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Best Practice Guideline

SEPTEMBER 2025

People-Centred Care

Third edition

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

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Funding

This work is funded by the Government of Ontario. All work produced by RNAO is editorially independent from its funding source.

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 orientation meeting, the recommendation build meetings 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 "Declarations of Conflicts of Interest Summary" under the "methodology documents" tab on the BPG webpage.

Land acknowledgement

We recognize that RNAO's 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 making a land acknowledgement we are taking part in an act of reconciliation, honouring the land and Indigenous heritage which dates back more than 10,000 years. We encourage readers to learn about the land where you reside 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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People-Centred Care

Third edition

Greetings from Dr. Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario

The Registered Nurses' Association of Ontario (RNAO) is delighted to present the third edition of the foundational best practice guideline (BPG) *People-Centred Care*. Evidence-based practice supports the excellence in service that health providers are committed to delivering every day.

We offer our heartfelt thanks to the many partners who made this BPG a reality. First, and most important, we thank the Government of Ontario that recognized, in 1999 RNAO's capacity to lead a program that has gained worldwide recognition and is committed to funding it. Our deepest gratitude to the co-chairs of the RNAO expert panel for their invaluable expertise and stewardship of this BPG:

- Michael Creek, Person with Lived Experience Representative and Director of Strategic Initiatives, Working for Change Organization (May 2023 – Present)
- Dr. Kateryna Metersky, RN,PhD, Assistant Professor, Daphne Cockwell School of Nursing, Toronto Metropolitan University
- Heather Thiessen, Patient Partner, Health Standards Organization (November 2021 to April 2023)

Special thanks to the expert panel for generously providing their time, knowledge and perspective to deliver a rigorous and robust evidence-based resource that will guide the education and practice of millions of health providers. We couldn't have done it without you!

We also recognize RN Giulia Zucal (senior manager, guideline development and research), RN Deborah Flores (guideline development methodologist co-lead), RN Gladys Hui (guideline development methodologist co-lead), Verity Scott (guideline development project coordinator), RN 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. The nursing and health communities, with their unwavering commitment and passion for excellence in patient care, provide the expertise and countless hours of voluntary work essential to developing new and next edition BPGs. Employers have responded enthusiastically by becoming Best Practice Spotlight Organizations® (BPSO®), 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 150,000 nurses, other health professionals and people with lived experience – all eager to advance people-centred evidence-based care. BPSOs are also diligently monitoring and evaluating the impact of BPG implementation and sustainability on individuals, organizations, and health systems.

We invite you to share this BPG with nursing and all other team members, client navigators and advisors in the wider health systems and communities in which you work. We have so much to learn from each other. Together, we must ensure that the public has access to, and receives, the best possible health and social services, always.

Dr. Doris Grinspun, RN, BScN, MSN, PhD, LLD (hon), Dr (hc), DHC, 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], other members of the **interprofessional team**[G], educators, **health and social service organizations**[G], academic institutions, **people**[G] receiving care and their **chosen families**[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 all people across the lifespan, **caregivers**[G], families or communities. The document provides evidence-based **recommendations**[G] and **good practice statements**[G] and descriptions of: a) practice, education and organizational policy b) benefits and harms c) values and preferences and d) health equity considerations.

Nurses and other members of 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. Clinicians in direct care will benefit from reviewing the recommendations and supporting evidence to guide their practice and that of others.

If your organization or integrated system of care is adopting this BPG, the Registered Nurses' Association of Ontario (RNAO) recommends establishing change teams whose responsibilities include at least the following:

1. Conduct a gap/opportunity analysis: assess your existing policies, procedures, protocols and educational programs in relation to the good practice statements, recommendations, and supporting discussions of evidence in this BPG and identify any strengths, needs or gaps.
2. Note the recommendations and good practice statements applicable to your setting that can be used to address existing priorities, needs or gaps within your organization(s).
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 (3,4).

Implementation science[G] resources, including the Leading Change Toolkit, are available online (5). A description of the Leading Change Toolkit can be found in **Appendix N**. For more information, see **Implementation strategies** on page 89.

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. Additional supplementary materials such as **evidence profiles**[G] and search strategies related to each recommendation can be found under the "methodology documents" tab on the BPG webpage.

RNAO has also curated a collection of publications that demonstrate the real-world impact of RNAO's BPGs. These publications are available for download, free of charge, from Open library | RNAO.ca.

We are interested in hearing your feedback on this BPG and how you have implemented it. Please share your experiences with us at RNAO.ca/contact.

The over two-decade journey of RNAO BPGs is documented in the following resource: Grinspun D, Bajnok I, editors. Transforming nursing through knowledge: best practices for guideline development, implementation science, and evaluation. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2018. Freely available at: RNAO.ca/bpg/transforming-nursing-through-knowledge.

A note on terminology and language

The terminology used to describe care that is people-centred can vary significantly across health disciplines, sectors, and organizations. Differences in language can lead to confusion or misinterpretation of the core principles of **people-centred care**[G] (6). While the key tenets of people-centred care are consistent (e.g., respect for dignity and autonomy, integration of perspectives of illness and wellness into health and social services, and engagement in the process of care), there is inconsistency as to what people-centred care is defined as (7), and a unified construct is lacking. For example, Najafizada et al. (2023) identified 15 different definitions that organizations use to refer to care that is people-centred, more than 12 substitutes for the term 'people-centred' (i.e., "person", "client", "family", and "community" for "patient", and "engagement", "involvement", "feedback" and "experience" for "centredness"), and 19 "patient-centered" interventions implemented to varying degrees. This heterogeneity in definitions, terminology and interventions to implement people-centred care makes it challenging to operationalize and assess people-centred approaches (7,8), and has the potential to misconstrue the foundational principles of people-centred care, which could lead to potential gaps in service delivery. **Table 1** outlines some definitions that are adopted by various organizations.

Table 1: Terms referring to people-centred care and their definitions

VARIOUS TERMS REFERRING TO PEOPLE-CENTRED CARE AND THEIR DEFINITIONS	
Patient-centred care	Care that is respectful of and responsive to individual patient preferences, needs, and values (9). Patient-centered care is perceived to be in alignment with the biomedical model. It's goal is to live a functional life (10).
Person-centred care	Care approaches and practices that see the person as a whole with many levels of needs and goals, with these needs arising from their own personal social determinants of health (11). The goal of person-centred care is to support individuals in leading meaningful lives. The term was developed to put less focus on the sick role and more focus on the unique individual living with an illness or impairment (10).

VARIOUS TERMS REFERRING TO PEOPLE-CENTRED CARE AND THEIR DEFINITIONS	
People-centred care	"An approach to care that consciously adopts the perspectives of individuals, families and communities with the view that they are participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways" (12). People-centred care focuses on the health needs and expectations of not just the person seeking care, but also their family, community and society (11). Within this model, everyone involved in the care of the person (e.g., person, doctor, nurses, family, social worker, spiritual care practitioners, etc.) contributes to the delivery of care and services (13).
Patient-as-partner approach	In this approach, the patient is considered as part of the health-care team; they bring their own life experience and expertise like all other health providers (14). A patient-as-partner approach emphasizes essential principles such as partnerships and collaboration (14).
People and family engagement	Intentional, quality engagement is required to achieve quality people-centred care. Engagement means involving people in the decision-making process, where they are active participants in the full range of activities (e.g., planning, evaluation, research, training, recruitment). When engaging and collaborating with people, their unique expertise is valued and supported (15). Engagement can be on a continuum, from consultation and involvement to partnership and shared leadership (16).

Discussion

The term "patient-centred" is open to different connotations. Notably, "patient" can be considered a paternalistic term for people with illnesses, as it implies they are passive recipients of the care they receive (7). Within the Canadian context and in particular from the lens of Indigenous People, the use of the term "patient" is often negatively associated with ethnocentric perspectives and colonial viewpoints, where a power imbalance with the health and social service providers and the health and social service organizations results in experiences of stigma, racism and institutional discrimination (17,18). Similarly, the term "client-centred care" can be problematic because "client" is seen as a transactional business relationship between a purchaser and a seller and therefore implies that health-care services are commodities and health care is a business industry (7). Alternatively, "person" is perceived as a neutral term that can perhaps "offset the historical discourse on the patient-centredness of health care" (7) and offer a new way to view the person-provider relationship. A recognition that these three terms focus on the individual rather than the individual's wider community led to the introduction of alternative terms such as "family-centred", "community-centred", and "people-centred" (7).

The respectful inclusion of families and communities, in addition to the person seeking care, has led to a move away from the term "person-centred care" to the more inclusive term "people-centred care". People-centred care focuses on the health needs and expectations of the person seeking care, their family, community and society (11). It is about treating people with dignity and respect, and including them in decision-making processes pertaining to their health and care (11). Within this model, effective partnerships are essential between people who need care and those that provide it (19). Everyone involved in the care of the person (e.g., person, family, doctor, nurses, social worker, spiritual care practitioner, occupational therapist, physiotherapist, etc.) contributes to the delivery of care and services (13).

Terminology will always continue to evolve with time. It is important to note that the underlying concepts of people-centred care remain integral in all health- and social-care interactions, regardless of the terminology used.

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, other members of the interprofessional team in direct care positions, educators, administrators and executives, policy-makers, and researchers in health and social service organizations and academic institutions. **People with lived experience**[G] are encouraged to become familiar with the BPG to support their involvement in evidence-based decision-making related to their care. 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. RNAO aims to meet international reporting standards for clinical practice guidelines, including the standards outlined in the Appraisal of Guidelines for Research and Evaluation (AGREE II) Instrument and the Reporting Items for Practice Guidelines in HealThcare (RIGHT) statement (20,21).

This BPG replaces the RNAO BPG *Person- and Family-Centred Care* (2015) (22), and includes the combination of two other BPGs, *Establishing Therapeutic Relationships* (2006) (23) and *Strengthening and Supporting Families through Expected and Unexpected Life Events* (2006) (24). These BPGs were merged because of the overlapping clinical concepts. Additionally, RNAO's **Best Practice Spotlight Organizations® (BPSO®)**[G] provided feedback that merging the three would streamline the implementation and evaluation of the BPGs.

The terms "people" and "people-centred care" are used throughout the BPG and replace the terms "person", "patient" and "person-centred care". For the purposes of this BPG, "people" is inclusive of individuals, caregivers, families and communities. In this BPG "person" is used only when it is makes sense to indicate the singular of "people", but note that in this context "person" includes consideration of their chosen family, caregivers and communities.

The purpose of this guideline is to promote the evidence-based cultural and equitable practices associated with people-centred care, and to help **health and social service providers**[G] acquire the knowledge, skills and judgment necessary to become more adept with people-centred care. The recommendations and good practice statements will assist health and social service providers to learn about and from people accessing health and social services, develop an authentic relationship with people, and co-design a **plan of care**[G]. The recommendations will also better align with and support the evolving health and social care landscape to embed the philosophy of people-centred care.

The BPG aims to optimize health over the life continuum and to improve the experience and outcomes of all involved within the health system based on the **quintiple aim**[G] (25,26) and United Nation's **Sustainable Development Goals**[G] (27). The quintiple aim outlines five goals for health care: improving population health, enhancing the experience of people receiving care, reducing costs, supporting the well-being of health and social service providers, and advancing health equity (25,26). The United Nation's Sustainable Development Goals outline 17 global objectives to end poverty, protect the plant, and ensure prosperity for all by the year 2030 (25).

From December 2022 to April 2023, RNAO convened an expert panel to determine the purpose and scope of the third edition of this BPG and to develop **recommendation questions**[G] to inform the **systematic reviews**[G]. The interprofessional RNAO expert panel included people with lived experience and individuals with knowledge and experience in all domains of practice – administration, clinical care, education, research and policy – across a range of health and social service organizations and academic institutions. They shared their insights on supporting and caring for people (including caregivers, families and communities) across the lifespan and across the continuum of care including (but not limited to) primary care, home and community care, acute care, rehabilitation, complex continuing care and long-term care (LTC).

The RNAO best practice guideline development and research team and the RNAO expert panel completed a comprehensive review and analysis to determine the scope and priority recommendation questions for this BPG (for more information refer to supplementary materials under the "methodology documents" tab on the BPG webpage).

Scope

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

- reviewed the previous RNAO BPGs *Person- and Family-Centred Care* (2015) (22), *Establishing Therapeutic Relationships* (2006) (23), and *Strengthening and Supporting Families through Expected and Unexpected Life Events* (2006) (24);
- conducted an environmental scan of existing guidelines and standards on this topic;
- undertook a review of the literature to determine available evidence on interventions related to people-centred care;
- led 37 key informant interviews with health and social service providers, researchers, patient advocates, and people with lived experience in relation to people-centred care;
- held five discussion groups with a total of 29 people, including health and social service providers, researchers, patient advocates, and people with lived experience; and
- consulted with the expert panel.

