter competencies [Internet]. Toronto (ON): Peer Support Canada; [date unknown]. Available from: https://peersupportcanada.ca/wp-content/uploads/2019/06/Peer_Supporter_Competencies-ENG.pdf</p>	<ul style="list-style-type: none"> ■ Resource from Peer Support Canada that outlines the skills and abilities that a peer worker should demonstrate.
<p>Phillips K, Harrison J, Jabalee C. A toolkit for implementing and supporting successful peer staff roles in mainstream mental health and addiction organizations [Internet]. Kitchener (ON): Centre for Excellence in Peer Support, Canadian Mental Health Association Waterloo Wellington; 2019. Available from: https://peerrecoverynow.org/wp-content/uploads/Supervising-Peer-Workers-Toolkit-CMHA-WW-2019.pdf</p>	<ul style="list-style-type: none"> ■ Toolkit from the Centre for Excellence in Peer Support that provides guidance on implementation of the peer worker role.

Research Gaps and Future Implications

The RNAO best practice guideline development and research team and the expert panel identified priority areas for future research (outlined in **Table 10**). Studies conducted in these areas would provide further evidence to support high-quality and equitable support for persons encountering transitions in care. The list is not exhaustive; other areas of research may be required.

Table 10: Priority Research Areas per Recommendation Question

RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
<p>RECOMMENDATION QUESTION #1:</p> <p>Should support from a system navigator be recommended or not for persons encountering a transition in care?</p> <p>Outcomes: Patient quality of life, emergency department visits (within 30 days of a transition in care), follow-up visit with a health or social service provider, patient satisfaction and readmission rates (within 30 days of a transition in care)</p>	<ul style="list-style-type: none"> ■ Studies identifying the essential components of navigation support and what type of support should be provided from the perspective of persons experiencing a transition in care. ■ Studies focused on navigation support during transitions in care for pediatric populations and their support network. ■ The impact of receiving peer support for more than four months following a transition in care on outcomes for persons with mental health needs. ■ The impact of receiving peer support during transitions in care on emergency department visits (within 30 days of a transition in care), follow-up visits with a health or social service provider and readmission rates (within 30 days of a transition in care). ■ The impact of peer support during transitions in care for persons with physical health conditions. ■ The value of peer support during transitions in care for caregivers and members of a person’s support network.
<p>RECOMMENDATION QUESTION #2:</p> <p>Should a formal interprofessional cross-sectoral approach be recommended or not to support persons experiencing a transition in care?</p> <p>Outcomes: Follow-up visit with a health or social service provider, emergency department visits (within 30 days of a transition in care), patient quality of life, patient satisfaction, readmission rates (within 30 days of a transition in care)</p>	<ul style="list-style-type: none"> ■ The impact of a formal interprofessional cross-sectoral approach during transitions in care on patient quality of life and patient satisfaction. ■ The impact of formal interprofessional cross-sectoral approach for persons transitioning from one community setting to another (e.g., primary care, outpatient rehabilitation, LTC and home care). ■ Research focused on formal interprofessional cross-sectoral approaches for pediatric persons and their support network.

RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
<p>RECOMMENDATION QUESTION #5:</p> <p>Should access to shared electronic health records for health and social service providers be recommended or not during transitions in care?</p> <p>Outcomes: Medication-related harm, health and social service provider satisfaction, follow-up visit with a health or social service provider, patient satisfaction</p> <p><i>*No recommendation stemmed from this question. For more information, refer to Appendix C.</i></p>	<ul style="list-style-type: none"> ■ Studies focused on systems in place that provide access to shared electronic health records for health and social service providers during transitions in care, and the impact on medication-related harm, health and social service provider satisfaction, and patient satisfaction.

Table 11: Additional Priority Research Areas Identified by the Expert Panel

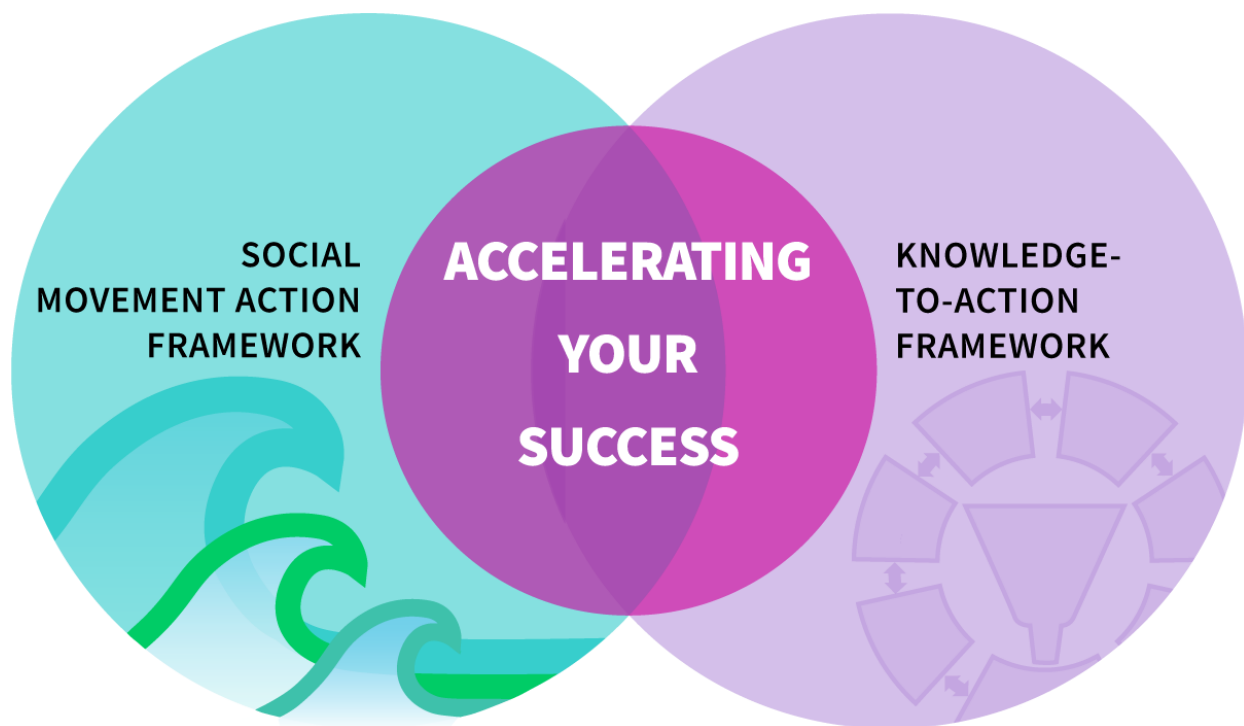
CATEGORY	PRIORITY RESEARCH AREA
<p>Settings and sectors</p>	<ul style="list-style-type: none"> ■ How health and social service providers in primary care, home care and community settings can best support persons during transitions in care. (The research literature largely focuses on transitions to and from hospital settings. Future research should also focus on transitions to and from other settings and sectors.) ■ How integrated systems of care can support transitions in care.
<p>Populations</p>	<ul style="list-style-type: none"> ■ Studies focused on pediatric populations during transitions in care.

Implementation Strategies

Implementing guidelines at the point of care is multi-faceted and challenging. It takes more than awareness and access to BPGs for practice to change: BPGs must be adapted for each practice setting in a systematic and participatory way to ensure that recommendations fit the local context (114). The *Leading Change Toolkit* (developed by RNAO, in partnership with Healthcare Excellence Canada) provides evidence-informed processes for this (see [Appendix M](#)) (4).

The *Leading Change Toolkit* uses two complementary frameworks to guide evidence uptake and sustainability (see [Figure 2](#)). They can be used together to maximize and accelerate change.

Figure 2: The *Leading Change Toolkit*: Two Complementary Frameworks to Accelerate your Success



Reprinted from: Registered Nurses' Association of Ontario (RNAO), Healthcare Excellence Canada (HEC). *Leading change toolkit* [Internet]. 3rd ed. Toronto (ON): RNAO; 2021. Available from: [RNAO.ca/leading-change-toolkit](https://rnao.ca/leading-change-toolkit)

The Social Movement Action Framework (1,2) is descriptive and identifies the defining elements of a **social movement for knowledge uptake and sustainability**^G. It integrates a bottom-up, people-led approach to change for a shared concern (or common cause) in which change agents and change teams mobilize individual and collective action to achieve goals. The framework's elements—categorized as preconditions, key characteristics and outcomes—are dynamic, interrelated and develop spontaneously as the social movement evolves.

The Knowledge-to-Action Framework uses a process model of action cycle phases to systematically guide the adaptation of the new knowledge (e.g., a BPG) to the local context and implementation. This framework suggests identifying and using knowledge tools/products (such as guidelines) to determine gaps and begin the process of tailoring the new knowledge to local settings.

The *Leading Change Toolkit* is based on emerging evidence in health and social sciences that successful uptake and sustainability of best practice in health care is more likely when the following occurs:

- BPGs are selected for implementation through a participatory process led by change agents and change teams.
- The selected BPGs reflect priority areas for a shared concern that are credible, valued and meaningful, or an urgency for action.
- Stakeholders are identified and engaged throughout implementation to engage in individual and collective action.
- Receptivity for implementing BPGs, including environmental readiness, is assessed.
- Implementation strategies are tailored to the local context and designed to address barriers.
- Use of the BPG is monitored and sustained.
- Evaluation of the BPG's impact is embedded in the process to determine if the goals and outcomes have been met.
- There are adequate resources to complete all aspects of the uptake and sustainability of the BPG.
- The BPG is scaled up, out or deep, where possible, in order to widen its influence and create lasting health improvements.

RNAO is committed to widespread dissemination, implementation and sustainability of our BPGs. We use a systematic approach deploying various strategies, including:

1. The RNAO Best Practice Champion Network[®], which powers the capacity of change agents to foster awareness, engagement, adoption and sustainability of BPGs. RNAO best practice champions are persons and organizations who are passionate about implementing evidence-based practices and mobilize others so together they improve care and health. Champions include nurses and other health professionals from all roles and health sectors, students, advocates, persons with lived experience, and caregivers.
2. RNAO BPG Order Sets[™] provide clear, concise and actionable intervention statements derived from practice recommendations. BPG Order Sets can be readily embedded within electronic records, and they can also be used in paper-based or hybrid environments. In the LTC sector, BPG Order Sets have evolved into RNAO Clinical Pathways[™] with the support of nurses that have extensive expertise in this setting. RNAO Clinical Pathways have been embedded within a commonly used electronic health record system and are accessible to all Canadian and international LTC homes.
3. The BPSO[®] designation 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 BPGs.

In addition, we offer annual capacity-building learning institutes on the implementation of practice change.

Information about our implementation strategies can be found at:

- RNAO Best Practice Champions Network[®]: [RNAO.ca/bpg/get-involved/champions](https://rnao.ca/bpg/get-involved/champions)
- RNAO BPG Order Sets[™]: [RNAO.ca/ehealth/bpgordersets](https://rnao.ca/ehealth/bpgordersets)
- RNAO BPSO[®]: [RNAO.ca/bpg/bpso](https://rnao.ca/bpg/bpso)
- RNAO capacity-building learning institutes and other professional development opportunities: [RNAO.ca/events](https://rnao.ca/events)
- RNAO Clinical Pathways[™]: [RNAO.ca/bpg/implementation/clinicalpathways](https://rnao.ca/bpg/implementation/clinicalpathways)

Appendix A: Glossary of Terms

Best possible medication history (BPMH): A best possible medication history (BPMH) is a medication history obtained by a health provider using: (1) a systematic process of interviewing the person/and or their support network; and (2) a review of at least one other reliable source of information to obtain and verify all regular medication use. The BPMH includes the drug name, dose, route and frequency of all medications (prescribed and non-prescribed) that a person is currently taking. The BPMH is a snapshot of the person's actual medication use, which may be different from what is listed in their records (115).

Best practice guidelines (BPG): “Best practice guidelines are systematically developed, evidence-based documents that include recommendations for nurses and the interprofessional team, educators, leaders and policy-makers, persons and their families on specific clinical and healthy work environment topics. BPGs promote consistency and excellence in clinical care, health policies and health education, ultimately leading to optimal health outcomes for people and communities and the health system” (116).

Best Practice Spotlight Organization[®] Ontario Health Team (BPSO OHT): Ontario Health Teams (OHT) are groups of providers and organizations that are accountable for delivering a full and coordinated continuum of care to a attributed population in Ontario, Canada (9). The Best Practice Spotlight Organization[®] (BPSO) model for OHTs offers a tailored program to scale up and spread RNAO BPGs within integrated systems of care. The BPSO OHT model helps OHTs advance all four elements of the Quadruple Aim and the United Nations Sustainable Development Goals (SDG) by addressing population health, supporting underserved populations and promoting health equity. BPSO OHTs are actively supported by RNAO to systematically implement evidence-based BPGs by mobilizing teams towards their collective goals, and evaluating outcomes. The BPSO OHT program is nested within the OHT, and program deliverables are designed to advance OHT goals.

Caregiver: “A family member, friend or person of choice who gives unpaid care to someone who has care needs due to a disability, a physical, neurological or mental condition, a chronic illness, frailty or age” (117). Caregivers are often key members of a person's support network.

Continuity of care: Continuity of care is about the quality of the transition in care. It is the extent to which care is well coordinated and connected as persons move between settings and through the health system (118).

Culturally safe care: People providing culturally safe care are attempting to provide respectful engagement that recognizes and aims to address power imbalances inherent across the health system (119). Culturally safe care aims to create and sustain an environment that is free of racism and discrimination, where people feel safe when receiving health care. Indigenous people, families and communities should be able to share their perspectives, ask questions and have their beliefs, behaviours and values be respected by health and social service providers (119).