This BPG provides evidence-based recommendations for:

- nurses and other members of the interprofessional team in all domains of practice (including clinical care, administration, education, policy and research)
- all health sectors and settings, across health systems (e.g., public health, primary care, home and community care, acute care, LTC, palliative care) and social service settings
- all people across the lifespan, caregivers, families and communities

Consideration has been given to **equity-deserving populations**[G] through an **intersectionality**[G] lens, incorporating Truth and Reconciliation (28) and respect for individual and social determinants of health.

Key concepts in this guideline

People: Replaces the terms "person", "patient," "client", "resident", "user", "consumer" used across health and social service organizations. The term is inclusive of caregivers, essential care partners, families and communities. It refers to individual(s) with whom a health and/or social service provider has established a therapeutic relationship for the purpose of partnering for health.

Caregiver: An individual that provides physical, psychological and emotional support, as deemed important by the person receiving care. This care can include support in decision making, support with activities in daily living, care coordination and continuity of care. Caregivers can include chosen family members, close friends or other individuals and are identified by people or their substitute decision-maker (29). The terms "essential care partner" (29) or "care partner" are also commonly used in practice.

Chosen Family: "A term used to refer to individuals who are related (biologically, emotionally, or legally) to and/or have close bonds (friendships, commitments, shared households and child rearing responsibilities, and romantic attachments) with the person accessing health and social services. A person's chosen family includes all those whom the person identifies as significant in his or her life (e.g., parents, caregivers, friends, substitute decision-makers, groups, communities, and populations). The person receiving care determines the importance and level of involvement of any of these individuals in their care based on [their] capacity" (22, 75).

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

> **Regulated health and social service provider:** 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 (30). The Social Work and Social Service Work Act 1998 provides a framework for regulating social workers and social service workers (31).
>
> **Unregulated health and social service provider:** Unregulated health and social service providers fulfill a variety of roles in areas 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 their roles and perform tasks 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 (32).

Interprofessional team: A team comprised of multiple health and social service providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health and social services to people within, between and across health-care settings (33). Team members bring their unique perspectives and cooperate, coordinate and collaborate toward a common goal through shared decision-making (34) with the person accessing health and social services. Key interprofessional team members may include: nurses, general practitioners, physicians, dietitians, pharmacists, social workers, occupational therapists, physiotherapists, spiritual care practitioners, and other allied health professionals. It is important to emphasize that people and their chosen family and/or caregivers are at the centre of the interprofessional team as active participants.

Shared Decision-Making[G]: A joint process where health and social service providers work together with people receiving health and social care to reach a decision (35). This involves choosing tests and treatments based on evidence and on the person's individual preferences, beliefs and values (35).

Therapeutic relationship[G]: A purposeful, goal-directed relationship, between the health and social service providers and people accessing the health system for care and treatment, that is grounded in an interpersonal process directed at advancing the best interest and outcome of the person (23,36).

Overview of methodology: Good practice statements and recommendations

Good practice statements and recommendations

This BPG includes both good practice statements and graded recommendations. 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 and evidence profiles, refer to supplementary materials under the "methodology documents" tab on the BPG webpage.

Good practice statements

Good practice statements are actionable statements that should be done in practice (37). These are believed to be so beneficial that summarizing the evidence would be a poor use of the expert panel's time and resources (37). Moreover, researchers may no longer be conducting studies on the topic, or the alternatives to the action may be unethical or studying them may go against human rights (37,38). Given the high level of certainty that the benefits derived from the good practice statements outweigh the harms, they are not based on a systematic review of the evidence and they 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) (39). While good practice statements may be supported by **indirect evidence**[G], there is a well-documented clear and explicit rationale connecting the indirect evidence to the statement (37). This does not diminish certainty in the evidence. As such, GPS should be interpreted as strong recommendations as there is an underlying assumption that there is high certainty in the benefits of implementing the action (37). 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.

Graded recommendations

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 (38). Recommendations are formulated as strong or conditional by considering the certainty in evidence, values and preferences of people who are impacted by the recommendation, and health equity (see **Interpretation of evidence and recommendation statements** on page 17). The expert panel formulates recommendations using **Evidence-to-Decision (EtD) frameworks**[G] through a process of informal consensus facilitated by the RNAO BPG team. Since the recommendations are explicitly linked to the body of evidence, agreement is generally reached (40). If agreement cannot be reached, formal voting methods are used to determine the action and strength of the recommendations (40,41).

Despite the fact that good practice statements and recommendations are developed differently, both provide comprehensive guidance on an action/intervention that should (or should not) be done (38). Therefore, both good practice statements and recommendations should follow the same process for implementation (see **Implementation strategies** on page 89).

Recommendation questions

Recommendation questions[G] are priority areas of practice identified by the expert panel that require a systematic review of 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 are brainstormed and prioritized by the expert panel for each recommendation question, and an individual systematic review is conducted for each question, in alignment with GRADE methods (42).

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

- **Recommendation question #1:** Should **decision aids**[G] used by health providers and people (to support shared decision-making [SDM] about treatment and care) be recommended or not?
- **Outcomes:**
  - people's participation in their care (involvement in decision making and options)
  - provider/people outcomes: provider satisfaction with care (or decision aid), people's knowledge (about benefits/harms) and people's selection of a treatment/screening option that reflected what was most important to them
  - provider care behaviours (establishing a therapeutic relationship respectful of people's preferences, culture etc.)
  - organizational or system outcomes (satisfaction with overall care, length of stay, re-admission rates, adoption and sustainability of decision aid use)
  - harms (people/caregiver burden, provider burden)
  - clinical outcomes
- **Recommendation question #2:** Should sensory-minimizing strategies that address noise and light (used to facilitate people-centred care) be recommended or not?
- **Outcomes:**
  - people, family or caregiver satisfaction with sensory-minimizing strategies
  - provider satisfaction
  - provider knowledge
  - physiological measures
  - satisfaction with overall care
  - length of stay
  - re-admission rates
  - adoption and sustainability (of sensory-minimizing strategies)
  - provider burden

Note: These priority recommendation questions are condensed versions of the more comprehensive PICO research questions developed by the RNAO expert panel to guide the systematic reviews. For more on the PICO research questions and the detailed process of how the RNAO expert panel determined the priority recommendation questions and outcomes, please refer to supplementary materials under the "methodology documents" tab on the BPG webpage.

The RNAO expert panel did not identify recommendation questions 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 individuals, caregivers, families or communities across the lifespan. Please refer to **Appendix C** 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 and merges the RNAO BPGs *Person- and Family-Centred Care* (2015) (22), *Establishing Therapeutic Relationships* (2006) (23), and *Strengthening and Supporting Families through Expected and Unexpected Life Events* (2006) (24).

A summary of how the recommendations in this BPG compare to those in the previous editions is available under the "methodology documents" tab on the BPG webpage.

RECOMMENDATIONS AND GOOD PRACTICE STATEMENTS	STRENGTH OF THE RECOMMENDATION
Therapeutic relationships	
Good practice statement 1.0: It is good practice for health and social service providers to establish and maintain a therapeutic relationship with people that is grounded in trauma-informed care and culturally safe practices, ensuring respect, trust and collaboration.	Not applicable*
Shared decision-making	
Good practice statement 2.0: It is good practice for health and social service providers to participate in shared decision-making with people as they make informed decisions about their treatment, care and services.	Not applicable*
Good practice statement 3.0: It is good practice for health and social service providers to regularly assess people for readiness for advance care planning and facilitate the process when ready.	Not applicable*
Recommendation 1.0: The expert panel recommends that people are provided with decision aids to enhance participation in making informed decisions related to health screening and health-care treatment options.	Strong
Plan of Care	
Good practice statement 4.0: It is good practice for health and social service providers to collaboratively develop a plan of care with people that reflects their values, beliefs, goals, needs, attitudes, and preferences.	Not applicable*

Health-care environments: Sensory-minimizing strategies	
Recommendation 2.0: The expert panel suggests that people are provided with eye masks and/or earplugs as a sensory-minimising strategy according to the needs and preferences of the person.	Conditional
Virtual care	
Good practice statement 5.0: Where virtual care can be offered as an alternative to in-person care, it is good practice for health and social service providers to determine appropriateness and modality based on people's care needs and preferences and to adjust as needs evolve.	Not applicable*

*Good practice statements are established, robust practices. They do not have a strength associated. For more information, refer to the **Overview of methodology: Good practice statements and recommendations**.

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 (43).

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 (43). There are five criteria for assessing the certainty of quantitative research per outcome and per study design: risk of bias, inconsistency, indirectness, imprecision and publication bias. After synthesizing the evidence for each prioritized outcome, the overall certainty of evidence is assessed. The overall certainty 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 2** for the definition of these categories).

Table 2: 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: Schünemann 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 Oct [cited 2018 Aug 31]. Table 5.1, Quality of evidence grades. Available from: https://gdt.gradepro.org/app/handbook/handbook.html#h.9rdbelsnu4iy

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 refer to supplementary materials under the "methodology documents" tab on the BPG webpage.

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 Schünemann 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)" (43). 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" (43). **Table 3** outlines the implications of strong and conditional recommendations.

When the overall certainty of the evidence is high or moderate, expert panel members can be confident in the effects of the intervention of interest and 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 people (44). 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 (44).

Table 3: Implications of strong and conditional recommendations

IMPLICATIONS OF STRONG AND CONDITIONAL RECOMMENDATIONS		
POPULATION	**STRONG RECOMMENDATION**	**CONDITIONAL RECOMMENDATION**
For health and social service providers	▪ The benefits of a recommended action outweigh the harms. Therefore, most people should receive the recommended course of action. ▪ There is little variability in values and preferences among people in this situation. ▪ There is a need to consider the person's circumstances, preferences and values.	▪ The benefits of a recommended course of action probably outweigh the harms. Therefore, the majority of people 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 people in this situation. ▪ There is a need to consider the person's circumstances, preferences and values more carefully than usual.
For people receiving care	▪ Most people would want the recommended course of action and only a small portion would not.	▪ The majority of people in this situation would want the suggested course of action, but many would not.
For policy-makers	▪ The recommendation can be adapted as policy in most situations.	▪ Policy-making will require substantial debate and involvement of many others impacted by the change. Policies are also more likely to vary between regions.
For researchers	▪ The recommendation is likely supported by high certainty evidence or other convincing judgments that make additional research unlikely to alter the recommendation.	▪ The recommendation is likely to be strengthened by additional research. An evaluation of the conditions and criteria that determined the conditional recommendation will help to identify possible research gaps.

Source: Adapted with permission from: Schünemann H, Brozek J, Guyatt G, Oxman A, editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013 Oct [cited 2020 May 11]. Table 6.1, Implications of strong and weak recommendations for different users of guidelines. Available from: https://gdt.gradepro.org/app/handbook/handbook.html#h.33qgws879zw

Note: The strength of each recommendation statement is detailed directly below 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 refer to supplementary materials under the "methodology documents" tab on the BPG webpage.

Discussion of evidence

The discussion of evidence that follows each recommendation includes the following main sections.

1. **Benefits and harms:** Identifies the potential desirable and undesirable outcomes reported in the literature when the recommended practice is used. Content in this section only includes research from the systematic review.
2. **Values and preferences:** Denotes the relative importance or worth placed on health outcomes derived from following a particular clinical action from a people-centred perspective. Content for this section may include research from the systematic reviews and, when applicable, observations and/or considerations from the RNAO expert panel.
3. **Health equity:** Identifies the potential impact that the recommended practice could have on health across different populations, 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 RNAO expert panel.
4. **Expert panel justification of recommendation:** Provides a rationale for why the expert panel made the decision to rate a recommendation as strong or conditional.
5. **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 review and/or from other sources (e.g., the RNAO expert panel).
6. **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 the supplementary materials under the "methodology documents" tab on the BPG webpage. 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 in this BPG, we ask you to consider how you will monitor and evaluate their impact.

The Donabedian model, which informs the development of indicators for evaluating quality health and social care, includes three categories: structure, process and outcome (45).

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

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

Outcome analyzes the effect of quality care on the health status of people and populations, health workforce, health and social service organizations or health systems (45).

For more details, see the **Monitor knowledge** use and **evaluate outcomes** sections in the Leading Change Toolkit (5).

The following indicators have been developed to support evaluation and quality improvements in health and social service organizations and academic institutions. Consider **Tables 4** and **5**, which provide a list of process and outcome indicators along with their operational definitions, numerators and denominators. Given that there is a lack of good practice statements and recommendations related to health and social service provider education, there are no associated structure indicators in this BPG. Each table also identifies if the indicator aligns with other indicators in local, provincial, national and/or international organizations. Alignment with organizations 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 organizations. Indicators may be adopted (in their current state) or adapted (modified) from organizations.

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 4 provides a list of process indicators that support the evaluation of practice changes during implementation and corresponding process improvements. Process indicators are derived from BPG recommendations and good practice statements.

Table 4: Process indicators

RECOMMENDATION OR GOOD PRACTICE STATEMENT	PROCESS INDICATORS	ALIGNMENT WITH INDICATORS IN OTHER ORGANIZATIONS
Good practice statement 2.0	Percentage of people who participated in shared decision-making about their treatment, care and services ***Numerator:*** *Number of people who participated in shared decision-making about their treatment, care and services* ***Denominator:*** *Total number of people who received care or total number of survey respondents*	Full alignment with Partnership for Quality Measurement (PQM) and Ontario Health Partial alignment with Accreditation Canada and Organisation for Economic Co-operation and Development (OECD)
Good practice statement 3.0	Percentage of people who were assessed for readiness for advance care planning ***Numerator:*** *Number of people who were assessed for advance care planning* ***Denominator:*** *Total number of people who received care*	New
Good practice statement 3.0	Percentage of people who participated in advance care planning after they were ready ***Numerator:*** *Number of people who participated in advance care planning after they were ready* ***Denominator:*** *Total number of people assessed to be ready for advance care planning*	Full alignment with PQM Partial alignment with Institute for Clinical Evaluative Sciences (ICES)
Good practice statement 4.0	Percentage of people who reported that their personalized care plan was developed collaboratively with providers ***Numerator:*** *Number of people who reported that their personalized care plan was developed collaboratively with providers* ***Denominator:*** *Total number of people who received care or total number of survey respondents*	Adapted from Nursing Quality Indicators for Reporting and Evaluation® (NQuIRE®) Full alignment with OECD Partial alignment with PQM

RECOMMENDATION OR GOOD PRACTICE STATEMENT	PROCESS INDICATORS	ALIGNMENT WITH INDICATORS IN OTHER ORGANIZATIONS
Recommendation 1.0	Percentage of people who were provided with a decision aid to enhance informed participation in decision-making related to health screening and/or health-care treatment options ***Numerator:*** *Number of people who were provided with a decision aid* ***Denominator:*** *Total number of people who received care for which a decision aid exists*	New
Recommendation 2.0	Percentage of people who were provided eye masks and/or earplugs as a sensory-minimizing strategy according to the needs and preferences of the person ***Numerator:*** *Number of people who were provided eye masks and/or earplugs as a sensory-minimizing strategy* ***Denominator:*** *Total number of people who were offered eye masks and/or earplugs as a sensory-minimizing strategy according to the needs and preferences of the person*	New
Good practice statement 5.0	Percentage of people who were assessed for their needs and preferences regarding virtual care to inform appropriateness and modality of care delivery **Numerator:** *Number of people who were assessed for their needs and preferences regarding virtual care to inform appropriateness and modality of care delivery* **Denominator:** *Total number of people who were assessed for virtual care*	Partial alignment with Canadian Institute for Health Information (CIHI)

RECOMMENDATION OR GOOD PRACTICE STATEMENT	PROCESS INDICATORS	ALIGNMENT WITH INDICATORS IN OTHER ORGANIZATIONS
Good practice statement 5.0	Percentage of people who received virtual care based on their assessed needs and preferences ***Numerator:*** *Number of people who received virtual care based on their assessed needs and preferences* ***Denominator:*** *Total number of people who were assessed for virtual care*	Partial alignment with Better Outcomes Registry & Network (BORN)

Table 5 provides outcome indicators to assess the impact of implementing evidence-based practice changes. Outcome indicators are associated with outcome(s) of the research question(s) and/or reflections of outcomes of all recommendations and good practice statements.

Table 5: Outcome indicators

OUTCOME INDICATORS	ALIGNMENT WITH INDICATORS IN OTHER ORGANIZATIONS
Percentage of people reporting an overall positive experience with care ***Numerator:*** *Number of people reporting a positive experience with care* ***Denominator:*** *Total number of people who received care or total number of survey respondents*	Full alignment with Canadian Institute for Health Information (CIHI), Ontario Health and Partnership for Quality Measurement (PQM) Partial alignment with ICES and Statistics Canada
Percentage of people who reported a positive experience with their involvement in the planning of care and treatment ***Numerator:*** *Number of people who reported a positive experience with their involvement in the planning of care and treatment* ***Denominator:*** *Total number of people who received care or total number of survey respondents*	Adapted from NQuIRE Full alignment with ICES and Ontario Health Partial alignment with OECD

OUTCOME INDICATORS	ALIGNMENT WITH INDICATORS IN OTHER ORGANIZATIONS
Rate of complaints received from people receiving care per 1000 care days/care visits ***Numerator:*** *Number of complaints received from people receiving care* ***Denominator:*** *Total number of care days/care visits*	Adopted from NQuIRE Full alignment with Ontario Health
Percentage of people reporting an overall positive experience with virtual care ***Numerator:*** *Number of people reporting a positive experience with virtual care* ***Denominator:*** *Total number of people who received virtual care or total number of survey respondents*	Partial alignment with CIHI, Canada Health Infoway and Statistics Canada
Percentage of people who report that their background and identity were respected by their provider(s) ***Numerator:*** *Number of people who report that their background and identity were respected by their provider(s)* ***Denominator:*** *Total number of people who received care or total number of survey respondents*	Full alignment with Ontario Health

Other RNAO resources for the evaluation and monitoring of BPGs:

Nursing Quality Indicators for Reporting and Evaluation® (NQuIRE®), a unique international data system housed at RNAO, allows BPSOs® to monitor and evaluate 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 indicators wherever possible, adhering to a "collect once, use many times" principle. By complementing other established and emerging repositories, NQuIRE strives to leverage reliable and valid measures, minimize the reporting burden and align evaluation measures to enable comparative analyses. The NQuIRE data system was launched in August 2012 to create and sustain evidence-based practice cultures, optimize the safety of people, 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 (46).

RNAO Clinical Pathways™ are digitized recommendations and good practice statements embedded into electronic medical records through a third party software. Currently, these clinical pathways are available to all Canadian LTC homes. The ability to link structure and process measures with specific outcome measures helps determine the impact of BPG implementation on specific health outcomes.

Background context

What is people-centred care?

Historically, a biomedical treatment model was the primary method for health-care service delivery, where an illness was explained as a physical or biological disease, and health was seen as the absence of disease (47). The biomedical model is associated with a paternalistic authority (assigned to the health and/or social service provider), and the people receiving care relegated to a passive role in the health and social care relationship. This creates a power differential between the health and social service provider (deemed as the expert in this patriarchal model) and the people receiving health and social care (48). Encounters with providers adopting this approach are often transactional; the health and social service provider focuses only on the physical symptoms of disease, not the person experiencing the disease or the environmental, cultural and social factors that influence their ability to access necessary care to manage their disease (47,49). Illness is a condition and an experience of the whole person, and treating the physical symptoms alone may not solve the real source of the problem (47). The biomedical model objectifies people receiving health and social care, and often blames them when their poor health does not improve rather than engaging them from the outset in decisions about their health process and potential early interventions (47). With the changing landscape of global health and a greater focus on people's needs, values and preferences, there is a need for a more comprehensive approach to care and management of disease.

Over the last twenty years, there has been growing momentum to adopt an approach in health and social care that emphasizes the relationship between health and social service providers, and people accessing health services (50). This work led to the conceptualization and growing acceptance of the concept of people-centred care, where health and social service providers aim to reach a shared understanding with people in order to respond more fully to their specific needs, preferences and values (14). The term people-centred care was adopted to move the focus from the individual seeking care to a more holistic approach and to account for the importance that family, community and society have on health (11). Refer to the **Note on Language and Terminology** for more details.

Why is people-centred care important?

When people across the lifespan require health and social services, they are seeking a safe and positive experience. The World Health Organization (WHO) defines high-quality health services as safe, effective, people-centred, timely, efficient, equitable and integrated (11). People-centred care is recognized internationally as a critical attribute, and foundational to high-quality health services (9,12,51,52). People-centred care is important because research demonstrates that when an individual's plan of care is concordant with their needs, wants, values and preferences, the care that is delivered is more effective and leads to the provision of quality outcomes for patients, organizations and health and social service providers alike (50,53,54). When people feel respected and genuinely heard, they are more likely to engage in their care, follow their care plan, make informed decisions, and report improved satisfaction with care (50). Moreover, people that have positive experiences with the health system are better equipped to actively participate in their care journey. This is why people's experiences with the health system is one of the pillars of the quintuple aim(26) and of evidence uptake and sustainability of social movements (2). Among people with heart failure, chronic obstructive pulmonary disease, acute coronary syndrome and rheumatology, people-centred interventions (e.g., effective communication, identification of problems/concerns, **co-creation**[G] of action plans, identifying resources for self-management of problems) are associated with reduced hospital admissions, reduced hospital length of stay, reduced mortality, reduction of unplanned visits, increased quality of life, and reduced costs of care (55).

What are the key tenets and attributes of people-centred care?

The key tenets of people-centred care include:

- integrity: recognizes that people are the experts of their own experiences (13);
- relevance: includes providing the opportunity to create space for mutual understanding of needs and expectations (13);
- communication: refers to the sharing of information in ways that affirm and serve and the welcoming of questions and clarification (13);
- inclusion and preparation: reminds health and social service providers to include active involvement of people in their care (13); and
- humility and learning: expectation that health and social service providers create safer spaces for people to share their problems and concerns (13).

The attributes of health and social service providers, non-clinical staff members and support staff are important in people-centred care (10,53,56). These attributes include:

- a caring attitude;
- empathy: where health and social service providers enter into the person's world (putting oneself "in the shoes" of the person) and strive to understand the lived experiences of people;
- respect: where people are approached with a respectful attitude;
- a holistic approach to health and social service planning and delivery;
- providing culturally safe and trauma-informed health and social care;
- communication skills that are attuned to the needs of others and that advance the relationship (trusted, respectful therapeutic relationship development and maintenance) (see **Good practice statement 1.0** and **Appendix D**);
- engagement in partnership with people where the health and/or social service provider is present and committed to people;
- actively including caregivers in the partnership with people and health and/or social service providers, acknowledging that they not only provide key insight into the values and needs of the person receiving care, but can also support and co-manage the needs of the person receiving care (e.g., medication management, scheduling appointments, etc.) (56);
- shared decision-making (see **Good practice statement 2.0**);
- encouraging people's autonomy and self-management;
- collaboratively co-creating a care plan tailored to the physical, psychological, spiritual and social or environmental preferences of the person accessing health and social services (see **Good practice statement 4.0**); and coordinated care, whereby care is coordinated between health and social service providers and people receiving care (see **Appendix E**).

How does implicit bias impact the delivery of people-centred care?

An implicit bias is an attitude or stereotype that is internalized and unconsciously affects the perceptions, actions and decisions of individuals (57). These biases are formed from personal life experiences, as well as through cultural and social upbringing (57). Implicit bias, both conscious and unconscious, influences how health and social service providers, non-clinical staff members and support staff assess people and how they act towards people. Implicit bias can often result in discriminatory, negative health experiences for people seeking access to necessary health and social services (58,59). Experiencing discrimination or negative treatment when accessing health and social services can discourage people from seeking care, lead to poorer health outcomes, and result in racial, ethnic, socioeconomic, age, weight and gender-based health inequities (60–65).

Given that all individuals hold preconceived ideas and opinions about others, it is important for health and social service providers, non-clinical staff members, and support staff across all health-care settings to critically reflect on their own personal pre-conceived assumptions, attitudes and biases. Access to implicit bias education is also imperative for all people working in the health and social service sector (57). Training that incorporates mindfulness, team-building and personal retrospection has been demonstrated to reduce the negative effects of implicit bias within the clinical environment (57). See **Supporting resources** in **Good practice statement 1.0** for education and resources pertaining to equity, diversity and inclusion and implicit bias, including how to determine your own implicit bias.

How does people-centred care promote health equity?

People-centred care can improve health equity by highlighting health inequities, addressing challenges in accessing health and social services, and ultimately helping to foster improved health outcomes for all populations (54,66). When a people-centred approach to care is adopted, health and social service providers reorientate their focus to include the significant role that social, cultural and socio-economic factors impose on people's ability to safely access health and social services (66). Ensuring that equity-deserving populations have access to health and social services and that these services align with their personal needs, values and preferences can reduce barriers to care (48). The following section presents diverse perspectives on how people-centred care promotes health equity within several equity-deserving populations.

Promoting equity for Indigenous Peoples in Canada

The health and wellness of **Indigenous**[G] Peoples in Canada is influenced by complex, intersecting and interrelated Indigenous determinants and contexts (67). The determinants of health that impact Indigenous Peoples go beyond the social determinants alone and are all interconnected (68). These include:

- historical determinants of health, such as colonialism and colonization;
- structural determinants, such as the social determinants of health (early childhood experiences, physical environments, income and social status, education and literacy, social support networks, healthy behaviours, access to health services, biology, employment, race/racism, culture and gender);
- other factors that facilitate or impede health and wellness, such as health promotion, health-care services, education, social support;
- Indigenous-specific determinants including relationship with the land, kinship networks, traditional languages and ceremonies and knowledge sharing (68); and
- the most profound and distal Indigenous determinants of health which include historical, political, ideological, economic and social foundations (worldviews, spirituality and self-determination (68).