Discharge summary: A summary of what happened during a person’s medical stay in a hospital, rehabilitation facilitation or other health-care setting (120). It often includes the person’s medical diagnosis, test results and pending test results, changes made to treatments or medications (including the reasons why), and follow-up needs. The discharge summary is a way of communicating a person’s transition plan to providers in the setting to which the person is transitioning (121). Discharge summaries written in plain language can also be created for persons and their support network in order to provide them with important information, such as changes to medications and follow-up appointments.

Downgrade: In GRADE, when limitations in the individual studies potentially bias the results, the certainty of evidence will decrease (122). For example, a body of quantitative evidence for one priority outcome may begin with high certainty, but due to serious limitations in one or more of the five GRADE criteria, it will be rated down by one or two levels (122).

Education statements: Organizational approaches to the delivery of education in health service organizations and academic institutions to support evidence-based practice. Education statements are based on an analysis of educational recommendations across several BPGs on diverse clinical topics and populations. Education statements can be applicable to all clinical BPGs and can be contextually adapted within health service organizations and academic institutions to support implementation of clinical recommendations.

Evidence-based practice: The integration of research evidence with clinical expertise and patient values. It unifies research evidence with clinical expertise and encourages the inclusion of patient preferences (123).

Evidence-to-Decision (EtD) frameworks: A table that helps expert panels make decisions when moving from evidence to recommendations. The purpose of the Evidence-to-Decision framework (EtD) is to summarize the research evidence, outline important factors that can determine the recommendation, inform panel members about the benefits and harms of each intervention considered, and increase transparency about the decision-making process in the development of recommendations (19).

Electronic health record: An electronic health record is a secure, private, lifetime digital record of a person’s health and care history that gives authorized health and social service providers real-time access to relevant medical information (124). Access to shared electronic health records refers to authorized health and social service providers in different organizations and sectors having joint access to a person’s electronic health record in order to streamline communication and coordinate care.

Follow-up visit with a health or social service provider: Refers to attending an outpatient follow-up appointment to assess a person’s health status following a transition in care.

Good practice statement: Good practice statements are directed primarily to nurses and the interprofessional teams who provide care to persons and their support network across the continuum of care, including (but not limited to): primary care; home and community care; acute care; and LTC.

Good practice statements are actionable statements that should be done in practice (16). These statements are believed to be so beneficial that summarizing the evidence would be a poor use of the expert panel's time and resources (16). Moreover, researchers may no longer be conducting studies on the topic, or the alternative to the action may be unethical or studying them may go against human rights (16,17). Given the high level of certainty that the benefits derived from good practice statement outweigh the harms, they are not based on a systematic review of the evidence. They also do not receive a rating of the certainty in their evidence or a strength (i.e., a rating of conditional or strong, which is further discussed below) (18). This does not diminish certainty in the evidence: while they may be supported by indirect evidence, there is a well-documented clear and explicit rationale connecting the indirect evidence to the statement (16). As such, good practice statements should be interpreted as strong recommendations, as there is an underlying assumption that there is high certainty in the benefits of implementing the action (16).

Grading of Recommendations Assessment, Development and Evaluation (GRADE): The Grading of Recommendations Assessment, Development and Evaluation (GRADE) is a methodological approach to assess the certainty of a body of evidence in a consistent and transparent way, and to develop recommendations in a systematic way. The body of evidence across identified important and/or critical outcomes is evaluated based on the risk of bias, consistency of results, relevance of studies, precision of estimates, publication bias, large effect, dose-response and opposing confounding (19).

When using GRADE, five components contribute to the assessment of confidence in the evidence for each outcome. These components are as follows:

1. Risk of bias, which focuses on flaws in the design of a study or problems in its execution.
2. Inconsistency, which looks at a body of evidence and assesses whether the results point in the same direction or if they are different.
3. Imprecision, which refers to the accuracy of results based on the number of participants and/or events included, and the width of the confidence intervals across a body of evidence.
4. Indirectness, whereby each primary study that supports an outcome is assessed and a decision is made regarding the applicability of the findings to the population, intervention and outcome outlined in the research question.
5. Publication bias, where a decision is made about whether the body of published literature for an outcome potentially includes only positive or statistically significant results (19).

Health and social service organizations: In this BPG, health and social service organizations refer to any settings in which a person, together with their support network, receives care or services during a transition in care.

Health service organizations are organizations delivering health-care services to defined communities or populations. This includes, but is not limited to, family health teams, home care organizations and hospitals.

Social service organizations are organizations that assist persons with social issues, including (but not limited to) housing, domestic violence and substance use.

Health and social service providers: Refers to both regulated health and social service providers (e.g., nurses, physicians, pharmacists, social workers, occupational therapists and paramedics) and unregulated health and social service providers (e.g., personal support workers, peer workers with lived experience) who are part of the interprofessional team.

Regulated health and social service providers: The *Regulated Health Professions Act, 1991* (RHPA) governs the regulation of health professions in Ontario in order to protect the public. It outlines the scope of practice and the profession-specific controlled or authorized acts that each regulated professional is authorized to perform when providing health care and services (10). The regulations for social workers and social service professionals are outlined in the *Social Work and Social Service Work Act, 1998* (11). In this BPG, nurses, physicians, occupational therapists and pharmacists are examples of regulated health providers, and social workers are an example of a regulated social service provider.

Unregulated health and social service providers: This provider fulfills a variety of roles in areas that are not subject to the RHPA. They are accountable to their employers but not to an external regulating professional body (for example, the College of Nurses of Ontario). Unregulated health and social service providers only have the authority to perform a controlled act as set out in the RHPA if the procedure falls under one of the exemptions set out in the Act (12).

Health literacy: The ability of a person to obtain and translate knowledge and information in order to maintain and improve health in a way that is appropriate to the individual and system contexts. Health literacy covers three broad elements: (1) knowledge of health, health care and health systems; (2) processing and using information in various formats in relation to health and health care; and (3) ability to maintain health through self-management and working in partnership with health providers (125).

Home: A person's usual place of residence. This may be a personal residence, assisted-living facility, LTC home, hospice or shelter (25).

Implementation science: Defined as “the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services and care” (126).

Indigenous: Introduced and used in a global context following the international efforts of Aboriginal peoples to achieve a greater presence in the United Nations (UN). The UN broadly defines Indigenous persons as peoples of long settlement and connection to specific lands who practice unique traditions and retain social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they reside (127). Under the UN definition, Indigenous is generally understood to include: self-identification at the individual level and acceptance by an Indigenous community as a member; historical continuity with pre-colonial or pre-settler societies; strong links to territories and surrounding natural resources; distinct social, economic or political systems; and distinct language, culture and beliefs. Indigenous peoples form non-dominant groups within society and resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities (127).

The Canadian Constitution recognizes three groups of Indigenous peoples: First Nations, Inuit and Métis. These are three distinct peoples with unique histories, languages, cultural practices and spiritual beliefs (128).

Integrated systems of care: Services organized across sectors and organizational boundaries so that persons receiving care receive coordinated and comprehensive services at the right time, from the right provider and in the right place (129).

Interprofessional cross-sectoral approach: Refers to a collaborative approach where two or more health or social service providers from different disciplines in different sectors work together in a formal way to ensure persons and their support network experience a safe transition in care. For example, providers in LTC can collaborate with providers in a hospital setting to coordinate care for a person transitioning from LTC to hospital.

Interprofessional team: A team composed of multiple health and social service providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health services to persons within, between and across health and social care settings (13). Key interprofessional team members supporting pediatric and adult persons and their support network during transitions in care include, but are not limited to: nurses, physicians, pharmacists, social workers, occupational therapists and paramedics. It is important to emphasize that persons and their support network who are encountering a transition in care are at the centre of the interprofessional team as active participants.

Medication reconciliation: A formal process in which health providers work together and with persons and their support network to ensure that accurate and comprehensive medication information is communicated consistently during a transition in care. Medication reconciliation requires a systematic and comprehensive review of all the medications a person is taking (known as a “best possible medication history”) to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the person (115).

See best possible medication history (BPMH)

Medication-related harm: Harms experienced by a person as a result of exposure to a medication that may be preventable (e.g., due to a medication error) or non-preventable (e.g., an adverse drug reaction) (88).

Navigation support: Refers to individualized and coordinated support provided by health or social service providers to help persons and their support network overcome challenges navigating the health and social care system during transitions in care. In this BPG, navigation support involves regular follow-up by a health or social service provider who attends to a person's individual needs and connects them with the right services and supports. This can include providing persons with the information and resources they need to achieve their goals of care, connecting persons with other health and social service providers, helping reduce barriers that prevent persons from accessing timely care, providing social and emotional support, and improving access to culturally safe care.

Non-randomized study: A quantitative study estimating the effectiveness of an intervention, where people are allocated to different interventions using methods that are not random (130).

Nurse: Refers to registered nurses, licensed practical nurses (referred to as “registered practical nurses” in Ontario), registered psychiatric nurses and nurses in advanced practice roles, such as nurse practitioners and clinical nurse specialists (10).

Outcomes: A dependent variable or the clinical and/or functional status of a patient or population used to assess if an intervention is successful. In GRADE, outcomes are prioritized based on if they: (a) are critical for decision making; (b) important but not critical for decision making; or (c) not important. Use of these outcomes helps make literature searches and systematic reviews more focused (19).

Peer worker with lived experience: A person who has lived through similar experiences to their peers, such as a mental health challenge or illness, and who is trained to support others in their journey by providing practical and emotional support (14). In this BPG, peer workers with lived experience are also referred to as “peer workers.” These peer workers are non-regulated.

Person: An individual with whom a health or social service provider has established a therapeutic relationship for the purpose of partnering for health. Replaces the terms “patient,” “client,” and “resident” that are used across health and social service organizations (131).

Person-centred: An approach to care in which the person is viewed as whole. The process of coming to know the whole person is nurtured through the formation of a therapeutic relationship between the person, those who are significant to them, and health and social service providers. This approach to care involves advocacy, empowerment, mutual respect and an understanding of the person's right to be autonomous, to self-determine and to participate actively in decisions about their health (both illness and wellness) (131).

Person with lived experience: Members of the community who have first-hand experience and knowledge of the topic of interest as a person, unpaid caregiver or advocate. Persons with lived experience are a diverse group with an array of backgrounds and experiences.

PICO research question: A framework to outline a focused question. It specifies four components:

1. The patient or population that is being studied.
2. The intervention to be investigated.
3. The alternative or comparison intervention.
4. The outcome that is of interest (19).

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram: A diagram that depicts the flow of information through the different phases of a systematic review. It maps out the number of articles identified, included and excluded (132).

Quadruple aim: An internationally-recognized framework for the delivery of health care that is centred around four overarching goals: (1) enhanced experiences for persons receiving care; (2) enhanced experiences for health and social service providers delivering care; (3) improved health outcomes for persons receiving care; and (4) reduced health care costs (45).

Quantitative research: An approach to research that investigates phenomena with tools that produce statistical measurements/numerical data (133).

Randomized controlled trial (RCT): An experiment in which the investigator assigns one or more interventions to participants who are randomly allocated to either the experimental group (receives intervention) and the comparison (conventional treatment) or control group (no intervention or placebo) (130).

Recommendation: A course of action(s) that directly answers a recommendation question (also known as a “PICO research question”). A recommendation is based on a systematic review of the literature and is made in consideration of its: (a) benefits and harms; (b) values and preferences; and (c) health equity. All recommendations are given a strength—either *strong* or *conditional*—through panel consensus.

It is important to note that recommendations should not be viewed as dictates, because recommendations cannot take into account all of the unique features of individual, organizational and clinical circumstances (19).

Recommendation question: A priority research area of practice, policy or education identified by expert panel members that requires evidence to answer. The recommendation question may also aim to answer a topic area around which there is ambiguity or controversy. The recommendation question informs the research question, which guides the systematic review.

Responsive behaviours: Refers to words, actions or gestures presented by persons with dementia or other neurological conditions in response to something frustrating, confusing or important in their social or physical environment (134).

RNAO Clinical Pathways™: RNAO Clinical Pathways are a digitized version of RNAO’s BPGs that can be embedded in an electronic health record system to promote evidence-based, person- and family-centred care.

Self-management: This term is often associated with self-care and includes an array of activities that persons undertake to live well with one or more chronic conditions (135).

Social determinants of health: The social determinants of health are “non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems” (136).

Social movement for knowledge uptake and sustainability: Individuals, groups and/or organizations who, as voluntary and intrinsically motivated change agents, mobilize to transform health outcomes (2).

Stakeholder: An individual, group or organization that has a vested interest in the decisions and actions of organizations, and which may attempt to influence decisions and actions (137). Stakeholders include all of the individuals and groups that will be directly or indirectly affected by the change or solution to the problem.

Strength-based approach: Strength-based approaches focus on identifying and supporting the various strengths, motivations, and ways of thinking and behaving, as well as the protective factors—within the person or the environment—that support people in their journeys towards health and well-being (138).

Support network: Individuals identified by a person as being significant in their life. The network can include individuals who are related (biologically, emotionally or legally) and/or those with close bonds (friendships, commitments, shared household and child-rearing responsibilities, and romantic attachment) (15). In this BPG, this term includes family, friends and caregivers providing support during a transition in care.

Sustainable Development Goals (SDG): The Sustainable Development Goals (SDG) were adopted by the United Nations in 2015 as a universal and urgent call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030 (46).

Systematic review: A comprehensive review of the literature that uses clearly formulated questions and systematic and explicit methods to identify, select and critically appraise relevant research. A systematic review collects and analyzes data from the included studies and presents them, sometimes using statistical methods (130).

See meta-analysis

System navigator: A health or social service provider who provides navigation support during a transition in care over an extended period of time (e.g., for 30 days or six months). In this BPG, the term “system navigator” is used as an umbrella term for all health or social service providers in different roles who provide navigation support in this capacity during a transition in care, including regulated and non-regulated providers (e.g., nurses, social workers, peer workers with lived experience, transition facilitators and patient navigators).