The Truth and Reconciliation Commission (TRC) of Canada includes seven "Calls to Action" on health (28). The five calls* to action particularly relevant to people-centred care and in alignment with this BPG are paraphrased briefly below (please see full statements for more detail).

The TRC stresses the need to:

- 19. Close the gap in health outcomes between Indigenous Peoples and non-Indigenous Peoples;
- 20. Recognize that Indigenous Peoples have distinct health needs that need to be respected and addressed;
- 22. Recognize that Indigenous healing practices have value and should be used (in collaboration with Indigenous healers and Elders) in the treatment of Indigenous Peoples, when requested.
- 23. Ensure that all health providers be provided with cultural competency training; and
- 24. Require that all medical and nursing schools mandate students to take a course pertaining to Indigenous health, along with training in cultural competency, human rights and anti-racism (28).

* the numbers above are those used in the TRC calls to action

In addition to the calls to action outlined in the TRC, four key dimensions are foundational to promoting the health and wellness of Indigenous peoples:

- equity-responsive care
- culturally safe care
- trauma- and violence-informed care
- contextually tailored care (expanding the concept of people-centred care) (48)

Health and social service providers must recognize the systemic barriers that Indigenous People and other equity-deserving populations face and actively work to improve conditions and outcomes for these populations by practicing people-centred care. For more information on the current issues that minority groups are facing in Canada (and across the globe) please visit: https://minorityrights.org/country/canada.

Promoting equity for Black people and communities

Racism is a structural system existing in society, based on the erroneous belief that certain races are superior or inferior to one another, affording some groups privileges and opportunities, while at the same time oppressing and marginalizing other groups (69). In health care, medical racism refers to the systemic discrimination and unequal treatment of people based on race or ethnicity. Whether this occurs consciously or unconsciously, it creates a barrier to health and health care for diverse racialized people (69). Biased medical practices, unequal access to care, and the perpetuation of false beliefs about biological differences between races all lead to disparities in health outcomes (70). For example, racism and racial discrimination have been shown to impact the physical and mental health of Black people, leading to a disproportionate disease burden experienced by Black populations worldwide (65).

Experiences of racism can include covert interpersonal manifestations, such as being dismissed by health and social service providers, indifference (e.g., to pain level), prejudice and racial microaggressions, or overt expressions, such as differential treatment and avoidance of provider-patient contact (65). It is not uncommon for Black people to feel as though they are silenced or dismissed by health workers, and that their experiences and self-knowledge of their own illness and body is not acknowledged (71) or their health concerns are being minimized (65). In a recent report released from the 2016 Canadian Census Health and Environment Cohort, trends in avoidable hospitalizations (i.e., admissions to hospital for treatable health conditions, such as asthma and diabetes) were examined among

racialized groups in Canada. The report found that the odds of avoidable hospitalizations were significantly higher among males, Black people and non-immigrants; during the COVID pandemic years (2020 to 2022) avoidable hospitalizations significantly increased for Black males, when compared to non-racialized males (72). This elucidates the gross health inequities Black Canadians face, including significant barriers to primary care. Prioritizing people, adapting health and social services to align with people's values, beliefs and needs, and empowering people to make informed health decisions, can contribute to mitigating health disparities and improve access to care for this population (73).

Promoting equity for 2SLGBTQI+ people and communities

Health and social service provider's lack of knowledge, training and understanding of 2SLGBTQI+ health issues can lead to negative health-care experiences and ultimately poorer health outcomes for the 2SLGBTQI+ population (74,75). Historically, health and social service providers' lack of awareness of the unique needs of 2SLGBTQI+ people has created barriers to inclusive and equitable care (75,76). 2SLGBTQI+ people who access health and social services often experience stigma and discrimination, and the provision of health services is found to not always be welcoming (74,75). Because of the unique health needs and lived experiences of 2SLGBTQI+ people, it is important for health and social service providers to critically examine how their own biases and assumptions affect care delivery (74,75). Providing affirmative, inclusive and respectful environments can lead to more trusting and supportive relationships between 2SLGBTQI+ people, their chosen families and health and social service providers (75). Many organizations exist (e.g., *Safer Spaces*) that can provide in-person or virtual training workshops and learning modules for health and social service providers with the goal of creating inclusive programs and workplaces for 2SLGBTQI+ people and communities.

Promoting equity for older adults

It is essential to translate a people-centred approach into aging-care facilities (e.g., LTC, retirement homes) where individuals often experience intersecting challenges related to disability, cognitive decline and chronic conditions that affect the daily life of people, chosen families and providers (77). High quality care in LTC is complicated by stigmas associated with aging, mental health and disability (78). Older people are oftentimes marginalized and perceived as burdensome, especially when there is also a loss of capacity (78). To uphold the rights of older people, and address their unique needs and preferences, a new Lancet commission was introduced to foster people-centred care in LTC, in alignment with the WHO Healthy Ageing Framework (78). Co-created with older adults with lived experience, the commission's goal is to focus on key policy, regulation, education and care issues to respect and restore the dignity of older adults and optimize their functional ability and well-being (78).

There is consistent evidence that a people-centred approach to care within LTC settings has positive benefits for residents. A systematic review that examined the impact of people-centred interventions for older adults in LTC found a positive association between residents' self-reported quality of life and higher cognitive functioning when residents participated in everyday activities (e.g., making coffee, watering plants). These interventions also contributed to improved psychological status secondary to reduced boredom and feelings of helplessness (79). In people with dementia, people-centred care has been found to reduce neuropsychiatric symptoms and depression, and short-term intensive and activity-based interventions have been effective in reducing agitation (80).

Promoting equity for low-income populations

Low-income populations often face significant barriers accessing health and social services, including cost-related obstacles even within publicly funded health systems (81,82). A study involving over 700 participants across Ontario, Canada found that individuals experienced substantial challenges accessing publicly funded home and community care services, such as physiotherapy, occupational therapy, and other rehabilitation supports and frequently had to pay out-of-pocket costs for essential medications and medically necessary equipment (83). These financial burdens were especially pronounced for those struggling to make ends meet. To ensure care is truly people-centred, health and social service providers should enquire and consider the individual's socioeconomic circumstances to tailor the plan of care. This approach ensures that care is not only responsive to personal needs but also financially accessible, helping to reduce health disparities and improve outcomes.

How can people-centred care be effectively implemented?

Education on people-centred care

Education on people-centred care is required to align people-centred language, health and social service provider competencies and capacity, and build a people-centred culture within health and social service organizations committed to continuous learning and improvement (84). Training is important for learners entering health professions and for health and social service providers practicing across a range of disciplines and practice settings. Integrating the key tenets of people-centred care at all levels of care delivery can also ensure sustainability of its implementation.

Challenges to implementing people-centred care and the role of champions

Despite the importance of a people-centred approach to care, challenges persist in its implementation. For instance, environmental factors can either inhibit or support the implementation of interventions that prioritize the preferences and values of people in the planning of care. Those working in a practice environment that endorses a biomedical paradigm may encounter strain, within existing provider-patient dynamics, with the introduction of a person-centred decision making-model (85). Providers may prioritize 'objective' and 'medicalized' aspects in the treatment of an illness (85), and not consider an individual's expectations for care and recovery. Other institutional barriers include nursing staff shortages, high workload, burnout and time constraints. With fewer than optimal staff members and thus increased workloads, it is difficult to effectively communicate and interact with people and establish strong and meaningful therapeutic relationships that form the foundation of people-centred care (86). Due to service, policy and systemic constraints, there can be an emphasis on task-centred care – a barrier to people-centred care – as care providers are more focused on completing tasks instead of attending to the needs and preferences of people and their family (86). In addition to barriers imposed at the institution or system level, providers' personalities and behaviours can also lead to challenges in the implementation of people-centred care. Diverse demographic characteristics, cultural and linguistic backgrounds, and beliefs, preferences and values about health and illness, all play a role in affecting provider-patient relationships and health and care outcomes (86).

Trained peer leaders, referred to as **champions**[G], are well situated to circumvent these barriers and facilitate implementation of evidence-based practices. Champions are trained peer leaders (for example, point-of-care nurses) who assume formal or informal leadership roles to support the introduction, implementation and/or sustainability of BPGs in workplace settings (87,88). While the adoption of a people-centred care approach has become more widespread, there remains a need to revise educational and training programs so that key partners can help support and implement the shift toward people-centred care (49). In this regard, champions can use their knowledge, skill and abilities to create meaningful changes in evidence-based practice that promote and support a people-centred approach to care.

CONCLUSION

People-centred care is about learning who people are – their values and preferences, beliefs and needs. It is about recognizing the lived experience of people and valuing and fostering that lived experience during interactions with health and social service providers. Through a people-centred care lens, people become full partners in their own care, and it is the responsibility of health and social service providers to support people in their goal to achieve good health by attentively listening to and understanding their life story and experiences (13).

Guiding principles

Guiding principles[G] are overarching concepts that denote a philosophy, belief, value, and/or standard of behaviour that nurses, other members of the interprofessional team and health and social service organizations should apply to their practice. It is important that guiding principles are followed to improve health outcomes for all people. The following guiding principles were selected by the expert panel and are considered foundational for people-centred care and all of the recommendations and good practice statements in this BPG.

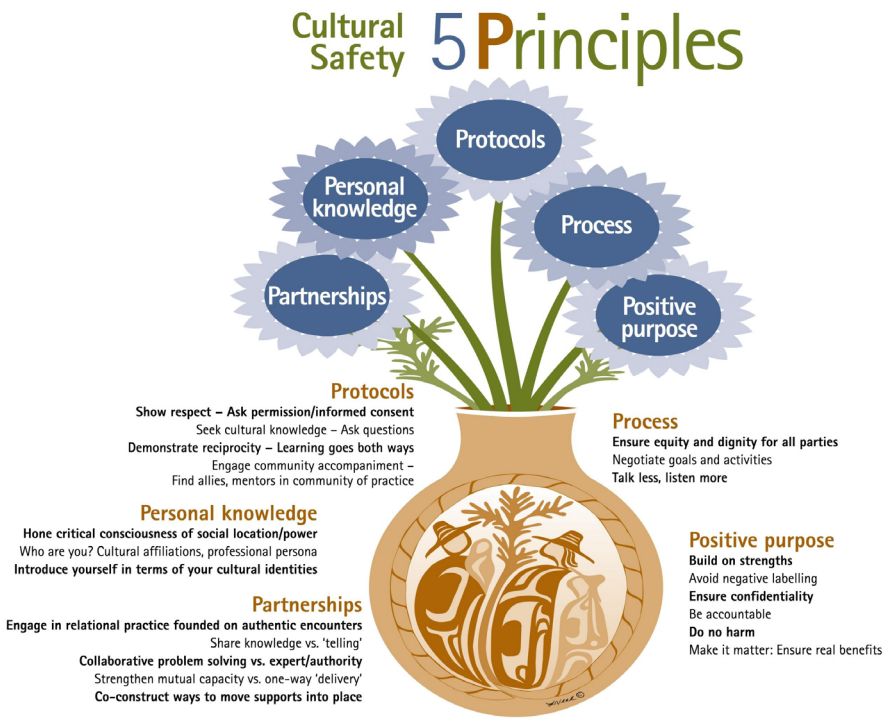
Cultural safety

Cultural safety[G] occurs when individuals respectfully engage in a manner that recognizes and aims to address power imbalances inherent across the health system. It involves health and social service providers embracing a humble, self-aware approach to clinical practice, positioning themselves as respectful and open-minded collaborators in people-centred care rather than authoritative experts (17). With culturally safe people-centred care, health and social services must be respectful and responsive to the cultural and linguistic needs and wishes of diverse populations. The goal is to create an environment free from microaggressions, racism and discrimination where people feel safe when receiving health and social care (17). Culturally safe health and social services recognize that populations most at risk of poor health outcomes should receive appropriate care that is free from harm to their cultural identity, sense of self and well-being (17).

There are several terms in the literature used to denote cultural safety; however these are distinct concepts on a continuum. They are: 1) **cultural awareness**[G], which is being cognizant of the differences and similarities between cultures; 2) **cultural sensitivity**[G], which is being aware of and acknowledging how one's own culture impacts their behaviours, knowledge and biases; 3) **cultural humility**[G], which is a journey of self-reflection and learning characterized by the ability to listen without judgment and be open to learning from and about other people; and 4) **cultural competency**[G], which occurs when people develop the knowledge, skills and attitudes to work effectively and respectfully with diverse people (89).

As shown in **Figure 1**, there are five principles that health and social service providers must consider to promote cultural safety and ensure they are providing culturally safe care. These include: protocols, personal knowledge, partnerships, process and a positive purpose.

Figure 1: Five principles to promote cultural safety



Source: Reprinted with permission from: Ball J. Cultural safety. In: Early Childhood Development Intercultural Partnership [Internet]. Victoria (BC): University of Victoria; c2024. Available from: https://ecdip.org/cultural-safety/

Please visit the Indigenous Primary Health Care Council's education program supporting Indigenous Cultural Safety to learn more about cultural safety, cultural awareness, cultural sensitivity, cultural competency and cultural humility, and to develop the essential skills and knowledge to create compassionate environments, improve health outcomes and build stronger relationships with people receiving care (https://iphcc.ca/cultural-safety-training/).

Trauma-informed care approach

A **trauma-informed approach to care**[G] is a framework that emphasizes physical, psychological and emotional safety with the goal to empower people in their recovery. When adopting a trauma-informed approach to care, the aim is to not only to understand the whole person, but to also be cognizant of how the impact of trauma and how people's lived experiences of trauma shape health status and behaviours (90). Trauma can include one incident or a series of incidents that a person finds emotionally disturbing or life-threatening (e.g., physical, sexual and/or emotional abuse; poverty; racism, discrimination and oppression; violence) which lead to a lasting impact on the person's mental, physical, social, emotional, and/or spiritual well-being (91). Health and social service providers who practice a trauma-informed approach realize that trauma has widespread impact on people's lives and behaviours, possess an understanding of the path to recovery from trauma and can recognize the signs and symptoms associated with trauma. These providers can incorporate their knowledge about trauma into policies, procedures and practices, and can actively avoid traumatizing and re-traumatizing people (91) by working collaboratively with people. There are six key principles that guide a trauma-informed approach, mainly:

1. safety: ensuring the physical, psychological and emotional safety of both health and social service providers and people;
2. trust and transparency: building trust and ensuring that all decisions are transparent;
3. peer support: encouraging connections with other individuals who also have experienced trauma, and when possible, integrating the perspectives of people with a lived experience of trauma into organizational and processes;

4. collaboration and mutuality: leveling any power differentials between health and social service providers, people and organizations to support shared decision-making;
5. empowerment, voice and choice: recognizing people's strengths and fostering a sense of control, while also providing choices and respecting individual autonomy in order to restore confidence and self-efficacy; and
6. cultural, historical and gender sensitivity: recognizing and addressing the cultural, historical and gender-specific contexts of trauma and recognizing the role of systemic oppression in shaping experiences of trauma (91,92).

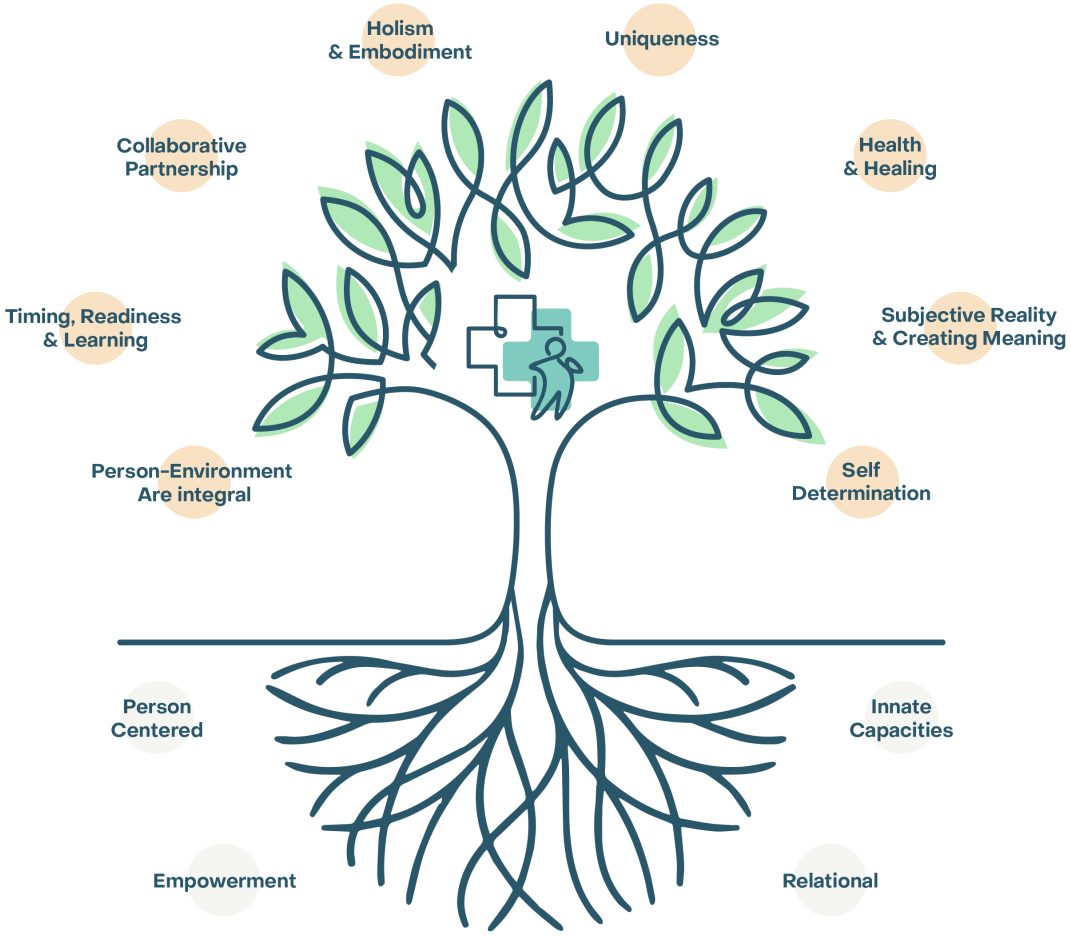
Intersectionality

Intersectionality refers to the study of intersecting social identities and related systems of oppression, domination or discrimination. In an intersectionality framework, categories of race, class, gender, sexuality, nation, disability and age are viewed as interrelated (93). It takes into account the full range of potential identities based on historical, political and social contexts, in addition to the unique lived experiences and circumstances of the individual, and how these may shape one another (93). Adopting a people-centred approach to care means the focus is on the whole person as a unique individual and their specific needs, preferences and values (14). By also adopting an intersectionality lens, health and social service providers can gain a deeper understanding into the factors that intersect and interact and contribute to people's individuality, including their specific strengths, needs, preferences and values.

Strengths-based nursing and health care

Strengths-based nursing and health care[G] is the understanding of a person's challenges and limitations within a larger context that includes their inner and outer strengths, such as resilience, coping skills, family support or community resources (94). It is an approach to care that emphasizes the capabilities and resources of people, discovering the strengths that can empower people to take greater control over their health and wellness journey (94). Strengths-based nursing and health-care approach is based on four underlying foundations: 1) person-centred care, which focuses on a person's capabilities, resources, values and goals in order to understand them as a person beyond their illness or current deficit; 2) empowerment, which acknowledges that people are resourceful and capable to participate in shared decision-making; 3) relational practice, that fosters people-provider relationships that are collaborative and partnership-based, not hierarchical; and 4) innate capacities, which focuses on building on what is working well for the individual (95). As shown in **Figure 2**, in addition to the four foundational pillars, strengths-based nursing and health care is also built on eight core values, including: health and healing; uniqueness; holism (systems thinking and embodiment); subjective reality (multiple perspectives) and creating meaning; self-determination; collaborative partnership; learning, readiness and timing; and recognizes the importance of a person's environment (94).

Figure 2: The 4 Foundational Pillars and 8 Values of Strengths-Based Nursing and Health Care



Source: Reprinted with permission from: Gottlieb LN. SBNH Tree [Illustration]. Montreal (QC): Ingram School of Nursing, McGill University; 2025. Available from: https://www.mcgill.ca/strengths-based-nursing-healthcare/about/strengths-based-nursing-and-healthcare.

A strengths-based nursing and health-care approach to care closely aligns with and reinforces people-centred care because it recognizes and builds on people's strengths and capabilities, encourages people to be active participants in their health and wellness journeys, fosters collaborative relationships between people and health and social service providers, and delivers tailored and holistic care.

Reflective practice

Reflective practice is a continuous process whereby individuals critically analyze and evaluate their experiences, actions and decisions (96,97) and the impact that these actions and behaviours have on their practice (98). By engaging in deliberate self-reflection, health and social service providers can identify people's strengths, as well as areas in their practice or knowledge-base that may need improvement and adapt them accordingly (96,97). Reflective practice therefore offers a tool that gives meaning to one's experiences and enhances understanding of one's own practice (99). Based on a concept analysis, Patel & Metersky (98) propose that three forms of reflection be included in nursing education and practice:

- reflection-in-action, the active process of not just thinking but doing, which offers opportunities to change actions as they occur (100);
- reflection-for-action, which involves thinking ahead to upcoming situations based on prior knowledge and experience (101); and
- reflection-on-action, which includes retrospectively looking at situations to learn from them and to change future actions (102,103).

Recommendations and good practice statements

Therapeutic relationships

GOOD PRACTICE STATEMENT 1.0: THERAPEUTIC RELATIONSHIPS

It is good practice for health and social service providers to establish and maintain a therapeutic relationship with people that is grounded in trauma-informed care and culturally safe practices, ensuring respect, trust and collaboration.

People-centred care is an approach to care in which the person is viewed holistically. To get to know a whole person requires the formation of a therapeutic relationship between the person and the provider (22). A therapeutic relationship is a fundamental and central component of people-centred care (22), and the ability to provide people-centred care is dependent on establishing an effective therapeutic relationship (23). Therefore, establishing and maintaining a therapeutic relationship with people is good practice (23,36). The expert panel felt that it was necessary to communicate this good practice statement, but that it was not necessary to conduct a systematic review of the literature.

A therapeutic relationship is one based on trust, mutual respect, reliability, and an absence of judgmental attitudes (104). Empathy, compassion, cultural humility, and an ability to understand and attentively listen to others' concerns, values and preferences are essential to building therapeutic relationships and ultimately providing people-centred care (36,105). Being open, available, offering time for people to share, and individualizing care, while also paying attention to verbal and nonverbal language that is communicated during interactions, have also been noted as important to establishing therapeutic relationships (106). For a list of communication strategies that can promote therapeutic relationships, see **Appendix D**, and for an example of three communication support frameworks (N-U-R-S-E-S, Wish-Worry-Wonder and Ask-Tell-Ask) see **Appendix F**.

High-quality and meaningful therapeutic relationships have been associated with improved outcomes for people, as measured by physical and mental health status and satisfaction with care, as well as for care providers, who report greater job satisfaction and lower rates of burnout (107). Improved self-efficacy, adherence to treatment and functional status, and reduced morbidity have also been associated with positive people-provider relationships (108,109). Importantly, the extent that people perceive their relationship with their health or social service provider to be positive is associated with increased participation in medical decision-making (105,109).

The importance of developing and maintaining therapeutic relationships using a people-centred lens is demonstrated in care coordination. Care coordinators organize a person's care activities and share information among everyone involved in the person's circle of care (110). Care coordination is a people-centred and team-based approach that assesses the needs, preferences and goals of people and then aims to address them by connecting the person to the right health and/or social services to ensure the provision of safe, appropriate and effective care as people navigate through the health system (110). Examples of care coordination activities include: communicating and sharing knowledge, assessing patient needs and goals, supporting people's self-management goals, and aligning resources with the needs of people (110). For a detailed list of people-centred activities and elements that are integral to care coordination, see **Appendix E**.

RNAO Framework – what you need to establish a therapeutic relationship

To establish and maintain a therapeutic relationship, there are seven forms of knowledge and five capacities that providers must possess (23). The requisite knowledge includes:

- background knowledge (i.e., what the provider brings to the interaction with people);
- knowledge of interpersonal and development theory (e.g., Erickson's (1963) (111) and Freud's (1912) (112) developmental theories);
- knowledge of diversity (equity, diversity and inclusion) and social determinants of health;
- knowledge of the person (i.e., understanding the person's world, identifying/confirming what is meaningful to the person, uncovering their strengths, and attentively listening to their life history);
- knowledge of the person's health and illness;
- knowledge of the broad influences on health care and health-care policy (e.g., social and political forces, scope of the various health professions, accessibility to resources, etc.); and
- knowledge of the health system (i.e., how the system operates so that the provider can help the person navigate the system and obtain access to appropriate services).

The requisite capacities include:

- self-awareness
- self-knowledge
- empathy
- an awareness of boundaries
- and the ability to be aware of the limits to the professional role (e.g., scope of practice) (36)

Although not all relationships follow a linear progression, providers need to understand that each relationship typically has an orientation phase, a working phase and resolution phase (36). In the orientation phase, the provider and person are strangers, but each brings preconceived notions to the encounter based on past relationships, experiences, attitudes and beliefs. Through trust, respect, honesty and effective communication, a relationship begins to form, information is gathered, and priority issues discussed (36). In the working phase of the therapeutic relationship, people can explore their thoughts, feelings and behaviours (the process of which is facilitated by the provider), issues are identified and plans to address these problems are made collaboratively (36). Finally, the resolution phase occurs when people's needs or goals are addressed and/or met. Both the person and provider share feelings related to the end of the relationship, and come to a mutual understanding (36).