See navigation support

Transition in care: A significant point 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 (8). A transition in care occurs when a person moves from one setting or sector where care or services are provided to another setting or sector, including (but not limited to): primary care; home and community care; mental health and substance use health settings; acute care; rehabilitation; LTC; correctional facilities; and shelters. Examples include transitions from home to LTC, or hospital to hospice. A transition can also occur within the same organization, such as when a person moves from an intensive care unit to a general ward in a hospital. During their care trajectory, a person may also experience multiple transitions in care, such as a transition from hospital to a rehabilitation facility, and then to home. Although the term “transition in care” is used throughout this BPG, the guideline title reflects how a transition may occur between any settings where care or services are provided.

Transition plan: A plan tailored to a person’s needs that is designed to support a transition in care. It is created by the interprofessional team in partnership with the person and their support network, and it describes the coordination of care and support required during and after the transition in care.

Trauma-informed: Trauma-informed approaches are based on an understanding that many people who access health and social services have had experiences of trauma in their lives. Trauma-informed approaches are not focused on providing treatment for trauma; rather, the approach is applied to ensure persons are not further traumatized while accessing care and services. Trauma-informed approaches are based on principles of safety, trustworthiness, collaboration and choice, empowerment, and the building of strengths and skills (139).

Underserved and underserved populations: Underserved populations can include Indigenous people, people who do not speak either of Canada’s official languages, people with alternate sexual orientation, immigrants, refugees, ethnically or racially diverse populations, people with disabilities, those experiencing homelessness, sex workers and people with low incomes. Underserved means there is an increased likelihood that individuals who belong to a certain population (and people can belong to more than one) may experience difficulties in obtaining needed care, receive less care or a lower standard of care, experience different treatment by health providers or receive treatment that does not adequately meet their needs, or that they will be less satisfied with health services than the general population (140).

Appendix B: RNAO Best Practice Guidelines and Resources That Align with This Guideline

The following are some topics and suggested Registered Nurses' Association of Ontario (RNAO) guidelines and resources from other organizations that align with this best practice guideline (BPG).

TOPIC	RESOURCE(S)
Promoting 2SLGBTQI+ health equity	Registered Nurses' Association of Ontario (RNAO). Promoting 2SLGBTQI+ health equity [Internet]. Toronto (ON): RNAO; 2021. Available from: RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity
A palliative approach to care in the last 12 months of life	Registered Nurses' Association of Ontario (RNAO). A palliative approach to care in the last 12 months of life [Internet]. Toronto (ON): RNAO; 2020. Available from: RNAO.ca/bpg/guidelines/palliative-approach-care-last-12-months-life
Implementation science, implementation frameworks and resources	<p>Registered Nurses' Association of Ontario (RNAO), Healthcare Excellence Canada (HEC). Leading change toolkit. [Internet]. 3rd ed. Toronto (ON): RNAO; 2021. Available from: RNAO.ca/leading-change-toolkit</p> <p>The National Implementation Research Network's Active Implementation Hub. Get Started [Internet]. [place unknown]: AI Hub; c2013–2018. Available from: http://implementation.fpg.unc.edu/</p> <p>Canadian Patient Safety Institute. Improvement frameworks: getting started kit [Internet]. [place unknown]: safer healthcare now!; 2015 Aug. Available from: http://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Documents/Improvement%20Frameworks%20GSK%20EN.PDF</p> <p>Helping navigate dissemination and implementation models. In: The Dissemination and Implementation Models in Health Research and Practice Webtool [Internet]. Denver (CO): University of Colorado Denver; c2014-2023. Available from: https://dissemination-implementation.org/</p>
Interprofessional collaboration	Registered Nurses' Association of Ontario (RNAO). Developing and sustaining interprofessional health care: optimizing patients/clients, organizational and system outcomes [Internet]. Toronto (ON): RNAO; 2013. Available from: RNAO.ca/bpg/guidelines/interprofessional-team-work-healthcare
Person- and family-centred care	Registered Nurses' Association of Ontario (RNAO). Person- and family-centred care [Internet]. Toronto (ON): RNAO; 2015. Available from: RNAO.ca/bpg/guidelines/person-and-family-centred-care

TOPIC	RESOURCE(S)
Social determinants of health	Registered Nurses Association of Ontario (RNAO). Social determinants of health [Internet]. Toronto (ON). Registered Nurses' Association of Ontario; 2013. Available from: RNAO.ca/sites/rnao-ca/files/rnao_sdh_brochure_2013.pdf



Appendix C: Best Practice Guideline Development Methods

This appendix presents an overview of the RNAO guideline development process and methods. RNAO is unwavering in its commitment that every BPG be based on the best available evidence. The Grading of Recommendations Assessment, Development and Evaluation (GRADE) methods have been implemented to provide a rigorous framework and meet international standards for guideline development.

Scoping the Best Practice Guideline

The scope sets out what an RNAO BPG will and will not cover (see **Purpose and Scope** on page 6). To determine the scope of this particular BPG, the RNAO best practice guideline development and research team conducted the following steps:

1. **A review of previous BPGs.** The RNAO BPG *Care transitions* (5) was reviewed to inform the purpose and scope of this BPG.
2. **An environmental scan of guidelines.** Two guideline development methodologists searched an established list of websites for guidelines and other relevant content published between January 2012 and January 2020. The purpose of the environmental scan of guidelines was to gain an understanding of existing guidelines on transitions in care in order to identify opportunities to develop the purpose and scope of this BPG. The resulting list was compiled based on knowledge of evidence-based practice websites and recommendations from the literature. RNAO expert panel members were asked to suggest additional guidelines (see the **Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)**^G diagram [online](#)). For more detailed information, please see the [search strategy](#) for existing guidelines, including the list of websites searched and the inclusion criteria used.

The guidelines were reviewed for content, applicability to nursing scope of practice, accessibility and quality. The two guideline development methodologists appraised four international guidelines using the AGREE II tool (141). Guidelines with an overall score of 6 or 7 (on a 7-point Likert scale) were considered to be of high quality and therefore considered for GRADE-ADOLOPMENT (142). GRADE-ADOLOPMENT provides a framework for adopting or adapting trustworthy recommendations from existing guidelines (142). However, the expert panel did not identify any priority recommendations from the existing guidelines to be adopted or adapted for this BPG.

The following guidelines were appraised as indicated:

- Canadian Association of Pediatric Health Centres (CAPHC). A guideline for transition from paediatric to adult health care for youth with special health care needs: a national approach [Internet]. [place unknown]: CAPHC; Jun 2016. Available from: https://www.childhealthbc.ca/sites/default/files/caphc_transition_to_adult_health_care_guideline_may_2017.pdf
 - Score: 3 out of 7.
 - This guideline was not used in this BPG.
- National Institute for Health and Care Excellence (NICE). Transition between inpatient hospital settings and community or care home settings for adults with social care needs [Internet]. London (UK): NICE; 2015 Dec 01. Available from: <https://www.nice.org.uk/guidance/ng27>
 - Score: 6 out of 7.
 - This guideline was used as a supporting resource.

- National Institute for Health and Care Excellence (NICE). Transition between inpatient mental health settings and community or care home settings [Internet]. London (UK): NICE; 2016 Aug 30. Available from: <https://www.nice.org.uk/guidance/ng53>
 - Score: 6 out of 7.
 - This guideline was used as a supporting resource.
- National Institute for Health and Care Excellence (NICE). Transition from children's to adults' services for young people using health or social care services [Internet]. London (UK): NICE; 2016 Feb 24. Available from: <https://www.nice.org.uk/guidance/ng43>
 - Score: 6 out of 7.
 - This guideline was not used in this BPG, as it focused on transitions from pediatric to adult services.

3. **An environmental scan of standards.** Two guideline development methodologists also searched for standards published within Canada between January 2012 and January 2020 to gain an understanding of existing standards on transitions in care and to identify their scope. The standards were reviewed for content, applicability to nursing scope of practice and accessibility. The standards were not quality appraised.

The following standards were reviewed as indicated:

- Health Quality Ontario (HQO). Transitions between hospital and home: care for people of all ages [Internet]. Toronto (ON): HQO Quality Standards; 2020. Available from: <https://www.hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-transitions-between-hospital-and-home-quality-standard-en.pdf>
 - The content of this standard was used in the background and glossary of this BPG, and as a supporting resource.
- Health Standards Organization (HSO). Integrated people-centred health systems [Internet]. Ottawa (ON): HSO; 2021. Available from: <https://healthstandards.org/standard/integrated-people-centred-health-systems/>
 - The content of this standard was used in the glossary of this BPG.
 - This standard is not open access and can be purchased for a fee.

4. **A review of the literature.** A literature review was undertaken to determine interventions and outcomes related to transitions in care that have been studied in the literature. Two guideline development methodologists searched for literature published between 2012 and 2020. Common findings across studies were summarized and shared with the expert panel during the initial planning meetings.
5. **Virtual key informant interviews.** Twenty-six interviews were conducted with experts in the field—including persons with lived experience, direct care health and social service providers, and researchers—to understand the needs of members of the interprofessional team and persons with lived experience during transitions in care.
6. **Virtual discussion group session.** One session was convened with nine representatives from four BPSO OHTs to understand the needs of nurses, members of the interprofessional health team and persons with lived experience within integrated systems of care.

Assembly of the Expert Panel

RNAO aims for diversity in membership of an expert panel; this is in alignment with its Organizational Statement on Diversity and Inclusivity, which is part of the RNAO Mission and Values (143). RNAO also aims for persons impacted by BPG recommendations, especially persons with lived experience, to be included as expert panel members.

There are numerous ways in which RNAO finds and selects members of an expert panel. These include:

- searching the literature for researchers in the topic area;
- soliciting recommendations from key informant interviews;
- drawing from established professional networks, such as RNAO Interest Groups, the Best Practice Champions Network[®] and BPSOs[®]; and
- contacting other nursing and health and social service provider associations, topic-relevant technical associations or organizations, and advocacy bodies.

For this BPG, the RNAO best practice guideline development and research team assembled a panel of experts from nursing practice, research, education and policy, as well as other members of the interprofessional team, and persons with lived experience representing a range of sectors and practice areas. The expert panel also included representatives from different geographical areas, including rural, urban and international settings (see the **RNAO Best Practice Guideline Expert Panel** on page 135).

The expert panel engaged in the following activities:

- developed and approved the purpose and scope of this BPG
- determined the recommendation questions and outcomes to be addressed in this BPG
- participated in a development process to finalize recommendation statements
- provided feedback on the drafting of this BPG
- participated in the development of evaluation indicators
- identified appropriate stakeholders to review the draft guideline prior to publication

In addition to the above, the expert panel co-chairs also:

- participated in meetings with the guideline development methodologists and guideline development project coordinator
- facilitated expert panel meetings
- provided in-depth guidance on clinical and/or research issues
- moderated voting processes

Declaration of Conflict of Interest

In the context of RNAO best practice guideline development, the term “conflict of interest” (COI) refers to situations in which an RNAO staff member or expert panel member’s financial, professional, intellectual, personal, organizational or other relationships may compromise their ability to conduct panel work independently. Declarations of COI that might be construed as constituting a perceived and/or actual conflict were made by all members of the RNAO expert panel prior to their participation in guideline development work using a standard form. Expert panel members also updated their COI at the beginning of each expert panel meeting and prior to guideline publication. Any COI declared by an expert panel member was reviewed by the RNAO best practice guideline development and research team and expert panel co-chairs. No limiting conflicts were identified by members of the expert panel. See the [Declarations of Conflicts of Interest Summary](#) online.

Identifying Priority Recommendation Questions and Outcomes

RNAO systematic review questions are developed in accordance with the PICO format (population, intervention, comparison and outcomes).

In March and April 2021, the RNAO best practice guideline development and research team and the expert panel convened three times virtually to determine the priority recommendation questions and outcomes for this BPG. The three meetings included an orientation meeting and two planning meetings. A comprehensive list of recommendation questions that the BPG could potentially address was developed at these meetings. This list was informed by:

- the environmental scan of guidelines
- the review of the literature
- key informant interviews and a discussion group
- an expert panel survey completed prior to the first planning meeting
- expert panel discussion during the planning meetings

This list of potential recommendation questions was sent to the expert panel in a confidential online survey after the expert panel had an opportunity to discuss the recommendation areas during the first planning meeting. Expert panel members were asked to rank order the recommendation questions from highest to lowest priority. The results were presented to the expert panel during the second planning meeting. The top six recommendation questions were deemed to be the final recommendation questions. Expert panel co-chairs did not participate in the rank ordering.

Following the rank ordering, the expert panel determined that systematic reviews would be conducted for four of the recommendation areas, and that the remaining two recommendation areas would be best suited as good practice statements. For further details, see “Developing Good Practice Statements.”

In alignment with GRADE standards for assessing and presenting the evidence, potential outcomes were brainstormed by the expert panel for each recommendation question that would be the focus of a systematic review. The list of outcomes was informed by a review of the literature, the key informant interviews and discussion group, and expert panel discussion.

It was deemed feasible to have three to five outcomes per recommendation question. During the brainstorming session at the second planning meeting, the expert panel identified between nine and 12 potential outcomes per recommendation question. As a next step, the RNAO guideline development and research team consulted with RNAO’s evaluation and monitoring team to have a closer look at all of the outcomes. During the consultation, the following factors were considered to refine outcomes: which outcomes are measurable; overlap between outcomes; consistency in outcomes across recommendation areas; and outcomes that could be captured through other means (e.g., implementation tips or values and preferences associated with each recommendation area). After this internal review process, the team narrowed down the initial list and modified some outcomes.

Following the internal review process, the expert panel was sent a confidential online survey to rate the relative importance of each outcome (per recommendation question). The expert panel co-chairs did not participate in rating the relative importance of the outcomes. The RNAO guideline development and research team then reviewed the results and calculated the top three to five most critical and important outcomes per recommendation question. The expert panel was provided an update via email regarding the final list of outcomes prioritized for each recommendation question.

The six recommendation questions and their respective PICO research questions are presented below.

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

PICO Research Question #1

Population: Adult and pediatric populations experiencing a transition in care.