It is important to note that while connections between people and providers can occur over time, they can also occur during brief one-time encounters; therefore, it is important to create a connection and begin building the relationship in the first moments of care (107,113).

Implementation tips

From the expert panel

For the health and social service provider

- It is important for health and social service providers to engage in self-reflection, have an understanding of their own biases, and be self-aware. Self-reflection also includes reflecting on each and every interaction with people and learning from those interactions. See **Appendix G** for the *TALK Clinical Debriefing Tool* that helps promote reflection and guides clinical teams in debriefing. See **Supporting resources** below for the *PEARLS Healthcare Debriefing Tool* which provides a structured framework to improve the debriefing process in educational and training contexts and includes a learner self-assessment.
- Establishing therapeutic relationships requires health and social service providers to set and maintain boundaries with people.
- Relationships that are grounded in trauma-informed and culturally safe approaches build trust between people and health and/or social service providers and can reduce fear, judgment or harm.
- Culturally safe care is defined by the people or communities receiving care, not the health or social service providers delivering care.
- Use a person's preferred first name when documenting and ensure records are kept current and up to date.
- Ask people who they would like to be involved in their care or included in any discussions about their care (e.g., caregiver, chosen family, etc.).
- Ask people directly if there are any personal or cultural preferences that the health or social service provider should be aware of that would make them (the person) feel more comfortable.
- Document and share findings of preferences and considerations with the interprofessional team (also see **Good practice statement 4.0**, plan of care).
- Pay attention to both verbal and non-verbal actions. Non-verbal actions, such as providing comfort (e.g., bringing a warm blanket, speaking at eye level) can help establish a therapeutic relationship.
- Provide information in different ways, for example verbally and in written form.
- Provide time and space for people to process the information given and to ask questions.
- Caregivers may have unique needs and may face high levels of stress, impacting their own experiences and health, as well as their ability to support the care of the person receiving care. Seek to understand the needs of caregivers that are playing an essential role in care and support.
- Use accredited interpreter services if there are language barriers.
- When time constraints exist:
  - Guidelines for engagement can be discussed and co-created with people at the first encounter. For example, people should be informed that in-depth conversations are best held with their primary nurses and not during shift changes, etc.
  - Basic rules for engagement are implemented. For example, introduce yourself to people by your name, clearly articulate the services you are going to provide and how you will do that, and have a conversation about what the person's goals are for the day.
- When establishing therapeutic relationships, it is important to stay current with engagement strategies, such as thoughtfully incorporating social media into interactions with people, when appropriate.

- To be able to establish a therapeutic relationship with people, health and social service providers need to also care for themselves. Self-care helps health and social service providers manage stress, maintain mental and physical health and prevent burnout and **compassion fatigue**[G]. Compassion fatigue, also known as vicarious or secondary trauma, results from a desire to relieve the suffering of others (114). It is a condition that occurs when health and social service providers engage so deeply with people's emotional pain and suffering that they themselves become emotionally challenged, resulting in emotional, physical and psychological exhaustion (115). For more information about compassion fatigue, including how to recognize the signs and symptoms, and strategies to cope with and manage it, see **Supporting resources** below.

For the health and social service organization

- Health and social service organizations need to recognize that organizational factors, such as increased workload (including increased patient load), longer working hours and a lack of practical supportive resources can lead to compassion fatigue and burnout (116). Alternatively, the presence and engagement of leadership, a positive work culture and workplace wellness activities can provide protection for health and social service providers against compassion fatigue and burnout (116).
- For health and social service organizations aiming to implement a trauma-informed approach across the organization, refer to the **Supporting resources** below for a link to the Substance Abuse and Mental Health Services Administration's guidance document, as well as **Appendix H** which provides implementation domains and sample questions that organizations can consider when implementing a trauma-informed approach.
- When academic institutions and health and social service organizations plan and design education for health and social service providers and students, they are to provide information, education and resources on trauma-informed care and cultural safety. Doing this will support health and social service providers implement these approaches in practice.

Supporting resources

RESOURCE	DESCRIPTION
Bajaj K, Meguerdichian M, Thoma B, Huang S, Eppich W et al. (2018). The PEARLS healthcare debriefing tool. Acad Med, 93(2), 336. DOI: 10.1097/ACM.0000000000002035	▪ A framework created to support health-care debriefings following clinical or simulated events ▪ The tool addresses each of five debriefing phases (i.e., setting the scene, reactions, description, analysis, application/summary), objectives and tasks, as well as example phrases and questions. ▪ Also provides a variety of performance domains that can be explored
Behavioural Supports Ontario (BSO). Person-centred language initiative. North Bay (ON): BSO; n.d. Available from: https://brainxchange.ca/BSOPCL	▪ Provides a wide range of resources, educational material and courses for individuals who work in LTC homes to ensure that language choices surrounding person-centred care are appropriate and inclusive
Centre for Addiction and Mental Health (CAMH). Preventing and recognizing burnout and compassion fatigue while working with older adults. Toronto (ON): CAMH; 2020. Available from: https://kmb.camh.ca/eenet/sites/default/files/2018/2019/2020/Compassion%20fatigue%20resource.pdf	▪ Provides information about burnout, compassion fatigue, how to identify the signs and symptoms of compassion fatigue and how to avoid it
College of Nurses of Ontario (CNO). Therapeutic Nurse-Client Relationship [Internet]. Toronto (ON): CNO; 2006. Available from: https://cno.org/Assets/CNO/Documents/Standard-and-Learning/Practice-Standards/41033_therapeutic.pdf	▪ A practice standard for nurses that provides expectations and guidance on the knowledge, skills and judgment required to establish therapeutic relationships with people ▪ This standard is foundational to nursing practice; therefore, it was included in the supporting resources, despite it being published in 2006.

RESOURCE	DESCRIPTION
Government of Canada. Trauma and violence-informed approaches to policy and practice. Ottawa (ON): Government of Canada; 2018 February 2. Available from: https://canada.ca/en/public-health/services/publications/health-risks-safety/trauma-violence-informed-approaches-policy-practice.html	▪ Government of Canada website that provides an overview of: ▫ why trauma and violence-informed approaches are necessary and important ▫ how trauma and violence are connected ▫ how gender and culture are connected to trauma and violence ▫ how organizations and individual practitioners can implement trauma-informed approaches ▫ how to address the impact on service providers who work with people who experienced (or are experiencing) violence and trauma
Healthcare Excellence Canada (HEC). Equity, diversity and inclusion virtual learning exchange. Ottawa (ON): HEC; 2025. Available from: https://healthcareexcellence.ca/en/resources/equity-diversity-and-inclusion-virtual-learning-exchange/#:%7E:text=The%20Equity%2C%20Diversity%20and%20Inclusion%20Virtual%20Learning%20Exchange,that%20impact%20the%20safety%20and%20quality%20of%20care	▪ Offers webinars and guided reflections to: ▫ identify and discuss the root causes of inequities in health care ▫ learn how to challenge and dismantle systemic and structural inequities ▫ explore accessible and equity-oriented approaches
Indigenous Primary Health Care Council (IPHCC). About the Anishinaabe Mino'Ayaawin – People in good health approach to Indigenous cultural safety. Port Perry (ON): IPHCC; n.d. Available from: https://iphcc.ca/cultural-safety-training/	▪ Approach to Indigenous Cultural Safety (ICS) ▪ Includes: online training courses, customized workshops, change management support, development of tools and resources
Klinic Community Health Centre. Trauma-informed: The trauma toolkit, second edition [Internet]. Winnipeg (MB): Klinic Community Health Centre; 2013. Available from: https://trauma-informed.ca/wp-content/uploads/2023/04/trauma-informed_toolkit_v07-1.pdf	▪ Provides knowledge and guidance to health and social service providers who work with people who have experienced (or are affected by) trauma ▪ Provides direction to providers and organizations on how to work from a trauma-informed perspective and to develop trauma-informed relationships

RESOURCE	DESCRIPTION
Massachusetts General Hospital. Nursing and patient care services: icare: Fostering a welcoming environment. Boston (MA): Massachusetts General Hospital; 2019. Available from: https://www.mghpcs.org/eed/pte/pte-icare.shtml	▪ A model and tool for all health and social service providers, reminding them to be reflective and grounded prior to engaging with people ▪ Outlines a set of simple reminders of how we shape the experiences of people everyday, whether providing care indirectly or directly ▪ Developed collaboratively between an interdisciplinary focus group and the office of Patient Experience ▪ icare stands for: ▫ communicate ▫ advocate ▫ respect ▫ empathize
Northern Health Indigenous Health. Cultural safety: Supporting increased cultural competency and safety throughout Northern Health. Prince George (BC): Northern Health; 2025. Available from: https://www.indigenoushealthnh.ca/cultural-safety	▪ Offers posters, videos and other resources with respect to cultural safety to increase awareness, understanding and capacity ▪ Outlines key terms, such as cultural humility, cultural awareness, cultural sensitivity, cultural safety and cultural safety and anti-Indigenous racism
Physician Wellness Hub. Compassion fatigue: Signs, symptoms, and how to cope. Ottawa (ON): Canadian Medical Association; 2020 December 8. Available from: https://www.cma.ca/physician-wellness-hub/content/compassion-fatigue-signs-symptoms-and-how-cope	▪ Provides information on what compassion fatigue is, what the warning signs of compassion fatigue are, coping and management strategies to address compassion fatigue, as well as additional wellness resources
Richardson L, Murphy T. Bringing reconciliation to healthcare in Canada: Wise practices for healthcare leaders. Ottawa (ON): HealthCareCan; April 2018. Available from: https://www.healthcarecan.ca/wp-content/themes/camyno/assets/document/Reports/2018/HCC/EN/TRCC_EN.pdf	▪ Report that discusses critical issues Indigenous Peoples in Canada are facing, and how Canadian health leaders can play a pivotal role to help close the health gap ▪ Includes wise practices for health leaders and organizations to address the health-related Calls to Action of the Truth and Reconciliation Commission of Canada (TRC)

RESOURCE	DESCRIPTION
Schulman, M. Laying the groundwork for trauma-informed care [Internet]. Hamilton (NJ): Centre for Health Care Strategies, Inc; 2018 January. Available from: https://www.traumainformedcare.chcs.org/wp-content/uploads/Brief-Laying-the-Groundwork-for-TIC_11.10.20.pdf	▪ Provides practical recommendations that health and social service organizations can implement to become trauma-informed ▪ Outlines the foundational steps that providers can take when adopting a trauma-informed approach to care
Substance Abuse and Mental Health Services Administration (SAMHSA). Practical guide for implementing a trauma-informed approach. SAMHSA Publication No. PEP23-06-05-005. Rockville (MD): National Mental Health and Substance Use Policy Laboratory, SAMHSA; 2023. Available from: https://library.samhsa.gov/sites/default/files/pep23-06-05-005.pdf	▪ A practical guide that provides strategies for organizations to implement trauma-informed approaches to care ▪ Chapters include how to conduct an organizational assessment; governance and leadership; training and workforce development; and evaluation and sustainability
Trauma-Informed Care Implementation Resource Center. What is trauma-informed care? Shifting the focus from "what's wrong with you?" to "what happened to you?". Hamilton (NJ): Center for Health Care Strategies; 2025. Available from: https://www.traumainformedcare.chcs.org	▪ Website provides numerous resources, including: ▫ information about trauma-informed care and the impact of trauma on health ▫ examples of how trauma-informed care can be integrated into health-care settings ▫ strategies and tools for how to implement trauma-informed approaches to care; and ▫ testimonials from people who have adopted the trauma-informed principles in their own practice
Vital talk. Vital talk makes communication skills for serious illness learnable. Available from: https://www.vitaltalk.org/resources/quick-guides/	▪ Provides a series of one-page guides that offer communication strategies for topics such as, serious news, discussing prognosis, transitions/goals of care and family conferences

Shared decision-making

GOOD PRACTICE STATEMENT 2.0: SHARED DECISION-MAKING

It is good practice for health and social service providers to participate in shared decision-making with people as they make informed decisions about their treatment, care and services.

Participating in shared decision-making with people as they make decisions about their treatment, care and services is a part of good practice (96,117) and is integral to a people-centred approach to care (118). The expert panel felt that it was necessary to communicate this good practice statement to health and social service providers, but that it was not necessary to conduct a systematic review of the literature. Shared decision-making is a process whereby health and social service providers collaborate with people to make decisions about the person's immediate or future health and care needs, including advance care planning (see **Good practice statement 3.0**) (35,119). These decisions are based on the risks and benefits and possible consequences of various care and treatment options using the best available evidence, in conjunction with the preferences, needs, beliefs and values of the informed person (35,119). This process of collaboration and choice is the essence of people-centred and trauma-informed care (91,119,120) because it empowers people to make decisions that are right for them (35), including the decision to not have treatment or make changes to what is currently being done (35).

Shared decision-making offers a structured approach where people can make informed decisions that balance the benefits and harms of an intervention (based on evidence), based on their personal values and preferences (121). By participating in shared decision-making, health and social service providers support the principle that people should play an active role in making decisions about their own health care, ensuring they are provided with the best available evidence to make informed decisions (122). Although shared decision-making can be an ongoing, iterative process, steps to shared decision-making generally include:

- consent by the informed person receiving care to participate in shared decision-making;
- a clear understanding by both the person and health or social service provider of what the decision to be made is, and what the options are;
- giving the person information about the clinical problem and the options (benefits, harms, impact) to be decided upon are presented to the person, and clearly explaining and comparing the options using evidence;
- the person's perspective on what matters most to them is elicited, and preferences are developed based on their priorities and values;
- the health or social service provider guides the informed person towards a final decision; and
- an assessment is made of the informed person's comfort with their decision (121,123).

When people participate in shared decision-making, they tend to feel more informed about their care (124), report having more knowledge about their health and the risks associated with treatment options (124), are more engaged in the decision-making process and have an improved people-provider experience overall (122). Conversely, poor satisfaction with shared decision-making (as reported by people) has been associated with increased odds of patient reported poor physical health scores and poor mental health scores, as well as increased emergency department utilization (125). Although there is limited evidence on the effectiveness of shared decision-making on health-care quality, cost and consultation time (126), it is likely that shared decision-making could lead to better health outcomes due to the benefits in people's satisfaction, people's increased knowledge and engagement in decision-making.

It should be noted that some people may not want to take an active role in making decisions about their health and care needs. In these circumstances, health and social services providers should give people the opportunity to choose their desired level of engagement, and the amount of information that is communicated to them (35). However, to consent to treatment, people will need an understanding of the options, benefits and risks.

Appendix I offers a three-talk model of shared decision-making, including: 'team talk', 'option talk' and 'decision talk'.

Implementation tips

Implementation tips from the expert panel

For the health and social service provider

- Establish a therapeutic relationship before initiating shared decision-making and ask people how health and/or social service providers can make them feel respected and comfortable (see **Good practice statement 1.0** for information on establishing therapeutic relationships).
- Decision aids are a tool that can be used to facilitate shared decision-making when people are making decisions about health screening and/or treatment options (see **Recommendation 1.0**).
- Whenever possible, ask people who they want to have included in these conversations and clarify the desired level of involvement of the chosen family/caregiver.
- Shared decision-making is driven by the person receiving care; consistently re-evaluate the person's level of involvement because their desire to be involved may change over time. Particularly when given a diagnosis, people may become distressed and not realize that they can be involved in decision-making. However, through discussion about the diagnosis, and the benefits/risks/side effects of treatments, health and social service providers can support people's involvement so that they can make informed decisions.
- If the person is unable to participate in shared decision-making (e.g., cognitive decline, etc.), the health and/or social service provider can engage the identified substitute decision-maker in shared decision-making.
- Ensure that enough time is set aside to have sensitive conversations with people, allotting time for any questions/concerns that may arise.
- Provide opportunities for multiple meetings and check-ins at times that work best for people. Do not expect decisions or goals to be made in one meeting, and allow flexibility for decisions to be changed as the agreed-upon plan evolves.
- Reserve a private room or a space that is conducive to having discussions with people. If a private space is not feasible, acknowledge this with the person and/or their chosen family and provide them with as much control as possible. Suggest alternate communication methods, such as a video or conference call.
- Acknowledge that people may have different belief systems and different decision-making pathways that are influenced by these beliefs.
- If interpretation services are required, the onus is on the health or social service organization to provide the services. Whenever possible, use endorsed, certified and credentialled people or methods for translation. Professional interpreters also understand culture, which is part of interpretation.
- Health-care teams must assess the capacity and readiness of children to be included in shared decision-making. If the child demonstrates readiness and would like to be involved in shared decision-making, support them and allow them to contribute in ways that are appropriate to their maturity level and understanding (127). Also provide support to children and young people if they do not wish to be involved in making decisions about their health and care (127).

- In situations where there is a conflict between the child and their family regarding decisions, health and social service providers should be prepared to assist the child develop the capability to manage their situation and the dynamics around the decision-making (see **Supporting resources** below for more information about this).
- Although integrating shared decision-making with people is integral to a people-centred approach to care, it should be noted that there are certain situations where this is not possible and where consent is not required (e.g., emergency situations). In these situations, intensive care protocols or standardized care pathways may need to be implemented to manage critical care situations and optimize the care of people in high-risk environments.

For the health and social service organization

- Health and social service organizations have a responsibility to review the necessary legislation in their region and deliver education to health and social service providers as required. In Ontario, Canada, health and social service providers need to be familiar with key legislation, such as the Health Care Consent Act (128) and the Substitute Decisions Act (129).
- When planning and designing education for health and social service providers and students, academic institutions and health and social service organizations are to provide education and information about 1) shared decision-making (e.g., purpose, goal, etc.), 2) how to recognize people's readiness to participate in shared decision-making and 3) effective communication strategies providers can adopt to engage in shared decision-making with people and elicit people's values, beliefs and preferences.

Supporting resources

RESOURCE	DESCRIPTION
Agency for Healthcare Research and Quality. The Share Approach [Internet]. Rockville (MD): AHRQ; 2024. Available from: https://www.ahrq.gov/sdm/share-approach/index.html	▪ Resources available on the SHARE approach, a clinician-led shared decision-making model that has five essential elements to support meaningful dialogue with people. ▪ Includes videos, models, and resources to support the use of the SHARE approach
Jonsen A.R., Siegler, M., & Winslade, W.J. 4-box method for clinical decision-making. In Clinical ethics: A practical approach to ethical decision in clinical medicine. 5th ed. New York, NY: McGraw-Hill: 2002. Available from: https://i-med.ac.at/medizinethik-lehre/documents/4-box_ethical_dillema_framework.pdf	▪ Outlines how to use the 4-box method for decision making, which is a practical approach that separates salient issues and helps people focus on what is really important. ▪ **Note:** this document is older than ten years but is considered germinal.
Lawson ML, Shepard AL, Feenstra B, et al. (2020) Decision coaching using a patient decision aid for youth and parents considering insulin delivery methods for type 1 diabetes: a pre/post study. BMC Pediatrics, 20(1): https://doi.org/10.1186/s12887-019-1898-4	▪ A primary research study looking at the effect that decision coaching, using a patient decision aid, had on decisional conflict between youth and parents.

RESOURCE	DESCRIPTION
National Institute for Health and Care Excellence (NICE). Babies, children and young people's experience of healthcare [Internet]. Manchester (UK): NICE; 2021 August. Available from: https://www.nice.org.uk/guidance/ng204	▪ Includes recommendations pertaining to involvement in health care, advocacy, planning health care and support
National Institute for Health and Care Excellence (NICE). Shared Decision Making [Internet]. Manchester (UK): Public Health England; 2021 June 17. Available from: www.nice.org.uk/guidance/ng197	▪ This clinical practice guideline includes recommendations on how to embed shared decision-making at an organization level; how to put shared decision-making into practice in all health-care settings; the use of patient decision aids; and how to communicate about the risks, benefits and consequences of treatment and care options.
The Ottawa Hospital Research Institute. Decision Guides (mostly for any decision) [Internet]. Ottawa (ON): The Ottawa Hospital Research Institute; 2025 May 2. Available from: https://decisionaid.ohri.ca/decguide.html	▪ Link to templates of personal decision guides that can be downloaded and used by individuals to identify a decision, reflect on what they know about it, clarify what matters most, and plan next steps. ▪ The guides can be used for any health or social related decision-making. ▪ Multiple languages available
The Ottawa Hospital Research Institute. Ottawa Decision Support Tutorial [Internet]. Ottawa (ON): The Ottawa Hospital Research Institute; 2024. Available from: https://decisionaid.ohri.ca/ODST/	▪ A tutorial for health providers aimed at enhancing their knowledge and skills to support people to participate in shared decision-making ▪ Freely available in French and English ▪ Requires users to create username and password, and provides a certificate of completion if a score of 75% or higher is achieved.

RESOURCE	DESCRIPTION
Shapherd HL, Barratt A, Jones A, et al. Can consumers learn to ask three questions to improve shared decision making? A feasibility study of the ASK (AskShareKnow) Patient-Clinician Communication Model® intervention in a primary health-care setting. Health Expectations 19(5), 1160-1168. DOI: Available at: https://doi.org/10.1111/hex.12409	▪ A primary study that assesses the feasibility, uptake and acceptability of implementing a consumer questions program. ▪ The program encourages users to ask: 1. What are my options? 2. What are the possible benefits and harms of those options? 3. How likely are each of those benefits and harms to happen to me?

GOOD PRACTICE STATEMENT 3.0: ADVANCE CARE PLANNING

It is good practice for health and social service providers to regularly assess people for readiness for advance care planning and facilitate the process when ready.

A prerequisite for people-centred care is shared decision-making (see **Good practice statement 2.0**), and advance care planning is a means to enable and empower people to actively participate in shared decision-making (130). Therefore, it is good practice for health and social service providers to regularly assess people for readiness to participate in advance care planning. The expert panel felt it was necessary to communicate this good practice statement, but that it was not necessary to conduct a systematic review of the literature. Advance care planning is a process that "enables individuals who have decisional capacity to identify their values, to reflect upon the meanings and consequences of serious illness, to define goals and preferences for future medical treatment and care, and to discuss these with family and health-care providers" (131). It addresses not only people's concerns with the physical domain, but also encompasses the psychological, social and spiritual domains (131). It can also include conversations about substitute decision-making, encouraging individuals to designate someone they trust to make decisions on their behalf should they be deemed incapable (132). The aim of advance care planning is to empower people and their chosen families to prepare for and plan end-of-life care at any age or stage (133). By respecting individual autonomy, the personal goals and values of the competent person become central, and their sense of control increases (130).

Research has consistently demonstrated that interventions that support advance care planning can positively affect patient outcomes. In a recent systematic review that assessed 132 randomized control trials (RCTs) evaluating the effectiveness of advance care planning interventions, there were consistent and positive findings that advance care planning: improves the quality of person-physician communication; increases treatment preference (particularly comfort care); decreases the probability of decisional conflict; and facilitates people-caregiver congruence in preferences (i.e., the person and caregiver have a shared understanding of what matters most to the person) (133,134). A systematic review (135) also found that advance care planning improves documentation of end-of-life preferences. Despite the benefits of advance care planning, the systematic reviews reported mixed results with respect to the efficacy of advance care planning on end of life care and its consistency with people's reported preferences and goals with respect to quality of life, mental health, and place of death (particularly home deaths) (133), and with the satisfaction of end-of-life care from the families' perspective (135).

To participate in advance care planning, people need to be prepared for these discussions. Without being adequately prepared, people can experience emotional distress, their goals of care may not be realized, and their needs may go unfulfilled (136). Various factors can impact people's readiness for advance care planning including: attitudes (affected by training/knowledge/experience in advance care planning, socio-demographic factors, psycho-spiritual readiness, and current or previous health concerns); subjective norms (social support and family participation, and accessibility to health and social services); and perceived behavioural control (practice with speaking and writing about advance care planning and baseline readiness) (137). It is crucial that health and social service providers first assess people's readiness to engage in advance care planning by understanding the factors that impact readiness.

The stages of change transtheoretical model is one framework that health and social service providers can use to assess a person's readiness for conversations pertaining to advance care planning (138,139). In this model, people move through five stages of change:

- pre-contemplative: when people have not heard about advance care planning or have never considered it;
- contemplative: people are aware of advance care planning, but are not yet ready to proceed with planning;
- planning: people review educational material and/or discuss the topic of advance care planning;
- action: people have chosen their substitute decision maker and have discussed their wishes, values and beliefs with the substitute decision maker, and may ask for further help and/or information; and
- maintenance: people revisit conversations about advance care planning with their substitute decision maker (138,139).

The "ACP conversation guide – clinician primer" in the **Supporting resources** below provides further guidance on how to use the stages of change transtheoretical model to assess readiness for advance care planning, as well as examples of activities and interventions that health and social service providers can implement at each stage.

See **Implementation tips** below for more information on how to assess people for readiness and initiate or continue conversations surrounding advance care planning. For a list of communication strategies and example phrases that may be useful when introducing and/or discussing advance care planning with people, see "Advanced Care Planning Linguistics", "Serious Illness Conversations" and "Motivational Interviewing" in **Appendix D**. See also **Appendix J** for the Serious Illness Conversation Guide, **Appendix K** for PAUSE Talking Map for Early Goals of Care Conversations and **Appendix L** for a workbook for people accessing health and social services.