Intervention: Support from a system navigator.

Comparison: No support from a system navigator.

Outcomes: Patient quality of life, emergency department visits (within 30 days of a transition in care), follow-up visit with a health or social service provider, patient satisfaction and readmission rates (within 30 days of 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?

PICO Research Question #2

Population: Adult and pediatric populations experiencing a transition in care.

Intervention: A formal interprofessional cross-sectoral approach.

Comparison: No formal interprofessional cross-sectoral approach.

Outcomes: Follow-up visit with a health or social service provider, emergency department visits (within 30 days of a transition in care), patient quality of life,* patient satisfaction* and readmission rates (within 30 days of a transition in care).

*For recommendation question 2, the outcomes “patient quality of life” and “patient satisfaction” were not found in the literature. As such, they were measured using a systematic observation survey completed by the expert panel. See “Updates to the Recommendation Questions and Outcomes” for details.

Recommendation Question #3: Should conducting a person-centred assessment be recommended or not for persons encountering a transition in care?

The expert panel initially brainstormed outcomes for this question in order to conduct a systematic review. However, upon further discussion, the expert panel determined this to be a good practice area.

Recommendation Question #4: Should conducting a review of medication history be recommended or not for persons encountering a transition in care?

The expert panel determined this to be a good practice area. Therefore, no outcomes were selected and a systematic review was not conducted.

Recommendation Question #5: Should access to shared electronic health records for health and social service providers be recommended or not during transitions in care?

PICO Research Question #5

Population: Health and social service providers and persons experiencing a transition in care.

Intervention: Access to shared electronic health records for health and social service providers.

Comparison: No access to shared electronic health records for health and social service providers.

Outcomes: Medication-related harm,* health and social service provider satisfaction,* follow-up visit with a health or social service provider, patient satisfaction.*

*For recommendation question 5, the outcomes “medication-related harm,” “health and social service provider satisfaction” and “patient satisfaction” were measured using a systematic observation survey completed by the expert panel. See “Updates to the Recommendation Questions and Outcomes” for details.

Recommendation Question #6: Should interprofessional collaboration within settings be recommended or not for persons encountering a transition in care?

The expert panel determined this to be a good practice area. Therefore, no outcomes were selected and a systematic review was not conducted.

Updates to the Recommendation Questions and Outcomes

Systematic reviews were conducted for **Recommendation Questions 1, 2, 3 and 5**. Systematic reviews were not conducted for **Recommendation Questions 4 and 6**, as they were voted to be good practice areas by the expert panel at the beginning of the BPG development process.

For **Recommendation Question 2**, the outcomes “patient quality of life” and “patient satisfaction” were not found in the evidence. In the absence of direct evidence, GRADE suggests that systematic observations can be collected from the expert panel (144). Therefore, an online survey was designed to systematically gather the expert panel’s observations and experiences on formal interprofessional cross-sectoral approaches being used to support transitions in care and the impact that these approaches have had on patient quality of life and patient satisfaction. Questions were also posed about benefits and harms, values and preferences, and the impact of implementing a formal interprofessional cross-sectoral approach on health equity. Thirteen expert panel members provided observational data based on their experiences. The systematic observation data was collated, the quality appraised using ROBINS-I, and the certainty of evidence was determined by the two guideline development methodologists. The data was summarized within the guideline and supplementary documents. These outcomes were identified as a gap that future research may explore.

While a systematic review was originally conducted for **Recommendation Question 3**, the panel later agreed that conducting an assessment prior to a transition in care is an established area of practice and better suited to be a good practice statement according to GRADE methods. Therefore, a good practice statement was drafted and consensus was reached that this was a good practice area. For further details, see “Developing Good Practice Statements.”

For **Recommendation Question 5**, only one study was identified that included the outcome “follow-up visit with a health or social service provider.” The outcomes “medication-related harm,” “health or social service provider satisfaction,” and “patient satisfaction” were not found in the literature. Therefore, an online survey was designed to systematically gather the expert panel’s observations and experiences regarding access to shared electronic health records for health and social service providers and the impact on medication-related harm, health and social service

provider satisfaction, and patient satisfaction. Questions were also posed about benefits and harms, values and preferences, and the impact on health equity of access to shared electronic health records for health and social service providers. Twelve expert panel members provided observational data based on their experiences. The systematic observation data was collated, the quality appraised using ROBINS-I, and the certainty of evidence was determined by the two guideline development methodologists. The data was summarized within supplementary documents. A recommendation statement was originally drafted for this recommendation question based on one study retrieved from the systematic review and the expert panel's systematic observations. Given the limited research available to answer this question, however, the expert panel decided to not proceed with the recommendation. More research is needed on this topic.

Developing Good Practice Statements

The process for determining good practice statements evolved throughout the BPG development process as new GRADE guidance became available. Good practice statements are actionable statements that should be done in practice and the benefits of the action clearly outweigh the harms (16).

During the initial two planning meetings, the RNAO best practice guideline development and research team reviewed the list of the six prioritized recommendations areas and presented three potential good practice areas for the expert panel to consider voting on. These included conducting an assessment, review of medication history, and interprofessional collaboration within settings. The expert panel discussed each of these areas and decided whether or not to proceed with a live poll to confirm they were good practice areas. The expert panel co-chairs did not participate in the voting process; they instead facilitated the discussion and acted as tie-breakers, if needed.

For the potential recommendation area on *conducting an assessment*, the expert panel suggested conducting a systematic review; as such, a live poll to determine if this was a good practice area was not initially done. For the potential good practice areas related to *review of medication history* and *interprofessional collaboration within settings*, the expert panel engaged in a discussion and proceeded to complete a live poll. The expert panel was asked to respond to four questions:

1. Is the message really necessary in regard to actual health care practice? (Yes/No/Unsure)
2. Will implementing the good practice statement result in large benefits and very small harms? (Yes/No/Unsure)
3. Is a systematic review of the evidence necessary for this good practice area? (Yes/No/Unsure)
4. Is there a clear and explicit rationale to support this good practice area? (Yes/No/Unsure)

A 70 per cent expert panel consensus was required for each question to pass as a good practice area. For both recommendation areas, a 70 per cent consensus was not reached for one of the questions, so the co-chairs acted as moderators and made the final decision to proceed with *review of medication history* and *interprofessional collaboration within settings* as good practice areas.

A good practice statement was drafted to focus on *interprofessional collaboration within settings* to develop a transition plan. Interprofessional collaboration within settings was defined as two or more health or social care providers from different disciplines collaborating within the same setting or organization to coordinate care. Upon further discussion, the panel felt that it is good practice for all members of the interprofessional team (both within and across settings) to collaborate in developing a transition plan. A decision was therefore made to remove the wording “within settings” from the good practice statement. To inform this good practice statement, a literature review of one database was conducted to search for literature published between 2016–2021.

Midway through the BPG development process, an additional good practice area that addressed the significance of health and social service providers collaborating with persons and their support network before, during and after transitions in care was identified by the expert panel. The expert panel agreed that this statement should be included in the BPG, and that collaboration with persons and their support network during transitions in care would result in clear benefits and no harms. As such, a good practice statement on this topic was drafted and a live poll to confirm this as a good practice area was completed by the expert panel during the recommendation build meeting. By this time, the process for determining good practice statements had evolved as new GRADE guidance became available and the live poll questions were revised to improve clarity. Furthermore, through discussion with a GRADE consultant, it was determined that the expert panel co-chairs would no longer act as moderators; they would participate in the live poll.

For the potential good practice area on *collaboration with persons and their support network*, the expert panel was asked to respond to five questions (with Questions 2a and 2b counting as a single question area):

1. Is the message necessary to communicate? (Yes/No)
- 2a. Is the evidence difficult to collect and summarize? (Yes/No)
- 2b. Would not performing the action be unethical or against human rights? (Yes/No)
3. Would implementing the action result in large benefits and very small harms? (Yes/No)
4. Is there a clear rationale for the action? (Yes/No)
5. Are there any other reasons why this statement should not be made (e.g., large costs, unacceptable, infeasible)? (Yes/No)

If a 70 per cent consensus was reached for one of the two parts of Question 2 (2a or 2b), the question was deemed to be a pass. A 70 per cent expert panel consensus was reached for all five questions. Therefore, *collaboration with persons and their support network* was determined to be a good practice area.

During the recommendation build meetings, the need for a good practice statement on assessment was also revisited. Through discussion, the expert panel determined that conducting an assessment prior to a transition in care is an essential area of practice and it would be illogical to not complete an assessment. This signaled the panel to consider developing a good practice statement rather than a recommendation on assessment, and the expert panel proceeded to complete a live poll. Seventy per cent expert panel consensus was reached for the aforementioned five question areas and *conducting an assessment* was determined to be a good practice statement.

Near the end of the BPG development process, an additional good practice statement on *providing persons and their support network with information and support to manage their needs during and after transitions in care* was discussed by the panel. Although the BPG contains a recommendation on providing navigation support to persons with complex care needs, the panel felt it was necessary to communicate that all persons should be provided with basic information and support to facilitate a successful transition. Despite the clear benefits of ensuring this support is provided, persons experiencing transitions do not always receive this support.

By this time, new GRADE guidance had become available regarding how to determine good practice statements (17) and the questions were once again revised to use more plain language. Through discussion with a GRADE consultant, it was determined that consensus on each of the five questions could be reached through discussion with the panel rather than formal voting.

For the potential good practice area on *providing persons and their support network with information and support to manage their needs during and after transitions in care*, the expert panel was asked to respond to five questions:

1. Is collecting and summarizing the evidence a poor use of time and energy? (Yes/No)
2. Is the message necessary to communicate? (Yes/No)
3. Would implementing the action result in large benefits and very small harms? (Yes/No)
4. Is there a clear rationale for the action? (Yes/No)
5. Is the statement clear and actionable? (Yes/No)

Through discussion, the expert panel determined that each of the five criteria had been met, so this area also became a good practice statement.

Systematic Retrieval of the Evidence

Strong and conditional recommendations are based on a comprehensive and systematic review of the literature.

For this BPG, a search strategy was developed by RNAO's best practice guideline development and research team and a health sciences librarian for each of the aforementioned PICO research questions. A search for relevant research studies published in English between January 2016 and August 2021 was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Medline, Medline in Process, Cochrane Central, Cochrane Database of Systematic Reviews, Embase, Emcare and PsycInfo.

Expert panel members were asked to review their personal libraries for key studies not found through the above search strategies (see [PRISMA diagrams](#)). Detailed information on the search strategy for the systematic reviews, including the inclusion and exclusion criteria and search terms, is available [online](#).

Systematic review search dates were limited to the last five years from the date of the initial planning meetings in order to capture the most up-to-date evidence (January 2016 – June 2021). All study designs were included in the search.

All studies were independently assessed for relevance and eligibility by two guideline development methodologists based on the inclusion and exclusion criteria. Any disagreements were resolved through consensus.

All included studies were independently assessed for risk of bias by study design using validated and reliable tools. **Randomized controlled trials**^G were assessed using the Risk of Bias 2.0 tool (145), and **non-randomized studies**^G were assessed using the ROBINS-I tool (146). The two guideline development methodologists reached consensus on all scores through discussion.

For data extraction, the included studies were divided equally between the guideline development methodologists. Each guideline development methodologist extracted information from their assigned studies and this was reviewed by the other guideline development methodologist for accuracy.

In January 2023, the health science librarian conducted an update search for relevant research studies published in English between June 2021- January 2023 that answered research questions 1 and 2. The search was applied to the following databases: CINAHL and Medline. The librarian found that a new subject heading had been created that was

not available at the time the original search was conducted in 2021, so this subject heading was added to the original search strategies for questions 1 and 2. Results from 6 studies were incorporated into the discussions of evidence for **Recommendations 3.1** and **5.1**. See the PRISMA diagrams [online](#) for studies included in the update search.

Determining Certainty of Evidence

Certainty of Evidence

The certainty of quantitative evidence (i.e., the extent to which one can be confident that an estimate of an effect is true) is determined using GRADE methods (19). First, the certainty of the evidence is rated for each prioritized outcome across studies (i.e., for a body of evidence) per recommendation (19). This process begins with the study design and then requires an examination of five domains—risks of bias, inconsistency, imprecision, indirectness and publication bias—to potentially **downgrade**^G the certainty of evidence for each outcome. See **Table 12** for a definition of each of these certainty criteria.

Table 12. GRADE Certainty Criteria

OVERALL CERTAINTY OF EVIDENCE	DEFINITION
Risk of bias	Limitations in the study design and execution that may bias study results. Valid and reliable quality appraisal tools are used to assess the risk of bias. First, risk of bias is examined for each individual study and then examined across all studies per defined outcome.
Inconsistency	Unexplained differences (heterogeneity) of results across studies. Inconsistency is assessed by exploring the magnitude of difference, and possible explanations in the direction and size of effects reported across studies for a defined outcome.
Indirectness	Variability between the research and review question and context within which the recommendations would be applied (applicability). There are four sources of indirectness which are assessed: <ul style="list-style-type: none"> ■ differences in population ■ differences in interventions ■ differences in outcomes measured ■ differences in comparators
Imprecision	The degree of uncertainty around the estimate of effect. This is usually related to sample size and number of events. Studies are examined for sample size, number of events and confidence intervals.
Publication bias	Selective publication of studies based on study results. If publication bias is strongly suspected, downgrading is considered.

Source: Adapted with permission from: Schunemann H, 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.gradeapro.org/app/handbook/handbook.html#h.wsfivfhuxv4r>.

Following the initial consideration for rating down the certainty of quantitative evidence, three factors are assessed that can potentially enable rating up the certainty of evidence for non-randomized studies.

1. **Large magnitude of effect:** If the body of evidence has not been rated down for any criteria other than risk of bias and a large estimate of the magnitude of intervention effect is present, there is consideration for rating up.
2. **Dose–response gradient:** If the body of evidence has not been rated down for any criteria other than risk of bias and a dose–response gradient is present, there is consideration for rating up.
3. **Effect of plausible confounding:** If the body of evidence has not been rated down for any criteria other than risk of bias and all residual confounders would result in an underestimation of treatment effect, there is consideration for rating up (19).

GRADE categorizes the overall certainty of evidence as high, moderate, low or very low. See **Table 13** for the definitions of these categories.

For this BPG, the five GRADE quality criteria for potentially downgrading quantitative evidence—and the three GRADE quality criteria for potentially rating up evidence—were independently assessed by the two guideline development methodologists. Any disagreements were resolved through consensus. An overall certainty of evidence per recommendation was assigned based on these assessments. The certainty of evidence assigned to each recommendation was based on the certainty of prioritized outcomes in the studies that informed the recommendation.

Table 13: Certainty of Evidence

OVERALL CERTAINTY OF EVIDENCE	DEFINITION
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Source: Reprinted with permission from: The GRADE Working Group. Quality of evidence. In: Schunemann H, 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 [cited 2018 Aug 31]. Table 5.1, Quality of evidence grades. Available from: <https://gdt.gradeapro.org/app/handbook/handbook.html#h.wsfvfhuxv4r>.

Formulating Recommendations

Summarizing the Evidence

The guideline development methodologists analyzed all studies pertaining to each recommendation question and drafted recommendations that answer the questions accordingly. For each draft recommendation, GRADE evidence profiles were constructed by the two guideline development methodologists. GRADE evidence profiles are used to present decisions on determining the certainty of evidence, and to present general information about the body of research evidence, including key statistical or narrative results (19).

The evidence profiles for the body of quantitative studies presented the decisions made by the two guideline development methodologists on the five key GRADE certainty criteria for rating down the population included in the studies, the countries where the studies were conducted, the key results and the transparent judgments about the certainty underlying the evidence for each outcome (19). For this BPG, **meta-analyses^G** were not performed.

For more detail, please see the GRADE evidence profiles for each recommendation, organized per outcome. As no recommendation stemmed from the question on access to shared electronic health records for providers, this evidence profile is not listed on RNAO's website. For more information about this evidence profile, please contact RNAO.

Evidence-to-Decision Frameworks

Evidence-to-Decision (EtD) frameworks^G outline proposed recommendations and summarize all necessary factors and considerations based on available evidence and expert panel judgements for formulating the recommendation statements. EtD frameworks are used to help ensure that all important factors (i.e., certainty of the evidence, benefits/harms, values and preferences, and health equity) required to formulate recommendation statements are considered by the expert panel (19). Both quantitative and qualitative evidence are incorporated into the frameworks. The guideline development methodologists draft the EtD frameworks with available evidence from the systematic reviews.

For this BPG, the EtD frameworks included the following areas of consideration for each drafted recommendation statement (see **Table 14**):

- Background information on the magnitude of the problem.
 - Includes the PICO question and general context related to the research question.
- The balance of benefits and harms of an intervention.
- Certainty of the evidence.
- Values and preferences.
- Health equity.

Decision Making: Determining the Direction and Strength of Recommendations

Expert panel members were provided with the EtD frameworks to review prior to two virtual half-day meetings to determine the direction (i.e., a recommendation for or against an intervention) and the strength (i.e., strong or conditional) of the BPG's recommendations. Expert panel members were also given access to the complete evidence profiles and full-text articles.

The expert panel co-chairs and the two guideline development methodologists facilitated the meetings to allow for adequate discussion for each proposed recommendation.

The decision on the direction and strength of each recommendation statement was determined by discussion and a consensus vote of at least 70 per cent of voting panel members. The voting process was anonymous and was moderated by the expert panel co-chairs and guideline development methodologists. The co-chairs were also voting members. In determining the strength of a recommendation statement, the expert panel was asked to consider the following (see **Table 14**):

- the balance of benefits and harms of an intervention
- certainty of the evidence
- values and preferences
- health equity

Table 14: Key Considerations for Determining the Strength of Recommendations

FACTOR	DEFINITION	SOURCES
Benefits and harms	<p>Potential desirable and undesirable outcomes reported in the literature when the recommended practice or intervention is used.</p> <p>“The larger the difference between the desirable and undesirable effects, the higher the likelihood that a strong recommendation is warranted. The narrower the gradient, the higher the likelihood that a conditional recommendation is warranted” (147).</p>	Includes research exclusively from the systematic review.
Certainty of evidence	<p>The extent of confidence that the estimates of an effect are adequate to support a recommendation. The extent of confidence that a review finding is a reasonable representation of the phenomenon of interest (148).</p> <p>Recommendations are made with different levels of certainty; the higher the certainty, the higher the likelihood that a strong recommendation is warranted (147).</p>	Includes research exclusively from the systematic review.

FACTOR	DEFINITION	SOURCES
Values and preferences	<p>The relative importance or worth of the health outcomes of following a particular clinical action from a person-centred perspective.</p> <p>“The more values and preferences vary or the greater the uncertainty in values and preferences, the higher the likelihood that a conditional recommendation is warranted” (147).</p>	<p>Includes evidence from the systematic review (when available) and other sources, such as insights from the expert panel.</p> <p>During the systematic review screening process, if studies did not directly answer the research question (i.e., they did not discuss the outcomes of interest) but were relevant to preferences for the intervention from a person-centred perspective, those studies were also included in this section.</p>
Health equity	<p>Represents the potential impact of the recommended practice or intervention on health outcomes or health quality across different populations.</p> <p>The greater the potential for increasing health inequity, the higher the likelihood that a conditional recommendation is warranted (149).</p>	<p>Includes evidence from the systematic review (when available) and other sources, such as insights from the expert panel.</p>

Source: Adapted with permission from: Schunemann H, 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#h.svwngs6pm0f2>

Supporting Resources and Appendices

Content for the supporting resources and appendices was submitted throughout the guideline development process by expert panel members and stakeholders. The two guideline development methodologists reviewed the content based on the following five criteria:

1. **Relevance:** Supporting resources and appendices should be related to the subject of the BPG or recommendation. In other words, the resource or appendix should be suitable and appropriate in relation to the purpose and scope of the BPG or the specific recommendation(s).
2. **Timeliness:** Resources should be timely and current. Resources should be published within the last 10 years or in line with current evidence.
3. **Credibility:** When assessing credibility, the trustworthiness and expertise of the source material’s author or authoring organization is considered. Potential biases are also assessed, such as the presence of advertising or the affiliation of the authors with a private company selling health-care products.

4. **Quality:** This criterion assesses the accuracy of the information and the degree to which the source is evidence-informed. The assessment of quality is in relation to the subject of the resource. For example, if a tool is being suggested, is that tool reliable and/or valid?
5. **Accessibility:** This criterion considers whether the resource is freely available and accessible online.

Drafting the Guideline

The guideline development methodologists wrote the draft of this BPG. The expert panel reviewed the draft and provided written feedback. The BPG then proceeded to external stakeholder review.

Stakeholder Review

As part of the guideline development process, RNAO is committed to obtaining feedback from: (a) nurses and other health and social service providers from a wide range of practice settings and roles; b) persons with lived experience; and (c) knowledgeable educators and administrators, throughout Canada and around the world.

Stakeholder reviewers for RNAO BPGs are identified in two ways. First, stakeholders are recruited through a [public call](#) issued on the RNAO website. Second, individuals and organizations with expertise in the guideline topic area are identified by the RNAO best practice guideline development and research team and the expert panel, and they are directly invited to participate in the review.

Stakeholder reviewers are individuals with subject matter expertise in the guideline topic or those who may be affected by its implementation. Reviewers may be nurses, members of the interprofessional team, administrators, research experts, educators, nursing students, or persons with lived experience and their support network.

Reviewers are asked to read a full draft of the BPG and participate in its review prior to its publication. Stakeholder feedback is submitted online by completing a survey questionnaire.

The stakeholders are asked the following questions about each recommendation and good practice statement:

- Is this recommendation/good practice statement clear?
- Do you agree with this recommendation/good practice statement?
- Is there a clear and explicit rationale to support this recommendation/good practice statement?

In addition, the stakeholders are asked the following:

- About the appendices:
 - Are the appendices included in this guideline appropriate?
 - Are there any gaps in the content provided?
- About the guideline title:
 - Do you think this title is appropriate?
 - Do you think this title is clear?

- About the guideline as a whole:
 - Do you have any additional comments/suggestions about the background section of this guideline?
 - Do you agree with the wording of the key concepts and accompanying definitions?
- With respect to the evaluation indicators, the stakeholders are asked:
 - Are these indicators relevant to your practice setting?
 - Do you have suggestions for other indicators and/or measures?

In addition, stakeholder reviewers are given the option to enter additional comments or suggestions. Survey submissions are compiled and feedback is summarized by the RNAO best practice guideline development and research team. Together with the expert panel, they review and consider the survey results, modifying BPG content and recommendations prior to publication to reflect the feedback received as required.

For this BPG, the written stakeholder review process was completed between October 13, 2022 and November 15, 2022. Stakeholders with diverse perspectives provided feedback (see **Stakeholder Acknowledgement**).

As part of the stakeholder review process, the guideline development methodologists shared the draft guideline with representatives from BPSO OHTs who will be implementing this BPG in their practice settings. Two discussion groups were held with representatives from BPSO OHTs to collect verbal feedback, and the following questions were asked:

- How do the recommendations advance BPSO OHTs goals (e.g., integrated care and population health management)?
- Are there any aspects that are incongruent or particularly challenging for BPSO OHTs?
- What supporting resources or appendices can we include in the BPG that would be useful for BPSO OHTs?
- Are there any aspects of the indicators that should be considered in order to support BPSO OHTs?

In addition, the summary of recommendations and good practice statements were shared with representatives from Indigenous-focused BPSOs. Two guideline development methodologists attended a meeting with representatives to collect feedback. The following questions were asked:

- Are the recommendations and good practice statements relevant to community members local to your organization? If no, what aspects of the recommendations or good practice statements are incongruent for Indigenous-focused BPSOs?
- Are there recommendations or good practice statements that particularly resonate with you? If yes, how can the recommendations and good practice statements advance the work of Indigenous-focused BPSOs?

Finally, Ontario Health, Health Standards Organization, and Healthcare Excellence Canada were provided the opportunity to review the draft recommendation statements and indicators and provided feedback.

Together with the expert panel, the RNAO best practice guideline research and development team reviewed the feedback received and modified the BPG content, where necessary.

Procedure for Updating the Guideline

The RNAO commits to updating all BPGs, as follows:

1. Each BPG will be reviewed by a team of specialists in the topic area every five years following publication of the previous edition.
2. RNAO International Affairs and Best Practice Guidelines Centre 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 period for a particular BPG. 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 BPG earlier than planned.
4. Three months prior to the review milestone, the staff commence planning of the review by doing the following:
 - a. Compiling feedback received and questions encountered during the implementation, including comments and experiences of BPSOs[®] and other implementation sites regarding their experiences.
 - b. Compiling a list of new clinical practice guidelines in the field and refining the purpose and scope.
 - c. Developing a detailed work plan with target dates and deliverables for developing a new edition of the BPG.
 - d. Identifying potential BPG panel co-chairs in consultation with RNAO's CEO.
 - e. Compiling a list of specialists and experts in the field for potential participation on the expert panel. The expert panel will be comprised of both members of the original expert panel and new members.
5. New editions of BPGs will be disseminated based on established structures and processes.

Appendix D: Education Statements

Education Statements for This BPG

RNAO has been at the forefront of creating BPGs since 1999, with its first BPGs being issued in 2001. From the outset, RNAO recognized the importance of individual and organizational approaches to the delivery of education on clinical BPG content to support evidence-based practice changes. As such, RNAO clinical BPGs included education recommendations directed to those responsible for the academic and in-service education of nursing students, nurses and the interprofessional team. These recommendations outlined core content and training strategies required for entry-level health programs, continued education and professional development.

An in-depth analysis of RNAO's educational recommendations was conducted in 2018. It included clinical BPGs published within a five-year time frame, as all clinical BPGs published within this period are based on a systematic review of the literature. It examined 26 education recommendations from nine different BPGs with diverse clinical topics and populations.

A rigorous thematic analysis showed similarities across BPGs. Thus, it was deemed appropriate to create standard education statements that would be applicable to all clinical BPGs to support evidence-based practice changes. The resultant two education statements and the associated discussion of the literature are described below. These statements can be contextually adapted within health and social service organizations and academic institutions to support the implementation of clinical recommendations for various guideline topic areas.

EDUCATION STATEMENT 1: ACADEMIC INSTITUTIONS INTEGRATE EVIDENCE-BASED GUIDELINES INTO CURRICULA FOR PRE- AND POST-LICENSURE NURSES AND OTHER REGULATED HEALTH AND SOCIAL SERVICE PROVIDERS

Discussion of Literature:

The thematic analysis of the education recommendation statements described above found a particular theme to be the foundation of evidence-based practice capacity building:

Academic institutions integrate evidence-based guidelines into curricula for pre- and post-licensure nurses and other regulated health and social service providers.

The following BPGs were analyzed:

- *Assessment and Management of Pain, Third Edition* (2013)
- *Care Transitions* (2014)
- *Preventing and Addressing Abuse and Neglect of Older Adults: Person-centred, Collaborative, System-wide Approaches* (2014)
- *Primary Prevention of Childhood Obesity, Second Edition* (2014)
- *Working with Families to Promote Safe Sleep in Infants 0–12 Months of Age* (2014)
- *Engaging Clients who use Substances* (2015)
- *Person- and Family-centred Care* (2015)
- *Delirium, Dementia and Depression in Older Adults: Assessment and Care, Second Edition* (2016)

Academic institutions should consider integrating BPG content into theoretical and practice-based courses for nurses and other regulated health and social service providers, including social workers, physiotherapists, occupational therapists, dietitians and pharmacists in pre-licensure (e.g., diploma and undergraduate) and post-licensure (e.g., graduate) programs. Pre-licensure education establishes foundational knowledge that can be strengthened and augmented, as necessary, within health and social service organizations. Post-licensure education at the graduate level may include preparing nurses and other regulated health and social service providers for advanced practice roles and functions within clinical practice, education, administration, research and policy (150). As such, the integration of guideline content into curricula will differ in terms of educational content and complexity based on the overall educational objectives of the program. In both cases, integrating guideline content into curricula supports student learning consistent with evidence-based practices, with the ultimate goal of enhancing the health outcomes of persons and families.

To support the integration of evidence-based BPGs into curricula, the following approaches may be utilized: (1) developing multi-level guideline-related learning objectives; and (2) designing BPG-related teaching and learning strategies. Both approaches are outlined below.

1. **Developing multi-level guideline-related learning objectives:** Guideline-related learning objectives at multiple levels of a program (pre-licensure and post-licensure) facilitate integration of guideline content into curricula.
 - At the program level, such integration broadens student knowledge, attitude, judgment and skill. For instance, a program-level outcome at the graduate level may include student awareness of elements of implementation science to support uptake and sustained use of guidelines in clinical settings (151).
 - At the course level, integration of guideline content supports student learning that is consistent with evidence-based practices within academic and practice settings. For example, course-level outcomes at the undergraduate level may include students being able to gain increased knowledge about guidelines, to select guidelines relevant to practice (and provide rationale for their selection), and to integrate guideline recommendations into plans of care for persons and families (151).
2. **Designing guideline-related teaching and learning strategies:** Teaching strategies should be tailored to address the program-level educational objectives and needs of learners, and to equip the learner to improve practice and promote positive outcomes (152). The various guideline-related teaching and learning strategies are outlined below.
 - **Lectures:** Educators can use lectures as a means of providing a broad understanding of guidelines, specifically the rigorous process of developing guidelines and their various recommendations. Lectures can provide students with an understanding of the scope and strength of evidence that inform the recommendations (151).
 - **Interactive classroom activities:** Interactive learning activities within the classroom setting can support students to obtain additional information, participate in problem-solving and articulate knowledge gained. Examples include: assigning group work to help students learn how to navigate a guideline and become familiar with its recommendations; using case studies to provide students with opportunities to identify and apply guideline recommendations in care plans; and using videos and role playing to promote skills in articulating the rationale for selecting specific guidelines/recommendations in care plans (151).

- **Simulation:** High-quality digital simulation within skills lab settings can ease the uncertainty of students related to clinical practice; it can also increase skill acquisition, self-confidence and satisfaction. Faculty trained in pedagogy can use simulation to teach students content related to safe and effective person and family-centred care within a standardized clinical environment. Educators can also support students to incorporate guideline content into simulated practice sessions when teaching evidence-based practice (151).
- **Pre- and post-clinical conference discussions:** Focusing on a guideline at pre- and post-clinical conference discussions can support the critical thinking of students when they develop care plans, consider modifications based on guideline recommendations, articulate rationale for clinical decisions and evaluate the outcome of interventions. Students have the opportunity to evaluate if policies and procedures within the practice setting align with best evidence, and they can identify potential areas for practice change and consider how to initiate change (151).
- **Access to BPG-related resources:** Educators can promote and facilitate access to BPG-related links and resources (151).
- **Assignments and tests:** Students may be asked to incorporate guidelines into their learning plans or to write a reflective journal related to a guideline that is important to their area of practice. Tests or exam questions that demonstrate critical thinking related to guidelines can also be used. Overall, guideline-related assignments and tests can assist students to reflect upon guidelines, understand their application and critique them (151).
- **Preceptorship or mentorship in clinical placements:** Preceptors within clinical settings play an integral role in teaching practical skills that complement the theoretical learning of students. Preceptors are responsible for providing clinical teaching and supervision, and they perform formal student evaluation (153). Preceptors can support students to integrate guideline content into their learning objectives and clinical activities to promote evidence-based knowledge and practice.

EDUCATION STATEMENT 2: HEALTH AND SOCIAL SERVICE ORGANIZATIONS USE STRATEGIES TO INTEGRATE EVIDENCE-BASED GUIDELINES INTO EDUCATION AND TRAINING OF NURSES AND OTHER HEALTH AND SOCIAL SERVICE PROVIDERS

Discussion of Literature:

The thematic analysis of the education recommendation statements in a number of BPGs found a second theme to be foundational to evidence-based practice capacity building:

Health and social service organizations use strategies to integrate evidence-based guidelines into the education and training for nurses and other health and social service providers.

The following BPGs were analyzed:

- *Assessment and Management of Pain, Third Edition* (2013)
- *Care Transitions* (2014)
- *Preventing and Addressing Abuse and Neglect of Older Adults: Person-centred, Collaborative, System-wide Approaches* (2014)
- *Primary Prevention of Childhood Obesity, Second Edition* (2014)
- *Working with Families to Promote Safe Sleep in Infants 0–12 Months of Age* (2014)
- *Engaging Clients who use Substances* (2015)
- *Person- and Family-centred Care* (2015)
- *Delirium, Dementia and Depression in Older Adults: Assessment and Care, Second Edition* (2016)

Nurses and other health and social service providers should continually seek new knowledge, identify opportunities for professional growth and pursue ongoing learning throughout their careers. Participation in education and training ensures congruence with evidence-based practices, enhances competence and improves care quality and individual outcomes (154). Integrating guideline content into education and training programs within health and social service organizations can improve evidence-based knowledge and skills for post-licensure nurses and other health and social service providers.

Education and training programs should be based on the principles of adult learning, including the following:

- Adults have an awareness of learning needs/goals.
- Adults are self-directed and autonomous.
- Adults value and utilize prior life experiences.
- Adults have a readiness to learn.
- Adults are motivated to learn.
- Adults are presented knowledge and skills in the context of practical, real-life situations (155).

Furthermore, education and training should be appropriate to the health or social service provider's scope of practice and their defined role. Education and training strategies may include the following:

- **In-service education sessions:** In-service education sessions can be planned by clinical experts within practice settings to support the utilization of a specific BPG or recommendations stimulating evidence-based practice among staff. The education may include one-on-one or group sessions, and it should address the needs of learners. It is recommended that the education sessions are followed with refresher or booster sessions to provide feedback and enhance staff learning (156,157).
- **Workshops/seminars:** Highly interactive workshops/seminars help nurses and health and social service providers maintain practice based on best evidence when they incorporate a variety of teaching–learning strategies, including pre-circulated materials, small group discussions using case studies, and multimedia such as Power Point and videos that integrate relevant BPGs/recommendations. RNAO's Best Practice Champions Workshop and BPG Learning Institutes are examples of programs that provide education on how to implement BPGs within practice settings (158).
- **Quality improvement:** Participating in quality improvement within workplace settings can support nurses and health workers to recognize sentinel events and examine ways to improve care. Meeting accreditation standards is an important quality improvement activity that bridges gaps between current and best practices and supports continued competence. Examples of strategies that nurses and other health and social service providers can use to meet accreditation standards include the following:
 - Participating in a unit-based guideline implementation process to promote patient safety, reduce risks and improve care outcomes.
 - Choosing guideline-specific recommendations to facilitate practice change.
 - Sharing knowledge and lessons learned from reviewing guidelines with the accreditation committee (159,160).

Additional quality improvement opportunities include participating in incident reporting, patient safety initiatives and other health initiatives within areas of practice.

- **Post-licensure mentorship:** Post-licensure mentorship involves providing new graduates or less experienced staff with guidance for skill development and support for the growth of professional roles. Research suggests that working with mentors reduces stress and improves satisfaction for new staff during the transition process (161). Mentors can support integration of guideline content while teaching evidence-based practice.

EVALUATION

All educational strategies require evaluation to: (a) monitor the adoption of knowledge; and (b) measure the impact on clinical outcomes.

RNAO has developed the *Practice Education in Nursing BPG* (162) to provide evidence-based recommendations that support the application of knowledge to various practice settings by student nurses. The BPG also assists nurses, nurse educators, preceptors and other members of the interprofessional team to understand the effective use of teaching–learning strategies in clinical settings.

The [Leading Change Toolkit](#) (4) identifies many strategies to support the evaluation of health outcomes at the levels of the person, provider, organization and health system. Examples of evaluation strategies may include:

- pre- and post-tests for staff educational sessions
- staff focus groups/interviews
- observation of patient–provider encounters
- chart audits to determine the impact on person and family outcomes
- person and family satisfaction surveys or interviews

Appendix E: Indicator Development Process

The following is a summary of the RNAO indicator development process (see Indicator Development Flow Diagram [online](#)).

1. **Guideline selection:** Indicators are developed for guidelines focused on health system priorities, with an emphasis on filling gaps in measurement while reducing reporting burden.
2. **Extraction of recommendations:** Practice recommendations, overall guideline outcomes and BPG Order Sets™ (if applicable) are reviewed to extract potential measures for indicator development.
3. **Indicator selection and development:** Indicators are selected and developed through established methodology, including alignment with external data repositories and health information data libraries.
4. **Practice test and validation:** Proposed indicators are internally validated through face and content validity, and externally validated by national and international organization representatives.
5. **Implementation:** Indicators are published in the Evaluation and Monitoring chart in the BPG, and data dictionaries are published on the NQuIRE® website for use by BPSOs®.
6. **Data quality assessment and evaluation:** Data quality assessment and evaluation, as well as ongoing feedback from BPSOs, ensure purposeful evolution of BPG indicators collected in NQuIRE.

Appendix F: Patient, Family and Caregiver Declaration of Values for Ontario

The Patient, Family and Caregiver Declaration of Values was drafted by the Minister’s Patient and Family Advisory Council in consultation with Ontarians to communicate patient, family and caregiver expectations of Ontario’s health-care system (163). The Declaration can serve as a compass for persons and organizations involved in health care and reflects a summary of important person, family and caregiver values. The Patient, Family and Caregiver Declaration of Values for Ontario is also available in [French](#).

Figure 3: Patient, Family and Caregiver Declaration of Values for Ontario

Patient, Family and Caregiver Declaration of Values for Ontario

ACCOUNTABILITY	<ul style="list-style-type: none"> ● We expect open and seamless communication about our care. ● We expect that everyone on our care team will be accountable and supported to carry out their roles and responsibilities effectively. ● We expect a health care culture that demonstrates that it values the experiences of patients, families and caregivers and incorporates this knowledge into policy, planning and decision making. ● We expect that patient, family and caregiver experiences and outcomes will drive the accountability of the health care system and those who deliver services, programs and care within it. ● We expect that health care providers will act with integrity by acknowledging their abilities, biases and limitations. ● We expect health care providers to comply with their professional responsibilities and to deliver safe care.
EMPATHY & COMPASSION	<ul style="list-style-type: none"> ● We expect that health care providers will act with empathy, kindness and compassion. ● We expect individualized care plans that acknowledge our unique physical, mental, emotional, cultural and spiritual needs. ● We expect that we will be treated in a manner free from stigma, assumptions, bias and blame. ● We expect health care system providers and leaders will understand that their words, actions and decisions strongly impact the lives of patients, families and caregivers.
EQUITY & ENGAGEMENT	<ul style="list-style-type: none"> ● We expect equal and fair access to the health care system and services for all regardless of ability, race, ethnicity, language, background, place of origin, gender identity, sexual orientation, age, religion, socioeconomic status, education or location within Ontario. We further expect equal and fair access to health care services for people with disabilities and those who have historically faced stigmatization. ● We expect that we will have opportunities to be included in health care policy development and program design at local, regional and provincial levels of the health care system. ● We expect an awareness of and efforts to eliminate systemic racism and discrimination, including identification and removal of systemic barriers that contribute to inequitable health care outcomes (with particular attention to those most adversely impacted by systemic racism).
RESPECT & DIGNITY	<ul style="list-style-type: none"> ● We expect that our individual identity, beliefs, history, culture and ability will be respected in our care. ● We expect health care providers will introduce themselves and identify their role in our care. ● We expect that we will be recognized as part of the care team, to be fully informed about our condition, and have the right to make choices in our care. ● We expect that patients, families and caregivers be treated with respect and considered valuable partners on the care team. ● We expect that our personal health information belongs to us, and that it remain private, respected and protected.
TRANSPARENCY	<ul style="list-style-type: none"> ● We expect that we will be proactively and meaningfully involved in conversations about our care, considering options for our care, and decisions about our care. ● We expect that our health records will be accurate, complete, available and accessible across the provincial health system at our request. ● We expect a transparent, clear and fair process to express a complaint, concern, or compliment about our care that does not impact the quality of the care we receive.

Updated: July 2021

Note: The purpose of this Patient, Family and Caregiver Declaration of Values, drafted by the Minister’s Patient and Family Advisory Council in consultation with Ontarians, is to articulate patient, family and caregiver expectations of Ontario’s health care system. The Declaration is intended to serve as a compass for the individuals and organizations who are involved in health care and reflects a summary of the principles and values that patients, families and caregivers say are important to them. The Declaration is not intended to establish, alter or affect any legal rights or obligations, and must be interpreted in a manner that is consistent with applicable law.

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Source: Reprinted with permission from: Government of Ontario. Patient family and caregiver declaration of values for Ontario [Internet]. Toronto (ON): Government of Ontario; 2021. Available from: <https://files.ontario.ca/moh-patient-family-caregiver-declaration-of-values-for-ontario-en-2021-08-31.pdf>.

Appendix G: Patient Oriented Discharge Summary

The Patient Oriented Discharge Summary (PODS) is an easy-to-use discharge summary designed for persons transitioning from hospital to home (164). Most traditional discharge summaries are dense documents with technical terms and are designed to communicate information to primary care providers, rather than persons receiving care. PODS was co-created with persons and their support network, including individuals with limited health literacy and language barriers, to help persons understand important information when leaving a hospital. The resource uses plain language, large fonts, space for persons to take notes and is available in [15 languages](#).


PODS contains useful information about medications, changes to diet and activities, follow-up appointments and symptoms to watch for after a transition (164). Organizations are encouraged to use the sample template and adapt it to meet the needs of the specific populations they support. PODS should be completed in the presence of persons and their support network using the teach-back method. The implementation of PODS can also be supported through the electronic health record as some electronic health records require mandatory PODS completion before every transition (165). PODS is not meant to replace a traditional discharge summary sent to a primary care provider (164).


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 H: My Transitional Care Plan[®]

My Transitional Care Plan[®] summarizes information to facilitate successful transitions in care for older adults presenting with, or at risk of, responsive behaviours or complex mental health, substance use or neurological conditions (166). It provides a synopsis of essential information that should be communicated to members of the interprofessional team to prepare and facilitate a transition in care. The tool is written in first person to promote person-centred care, and health and social service providers should collaborate with persons and their support network when completing the form. My Transitional Care Plan[®] can be built within an electronic health record. The form is also available in [French](#) (166).

Figure 5: My Transitional Care Plan[®]

 Behavioural Supports Ontario Soutien en cas de troubles du comportement en Ontario				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: <input type="checkbox"/> Hospital <input type="checkbox"/> Retirement Home <input type="checkbox"/> Private Dwelling <input type="checkbox"/> Other:					
Details:					
Destination:			Date & Time of Move:		
Transportation Plan:			Arrival Plan: <input type="checkbox"/> Arriving alone <input type="checkbox"/> Arriving with others		
My Room Setup:					
Who will set up my room:			Favourite items to make my room feel like home:		
<input type="checkbox"/> In advance <input type="checkbox"/> On the day of the move					
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):					
<input type="checkbox"/> Mobility Aids <input type="checkbox"/> Communication/Cognition Aids <input type="checkbox"/> Hearing/Vision/Dental Aids <input type="checkbox"/> Other:					
Details:					
I May Need Help/Reminders for the Following Tasks:					
Hygiene/Personal Care:		<input type="checkbox"/> Independent	<input type="checkbox"/> Set Up Only	<input type="checkbox"/> Some Assistance	<input type="checkbox"/> Full Assistance
Details:					
Elimination Care:		<input type="checkbox"/> Independent	<input type="checkbox"/> Reminder/Routine	<input type="checkbox"/> Incontinent	
Details:					
Ambulation/Transfers:		<input type="checkbox"/> Independent	<input type="checkbox"/> Supervision	<input type="checkbox"/> Full Assistance	
Details:					
Nutrition/Eating:		<input type="checkbox"/> Independent	<input type="checkbox"/> Set Up Only	<input type="checkbox"/> Full Assistance	
Details:					
Medication Administration:		<input type="checkbox"/> Whole	<input type="checkbox"/> Crushed		
Details & Recent Changes:					
Section 2 completed by:					

3. Current Risks (check all that apply):				
<input type="checkbox"/> Delirium <input type="checkbox"/> Falls <input type="checkbox"/> Exploring/Searching/Leaving <input type="checkbox"/> Suicide Ideation <input type="checkbox"/> Fire (e.g. smoking, cooking) <input type="checkbox"/> Security (e.g. finances, housing, food) <input type="checkbox"/> Other:				
Details:				
Responsive Behaviours/Personal Expressions (Check all that apply and describe the behaviour(s)/expression(s) and context in which they occur [e.g., during personal care]. Identify contributing factors and personalized approaches/strategies to prevent and/or respond).				
<input type="checkbox"/> Vocal Expression(s):				
<input type="checkbox"/> Motor Expressions(s):				
<input type="checkbox"/> Sexual Expression(s) of Risk:				
<input type="checkbox"/> Verbal Expressions(s) of Risk:				
<input type="checkbox"/> Physical Expressions(s) of Risk:				
Contributing Factors to My Behavioural Expression(s):				
Personalized Approaches/Strategies to Support Me:				
Section 3 completed by:				
4. My Family Connections and Social Supports (i.e., how will family/friends connect with me following my move?)				
<input type="checkbox"/> In-Person Visit(s):				
<input type="checkbox"/> Virtual Visit(s)/Phone Call(s):				
<input type="checkbox"/> Other(s):				
The Following Services will Support Me after My Move:				
The Following Reports are Available to Assist in Getting to Know Me Better:				
<input type="checkbox"/> Vaccination List <input type="checkbox"/> Medication List <input type="checkbox"/> Behavioural Assessment <input type="checkbox"/> Mental Health Assessment <input type="checkbox"/> Personhood Tool <input type="checkbox"/> Isolation Care Plan <input type="checkbox"/> Other:				
Section 4 completed by:				
5. The Following Healthcare Providers/Individuals Have Contributed to this Transitional Care Plan:				
Name & Designation	Organization:	Phone Number:	Date: (dd/mm/yyyy)	Signature:

This transitional care plan was developed based on the individual's presentation in their environment at the time of transition. This plan may require adaptation in the new environment as different behaviours may present themselves throughout the transition period.

Source: Reprinted with permission from: Behavioural Supports Ontario (BSO). My Transitional Care Plan® [Internet]. [place unknown]: BSO; [date unknown]. Available from: <https://brainxchange.ca/Public/Special-Pages/BSO/Clinical-Tools-and-Resources/My-Transitional-Care-Plan/My-Transitional-Care-Plan%C2%A9-Tool-Download-Permis>.

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

<p>Preparation</p> <p>Prior to beginning the interview, gather any of the patient's medication information that may be readily available.</p> <p>Introduction</p> <p>Introduce self and profession.</p> <ul style="list-style-type: none"> • 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? <p>Information Gathering</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> - 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? 	<p>Medication Allergies</p> <ul style="list-style-type: none"> • Are you allergic to any medications? • If yes, what happens when you take (allergy medication name)? <p>Community Pharmacy</p> <ul style="list-style-type: none"> • 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? <p>Prescription Medicines</p> <ul style="list-style-type: none"> • These include anything you can only obtain with a doctor's order such as heart pills, inhalers, sleeping pills. <p>Antibiotics</p> <ul style="list-style-type: none"> • Have you used any antibiotics in the past 3 months? If so, what are they? <p>Inhalers/Patches/Creams/Ointments/Injectables/Samples</p> <ul style="list-style-type: none"> • Do you use: <ul style="list-style-type: none"> - Inhalers? - Medicated patches? - Medicated creams or ointments? - Injectable medications (e.g. insulin)? • For each, if yes, <ul style="list-style-type: none"> - 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? 	<p>Eye/Ear/Nose Drops</p> <ul style="list-style-type: none"> • Do you use any eye drops? If yes, <ul style="list-style-type: none"> - What are the names? - How many drops do you use? How often? - In which eye? • Do you use ear drops? If yes, <ul style="list-style-type: none"> - What are the names? - How many drops do you use? How often? - In which ear? • Do you use nose drops/nose sprays? If yes, <ul style="list-style-type: none"> - What are the names? - How do you use them? - How often? <p>Over the Counter (OTC) Medications</p> <ul style="list-style-type: none"> • Do you take any medications that you buy without a doctor's prescription? Give examples, (i.e., Aspirin). If yes, <ul style="list-style-type: none"> - How do you take (OTC medication name)? <p>Vitamins/Minerals/Supplements</p> <ul style="list-style-type: none"> • Do you take any: <ul style="list-style-type: none"> - 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? <p>Tips on Concluding the Interview</p> <ul style="list-style-type: none"> • 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>

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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


Figure 8
FRONT SIDE



MEDICATION RECONCILIATION FORM



Institute for Safe Medication Practices Canada
Institut pour l'évaluation sécuritaire des



Health Quality Ontario
Qualité des services de santé Ontario

This is a schematic representation of potential elements of a MedRec form for use in paper or electronic charts.

BEST POSSIBLE MEDICATION HISTORY

Sources of Information Use to Complete History: (please check all that apply)

- Patient interview
- Caregiver interview
- Medication vials / boxes
- Blister packs
- Patient's own list
- Community pharmacy profile
- MedsCheck
- Ontario Drug Benefits Drug Profile Viewer
- Specialist letter
- Hospital Discharge Summary
- Best Possible Medication Discharge Plan
- Rapid Response Nurse BPMH
- Ontario Telemedicine Network BPMH
- Other: _____

PATIENT'S NAME: _____

COMMUNITY PHARMACY NAME: _____
Phone Number: _____

Medication Management:

Self-administration
 Caregiver administration

Compliance packs:

No
 Yes If yes, Pharmacy filled blister pack Personal dosette

Medication Allergies:
Reaction: _____

Date: _____

Medication Name	Dose	Route	Frequency	Indication	Start Date	Prescriber	Comments

► **BPMH completed by:** _____

RECONCILIATION PLAN

Discrepancies Identified	Suggested Resolution Plan	Reconciliation Decision

► **Reconciliation completed by:** _____

APPENDICES

Determine practice documentation guidelines (e.g., brand names v. generic names, combination products etc.)

Include additional information that would provide value in establishing the patient's medication regimen

Are there differences between the BPMH compared to what is documented in the patient's chart?

Recommendations by the nurse or pharmacist to PCP on possible options for resolution of the discrepancy

Appendix K: 5 Questions to Ask About Your Medications (for Adults)

5 Questions to Ask about Your Medications is a guide to help persons and their support network start conversations with health providers about their medications (168). Ensuring persons are active partners in their care, and ensuring they receive important information about their medications helps promote medication safety. It may be particularly helpful for persons to ask the following five questions about their medications when attending appointments with their primary care providers, communicating with their community pharmacist, and when preparing for a transition from hospital to home. The 5 Questions to Ask About Your Medications resource is available in [30 languages](#).

Figure 8: 5 Questions to Ask about Your Medications

APPENDICES

5 QUESTIONS TO ASK ABOUT YOUR MEDICATIONS
when you see your doctor, nurse, or pharmacist.

- 1. CHANGES?**
Have any medications been added, stopped or changed, and why?
- 2. CONTINUE?**
What medications do I need to keep taking, and why?
- 3. PROPER USE?**
How do I take my medications, and for how long?
- 4. MONITOR?**
How will I know if my medication is working, and what side effects do I watch for?
- 5. FOLLOW-UP?**
Do I need any tests and when do I book my next visit?

Keep your medication record up to date.

Remember to include:

- ✓ drug allergies
- ✓ vitamins and minerals
- ✓ herbal/natural products
- ✓ all medications including non-prescription products

Ask your doctor, nurse or pharmacist to review all your medications to see if any can be stopped or reduced.

Visit safemedicationuse.ca for more information.

Logos: ismp (Institute for Safe Medication Practices Canada), cpsp*icsp (Canadian Patient Safety Institute), Canadian Society of Hospital Pharmacists, Société canadienne des pharmaciens d'hôpitaux, CANADIAN PHARMACEUTICAL ASSOCIATION, ASSOCIATION DES PHARMACIENS DU CANADA, SafeMedicationUse.ca, and the Health Services and Support for Patients and Families logo.

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Source: Reprinted with permission from: Institute for Safe Medication Practices (ISMP) Canada, The Canadian Patient Safety Institute (CPSI), Patients for Patient Safety Canada (PFPS), et al. 5 questions to ask about your medications [Internet]. Toronto (ON): ISMP Canada; 2016. Co-published with CPSI and CFPSC. Available from: https://www.ismp-canada.org/download/MedRec/MedSafety_5_questions_to_ask_poster.pdf.

Appendix L: 5 Questions to Ask About My Medicine (for Kids)

5 Questions to Ask about My Medicine is a medication safety resource to help children and youth understand what questions they should ask when receiving medications from health providers (168). This resource was co-designed with children and their support networks and health providers to facilitate conversations about medications. The 5 Questions to Ask About My Medicine resource is also available in [French](#).

Figure 9: 5 Questions to Ask about my Medicine

5 Questions to Ask About My Medicine

- Why do I need this medicine?
- When do I take it?
- How long do I take it?
- How could it make me feel?
- When do I see my health team again?

Keep a list of all your medicines.

Never share your medicine!

Keep your medicine in a safe place.

Write or draw your questions here: _____

Download this app to keep track of your medicine. **MyMedRec**

Logos: **ismp** (Institute for Safe Medication Practices Canada), **SafeMedicationUse.ca**, **cpsi-icsp** (Canadian Patient Safety Institute / Canadian Patient Safety Institute), **PPFSC** (Patients for Patient Safety Canada).

Vertical text on the right: Made by kids, for kids! © 2021 ISMP Canada

Source: Reprinted with permission from: Institute for Safe Medication Practices (ISMP) Canada, The Canadian Patient Safety Institute (CPSI), Patients for Patient Safety Canada (PPFSC). 5 questions to ask about my medicine (for kids) [Internet]. Toronto (ON): ISMP Canada; 2021. Co-published with CPSI and PFPSC. Available from: https://safemedicationuse.ca/tools_resources/downloads/5QuestionsKids-EN.pdf.

Appendix M: Description of the *Leading Change Toolkit*

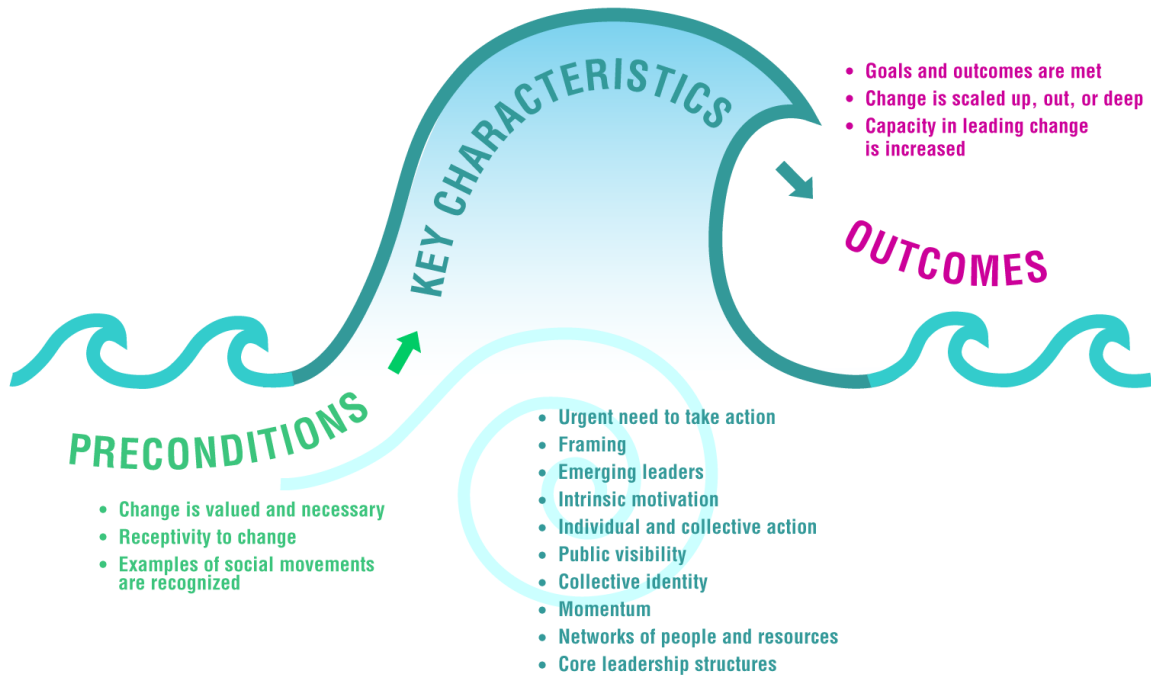
BPGs can only be successfully implemented and sustained if planning, resources, organizational and administrative supports are adequate, and if there is appropriate facilitation. Active engagement and involvement of formal and informal leaders (e.g., change agents and peer champions) are also essential. To encourage successful implementation and sustainability, an international expert panel of nurses, researchers, patient/person advocates, social movement activists and administrators has developed the *Leading Change Toolkit* (4). The toolkit is based on available evidence, theoretical perspectives and consensus. We recommend the *Leading Change Toolkit* for guiding the implementation of any BPG in health or social service organizations, including academic centres.

The *Leading Change Toolkit* includes two frameworks—the Social Movement Action (SMA) Framework (1,2) and the Knowledge-to-Action (KTA) Framework (3)—for change agents and change teams leading the implementation and sustainability of BPGs. Both frameworks outline the concept of implementation and its interrelated components. As such, either framework—the SMA or the KTA—can be used to guide change initiatives, including the implementation of BPGs. Using both frameworks serves to enhance and accelerate change (1).

The SMA Framework includes elements of social movements for knowledge uptake and sustainability that have demonstrated powerful impact and long-term effects. Based upon the results of a concept analysis, the framework includes 16 elements categorized as preconditions (i.e., what must be in place prior to the occurrence of the social movement), key characteristics (i.e., what must be present for the social movement to occur) and outcomes (i.e., what will likely happen as a result of the social movement) (1,169). The three categories and elements of the SMA Framework are shown in **Figure 10**.

Figure 10: Social Movement Action Framework

SOCIAL MOVEMENT ACTION FRAMEWORK FOR KNOWLEDGE UPTAKE AND SUSTAINABILITY



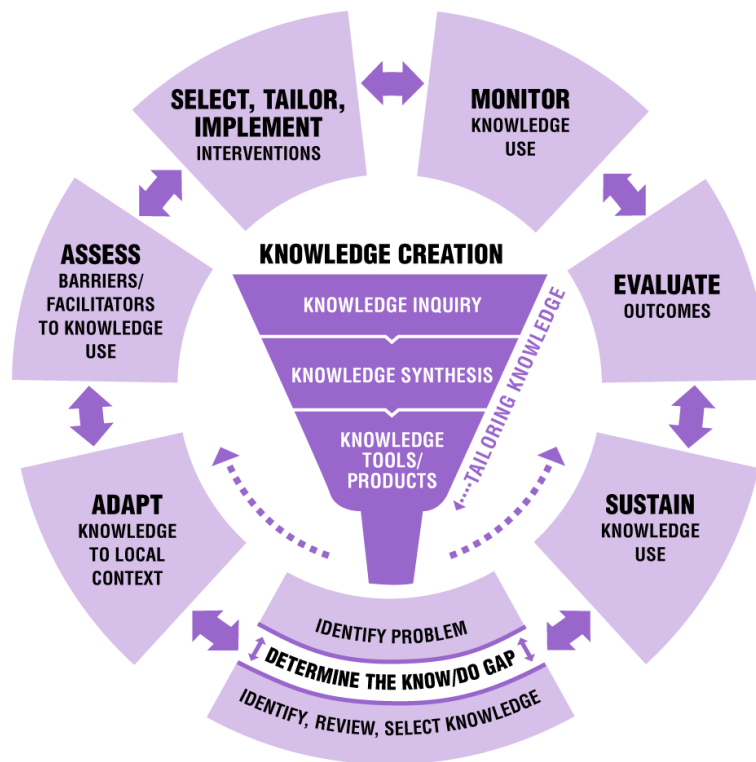
Source: Reprinted with permission from: Grinspun D, Wallace K, Li SA, McNeill S, Squires JE, et al. Exploring social movement concepts and actions in a knowledge uptake and sustainability context: a concept analysis. *Int J Nurs Sci.* 2022 Oct;9(4):411-21.

Grinspun D, Wallace K, Li SA, McNeill S, Squires J. Leading change through social movement. *Registered Nurse Journal.* 2020.

The KTA Framework is a planned cyclical approach to change that integrates two related components: the knowledge creation process and the action cycle. The knowledge creation process is what researchers and guideline developers use to identify critical evidence results to create a knowledge product, like an RNAO BPG. The action cycle is comprised of seven phases in which the knowledge created is implemented, evaluated and sustained (3). Many of the action cycle phases may occur or need to be considered simultaneously. The KTA Framework is depicted in **Figure 11** (4).

Figure 11: Knowledge-to-Action Framework

KNOWLEDGE-TO-ACTION FRAMEWORK



Source: Adapted with permission from: Graham ID, Logan J, Harrison MB, et al. Lost in translation: time for a map? J Contin Educ Health Prof [Internet]. 2006;26(1):13-24. Available from: https://journals.lww.com/jcehp/Abstract/2006/26010/Lost_in_knowledge_translation_Time_for_a_map_.3.aspx

Implementing and sustaining BPGs to effect successful practice changes and positive health outcomes for patients/ persons and their families, providers, organizations and systems is a complex undertaking. The *Leading Change Toolkit* is a foundational implementation resource for leading this process. It can be downloaded at [RNAO.ca/leading-change-toolkit](https://rnao.ca/leading-change-toolkit).

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East Community Health and Wellness Collaborative

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The following individuals provided verbal feedback on the BPG draft through discussion groups or individual consultations.

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Representatives from Mnaamodzawin Health Services

Little Current, ON

Representatives from the following BPSO OHTs:

Archipel OHT, Chatham-Kent OHT, East Toronto Health Partners OHT, Maamwesying OHT, Nipissing Wellness OHT, North Western Toronto OHT, Sarnia Lambton OHT and Southlake Community OHT.

Finally, Ontario Health, Health Standards Organization, and Healthcare Excellence Canada were provided the opportunity to review the draft recommendation statements and indicators and provided feedback.

Letters of Support and Endorsement



People powered health™

Wednesday, September 20, 2023

Dr. Doris Grinspun, RN, BScN, MSN, PhD, LLD (hon), Dr (hc), DHC, FAAN, FCAN, O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)

Dear Dr. Grinspun:

Health Standards Organization (HSO) is delighted to endorse the Registered Nurses' Association of Ontario's (RNAO) best practice guideline *Transitions in Care and Services, Second Edition*. HSO supports RNAO in disseminating this important work. The guideline supports safe and effective transitions in care for pediatric and adult persons and their support network.

Our focus at HSO is on developing standards, assessment programs and other tools to help care providers save and improve lives. HSO is focused on the people that power health systems around the world: patients, providers, and policy-makers. We believe that our people-centred approach to the design of products, standards and assessments makes a real difference in improving quality and health outcomes.

We thank RNAO for this important work that will make a difference to nurses and other health care interprofessional teams. This evidence-based resource will help to meet the needs of patients, providers, and policy-makers.

Congratulations on this important contribution!

Regards,

A handwritten signature in black ink, appearing to read 'Phillip', is written over a light grey rectangular background.

Executive Director, Global Programs

A handwritten signature in blue ink, appearing to read 'Nelea Lungu', is written over a light grey rectangular background.

Nelea Lungu
Interim Executive Director, Canadian Accreditation

Health Standards Organization
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May 9, 2023

Dr. Doris Grinspun, RN, BScN, MSN, PhD, LLD(hon), Dr(hc), DHC, FAAN, FCAN, O.ONT.
 Chief Executive Officer
 Registered Nurses' Association of Ontario (RNAO)
 4211 Yonge Street, Toronto, Ontario, M2P 2A9

Dear Dr. Grinspun:

Healthcare Excellence Canada is pleased to offer our support for RNAO's second edition best practice guideline *Transitions in Care and Services*.

Healthcare Excellence Canada works with partners to spread innovations, build capability and catalyze policy changes so that everyone in Canada has safe and high-quality healthcare. Supporting safe, quality transitions in care is a key priority for Healthcare Excellence Canada. We're committed to fostering inclusive and equitable care through meaningful partnerships with different groups, including patients and caregivers, First Nations, Inuit and Métis, healthcare providers and more.

Many of our programs are focused on ensuring safe transitions in care in an equitable way. These include but are not limited to: [Bridge-to-Home](#), [Presence of Safety](#), [Essential Together](#), [Engagement-Capable Environments](#) and [TeamSTEPPS Canada](#).

Thank you for the opportunity to review and incorporate our feedback to strengthen transitions with and for people. Healthcare Excellence Canada commends RNAO on the development of this evidence-based guideline that will support the delivery of coordinated and person-centred transitions in care. The implementation of this guideline will also help to remove barriers to system navigation and promote equitable access to services. We congratulate RNAO on their leadership and commitment to promoting safe and high-quality transitions.

Sincerely,

Kim Kinder
 Director, Health Innovation Programs



May 19, 2023

Dr. Doris Grinspun,
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
4211 Yonge Street, Toronto, Ontario, M2P 2A9

Re: Support for and endorsement of RNAO's second edition best practice guideline *Transitions in Care and Services*.

Dear Dr. Grinspun,

The Association of Family Health Teams of Ontario (AFHTO) is pleased to offer our support for and endorsement of RNAO's second edition best practice guideline *Transitions in Care and Services*.

AFHTO works hard to support the implementation and growth of interprofessional primary care teams by promoting best practices, sharing lessons learned, and advocating on behalf of teams across Ontario. Evidence and experience show that team-based comprehensive primary care results in better outcomes for patients and providers. High-quality primary care also delivers better value to health systems.

When it comes to providing care that is timely, accessible, and comprehensive, it takes a team. Team-based primary care involves family doctors, nurse practitioners, nurses, social workers, pharmacists, dietitians, and other professionals, all working collaboratively to support patients and their well-being. With the support of team-based primary care, Ontarians have one door to a team of health care providers who know them, their family, and their history, to support their everyday health and social needs. Team-based primary care leads to:

- Timely access to care
- Better coordination of care
- Fewer hospital visits
- Savings for the health system

The *Transitions in Care and Services* guideline recognizes the essential role primary care plays in supporting people as they transition through the health care system.

AFHTO commends RNAO and the expert panel on their leadership in developing this important guideline.

Sincerely,

A handwritten signature in black ink that reads 'Bryn Hamilton'.

Bryn Hamilton
Chief Executive Officer (Interim), AFHTO





July 25, 2023

Dr. Doris Grinspun, RN, BScN, MSN, PhD, LLD(hon), Dr(hc), DHC, FAAN, FCAN, O.ONT.
 Chief Executive Officer
 Registered Nurses' Association of Ontario (RNAO)
 4211 Yonge Street, Toronto, Ontario, M2P 2A9

Dear Dr. Grinspun:

Chatham-Kent Best Practice Spotlight Organization Ontario Health Team (BPSO OHT) is pleased to offer our support and endorsement of RNAO's *Transitions in Care and Services, Second Edition* best practice guideline. This guideline provides evidence-based recommendations for nurses and members of the interprofessional team, organizations, and the health system. More specifically the recommendations support safe and effective transitions in care for pediatric and adult persons and their support network.

Our goal at Chatham – Kent BPSO OHT is to bring together health care partners from all sectors, including hospital, home and community care, primary care, long-term care, and community support agencies to provide seamless, fully coordinated care for patients, while creating a more efficient system. Our vision to achieve the best health and well-being together drives our efforts. RNAO's *Transitions in Care and Services* BPG will enable us to provide collaborative, evidence-based, and person-centred care as we support persons during transitions in care.

Congratulations on this important contribution to the health care system. We are certain that this BPG will support persons and their support network during transitions in care.

Sincerely,

The Chatham-Kent Ontario Health Team Collaborative Steering Committee
 (inclusive of 15 signatory partners)



June 2, 2023

Dr. Doris Grinspun, RN, BScN, MSN, PhD, LLD(hon), Dr(hc), DHC, FAAN, FCAN, O.ONT.
Chief Executive Officer
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4211 Yonge Street, Toronto, Ontario, M2P 2A9

Dear Dr. Grinspun,

The Ontario Caregiver Organization is delighted to endorse RNAO's second edition best practice guideline *Transitions in Care and Services*.

The Ontario Caregiver Organization exists to support Ontario's 4 million caregivers; ordinary people who provide physical and emotional support to a family member, partner, friend or neighbour. This guideline recognizes the essential role that caregivers play in supporting persons during care transitions and the need to ensure their information and support needs are adequately met during transitions in care. Collaboration with persons receiving care, caregivers, and other members of a person's support network is critical during any transition in care.

We commend RNAO for the publication of this guideline and their leadership and commitment to improving the safety and quality of transitions in care.

Sincerely,

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