Implementation tips

Implementation tips from the expert panel

For the health and social service provider

- Assess for readiness using collaborative communication approaches and strategies, such as motivational interviewing and ask-tell-ask. For more guidance on indicators of readiness see the **Supporting resources** below. For more guidance on collaborative communication approaches see **Appendix D** and for specific communication strategies, see **Appendix J**, **Appendix K** and **Appendix L**.
- Discuss goals and preferences regularly and tailor discussions to the person's understanding of advance care planning, their health and disease stage, their cultural and religious beliefs and their willingness to engage in discussions.
- If people are not ready to engage in conversations about advance care planning, health and social service providers can explore reasons why and document this in their care plan.
- Ensure people have an understanding of who a substitute decision maker is, review the qualities of the substitute decision maker (see **Supporting resources** below for information about substitute decision makers) and follow legislative regulations surrounding substitute decision makers (e.g., in Ontario it is the Substitute Decision Act (129)).
- Be familiar with palliative care resources to help you facilitate conversations surrounding advance care planning and connect people to the resources they need and/or want.
- Encourage people to have conversations at home with their chosen family, caregivers or others in their social network about what matters most to them, including their preferences, goals and wishes (see **Supporting resources** below for information on how people can start the conversation and **Appendix L** for a workbook aimed to prepare people to talk to their chosen family and health-care team about what is important to them).

For the health and social service organization

- Skill and competence are required to initiate and maintain conversations about advance care planning. Health and social service organizations and academic institutions are to provide education and information about 1) advance care planning (e.g., purpose, goal, etc.), 2) how to recognize people's readiness to have conversations pertaining to advance care planning, and 3) effective communication strategies providers can adopt to engage in advance care planning with people from diverse populations.
- Simulation-based learning may be beneficial to learn strategies to address advance care planning and have difficult conversations with people about care plans, depending on the person's condition and prognosis.
- Create an organizational policy for advance care planning (including assessing readiness, documenting conversations, measuring outcomes, etc.) that can be implemented across health and social service organizations.
- Health and social service organizations may have literature for both people and health and social service providers on advance care planning. It is important to review these documents and tools, as they will be aligned with the policies within your organization and jurisdiction.
- If interpretation services are required, the onus is on the health or social service organization to provide the services. Whenever possible, use endorsed, certified and credentialled people or methods for translation. Professional interpreters also understand culture, which is part of interpretation.

Implementation tips from the literature

- Elements of advance care planning include:
  - an exploration of the individual's understanding of advance care planning and an explanation of the aims, elements, benefits, limitations and legal status of advance care planning;
  - adaptation to the individual's readiness to engage in the advance care planning process;
  - exploration of the individual's health-related experiences, knowledge, concerns, and personal values across the physical, psychological, social and spiritual domains;
  - exploring goals for future care;
  - providing information about diagnosis, disease course, prognosis, advantages and disadvantages of possible treatment, and care options;
  - clarification of goals and preferences for future medical treatment and care, and exploration of the extent to which these goals and preferences are realistic;
  - discussion about the option of having a personal representative (substitute decision-maker) who might act on the individual's behalf when they are unable to express their preferences, as per local legal jurisdiction;
  - exploration of the extent to which the individual allows their substitute decision maker to consider their current clinical context in addition to their previously stated preferences when expressing preferences on their behalf;
  - appointment of a personal representative and documentation thereof;
  - information about the option and role of an advance care directive, as per local legal jurisdiction;
  - completion of an advance care directive (depending on the local legal jurisdiction); and
  - encouraging the individual to provide their chosen family and health and social service providers with a copy of the advance care directive (131).

- Who can facilitate conversations
  - Health and social service providers need to have the necessary skills and demonstrate an openness to talk about diagnosis, prognosis, death and dying with people and their families (131). This information should be provided in a clear and coherent manner (131).
  - "Appropriate health providers are needed for clinical elements of advance care planning, such as discussing diagnosis, prognosis, treatment and care options, exploring the extent to which goals and preferences for future medical treatment and care are realistic, and documenting the discussion in the medical file of the [person receiving care]" (131).
- Timing of advance care planning
  - Advance care planning can occur at any stage of life, but may be more targeted as the health condition of the person progresses or as they age (131)
  - Update documentation about conversations regularly, as a person's values and preferences might change over time (131).

Supporting resources

RESOURCE	DESCRIPTION
Advance care planning Canada. 2024. Available from: https://www.advancecareplanning.ca/resources/tool-kits-and-guides/	▪ Toolkits and guides for families, caregivers and health-care professionals. ▪ Includes "how-to" resources to help make informed decisions about advance care planning.
Advance care planning in Canada (Speak up). Advance care planning in Canada: A pan-Canadian framework [Internet]. Ottawa (ON): Canadian Hospice Palliative Care Association; 2020. Available from: https://www.chpca.ca/initiatives/advance-care-planning-canada/	▪ Provides an updated framework and strategy to help people move from thinking about advance care planning, to actually having conversations centered around advance care planning ▪ The updated framework recognizes the importance of culture, and its role in how people view their health and make health-care decisions.
Alberta Health Services. Advance care planning/goals of care: Information for health professionals [Internet]. Edmonton (AL): Alberta Health Services; 2025. Available from: https://albertahealthservices.ca/info/Page9099.aspx	▪ Provides tools and resources, quality improvement projects and education for health and social service providers regarding advance care planning and goals of care discussions.
Healthwise Staff. Advance Care Planning for Your Child [Internet]. Health Link BC; 27, March 2023. Available from: https://www.healthlinkbc.ca/health-topics/advance-care-planning-your-child	▪ Overview of advance care planning, and how to prepare one for a child.

RESOURCE	DESCRIPTION
Hospice Palliative Care Ontario. Advance care planning in Ontario. Toronto (ON): Hospice Palliative Care Ontario; 2024. Available from: https://www.advancecareplanningontario.ca	▪ Provides people with knowledge about what advance care planning is, and the process of advance care planning in Ontario ▪ Also explains concepts, such as informed consent, mental capacity and substitute decision-making.
Hospice Waterloo Region. Advance care planning: conversations worth having. Healthcare provider resources [Internet]. Waterloo (ON): Hospice Waterloo Region; 2015. Available from: https://advancecareplanning.hospicewaterloo.ca/resources/healthcare-provider-resources/	▪ Resources for health and social service providers, including: shared decision-making conversation starters, advance care planning conversation starters, clinician conversation guide and speak up workbook.
Incardona N, Myers J. ACP conversation guide – clinician version 2.0. Waterloo (ON): Hospice Waterloo Region; 2018. Available from: https://www.pcdm.ca/HPCO/Assets/Documents/ACP%20Clinician%20Guide%20Feb%202023.pdf	▪ This resource provides: ▫ guidance on how to prepare for conversations pertaining to advance care planning with people and their substitute decision maker(s); ▫ practical information on consent, capacity and decision-making, and determining the substitute decision maker(s); and ▫ how to prepare the substitute decision maker(s) for making decisions about future health care.
Institute for Healthcare Improvement (IHI). The conversation project [Internet]. Boston (MA): IHI; 2025. Available from: https://theconversationproject.org/	▪ Provides freely accessible guides for people and their families, including: conversation starters, how to choose a health-care proxy, how to be a health-care proxy, how to talk to your health-care team, etc. ▪ Also includes health-care resources, faith resources and community resources.
Kiran D, Jerome D, Teeluck R, et al. Guide to Advance Care Planning Discussions [Internet]. Mississauga (ON): College of Family Physicians of Canada; 2018. Available from: https://www.cfpc.ca/CFPC/media/Resources/Education/ACP_GIFT_1pager_ENG_FINAL_RevMay18_Web.pdf	▪ Fact sheet outlining what advance care planning is, benefits of advance care planning, and how to perform advance care planning. ▪ Includes a framework for clinicians to conduct advance care planning discussions.

RESOURCE	DESCRIPTION
Pallium Canada. Palliative care resources. Ottawa (ON): Pallium Canada; 2025. Available from: https://www.pallium.ca/palliative-care-resources/	▪ Resources and tools for health-care professionals related to palliative care. ▪ Includes educational resources, practical clinical tools, strategies for quality improvement and opportunities to engage with communities of practice.
Pediatric Palliative Care. Advance Care Planning [Internet]. Palliative Care Australia; 2025. Available from: https://paediatricpalliativecare.org.au/resource/advance-care-planning/	▪ Describes what advance care planning is, guiding principles for advance care planning, how to talk to children and families about advance care planning, and advance care directives.
Rapoport A. Goals of care conversations and advance care planning for paediatric patients living with serious illness. 2024. Paediatrics & Child Health, 29, 397-403. DOI: https://academic.oup.com/pch/article/29/6/397/7896349	▪ Position statement from the Canadian Paediatric Society to assist paediatric health and social service providers have important and effective conversations regarding goals of care and appropriate treatments concerning paediatric population.
Rezaei MA, Zahiri A, Kianian T, et al. Factors related to patients' readiness for advance care planning: a systematic review. BMC Public Health. 2025; 25(78). DOI: doi.org/10.1186/s12889-024-21209-x	▪ A systematic review exploring the factors related to individual's readiness for advance care planning.

RECOMMENDATION 1.0:

The expert panel recommends that people are provided with decision aids to enhance participation in making informed decisions related to health screening and health-care treatment options.

Strength of the recommendation: Strong

Certainty of the evidence of effects: High

Decision aids are available for a wide range of health-care screening and treatment decisions. Using decision aids does not replace the ongoing dialogue and process of shared decision- making involving a health provider engaging in a therapeutic relationship with people making decisions about their care. Decision aids do not exist for every health-care decision faced by people today nor are they well suited for every individual. In the absence of a validated decision aid tool, the health provider is to proceed with the shared decision-making process to support people in making health-care screening and treatment decisions. Where no specific decision aid exists, health providers and people making health-care decisions can use decision-making guides (see **Supporting resources** below). Decision-making guides can help people identify a decision and work through the steps of what they already know about the decision, what needs clarification, and how to plan the next steps. These guides differ from (patient) decision aids because they do not meet all of the qualifying criteria from the International Patient Decision Aid Standards (IPDAS), which are required to be called a (patient) decision aid (140).

Discussion of evidence:

A key element of a people-centred care approach includes the integration of shared decision-making processes between health providers and people receiving health-care services (118) (Refer to **Good practice statement 2.0** for detailed guidance on shared decision-making). Substitute decision makers (chosen family members, power of attorney, etc.) may also be called upon to make these decisions for someone who is unable to do so. Decisions regarding health screening or health-care treatments can be "preference sensitive" because there can be multiple options (choices), including the option of not making a change (i.e., keeping the status quo), some of which have insufficient evidence related to their outcomes (141). The use of decision aids is one way to support the shared decision-making process between health providers and people with respect to health screening and/or health-care treatment options.

For the purpose of the BPG, decision aids are people-centred tools that support people in making informed health-care decisions. Decision aids clearly identify the health-care decisions to be made, provide evidence-based information regarding screening or treatment options, provide information on the associated benefits and harms for each option and elucidate personal values and preferences (141). Decision aids offer a process that can help guide people to make decisions when there is more than one option, including no change (141). This is different from health education materials, which provide people with general information about their diagnosis, treatment and its management, but do not focus on decision-making or facilitate the decision-making process (141). Decision aids come in a range of formats, such as paper-based, web-based, computer-based (or a combination of audio, computer

and computer/web), video or scripts. See **Supporting resources** below for more information about decision aids, including links to the Ottawa Hospital Research Institute's Patient Decision Aids Research Group and the National Institute for Health and Care Excellence (NICE), which house databases of decision aids that are freely accessible and downloadable. See also **Appendix M** for a template of a decision aid that can be used for people making any health or social decision.

Regardless of the format, the goal of a decision aid is to support and enhance consultations and discussions with health providers, not replace them (141). For this recommendation, the intervention of interest was the provision of decision aids by health providers to people receiving care, enabling them to actively participate in decisions related to health screening or health-care treatment options. This approach was compared to usual care, where decisions are usually made through standard decision-making processes without the use of decision aid tools.

Benefits and harms

There was one large systematic review of 209 **randomized controlled trials**[G] (RCTs) included for this recommendation (141). The interventions in the primary RCTs included a range of decision aids used for screening a variety of health conditions (e.g., cancer prevention screening) and medical and/or surgical treatment options(141). The decision aids were accessible through a variety of formats such as paper-based, web-based or computer program (or a combination of audio, video and computer/web-based), video or scripts (141). The population included adults 18 years of age or older, adults acting as substitute decision makers for children (e.g., parents), or adults who were unable to participate in decision-making due to their health condition. The comparator groups across the RCTs consisted of usual care, including general information, assessment of risk, clinical practice guideline summaries created for health consumers, information on a different topic area (i.e., placebo intervention) or no intervention. For further details about the intervention noted in the literature, please refer to the **Implementation tips** below.

Table 5 below provides a summary of the outcomes assessed in Stacey et al.'s 2024 systematic review, as well as the effectiveness of decision aids (compared to usual care) on those outcomes as reported across RCTs. Overall, decision aids probably helped more adults reach informed values-congruent choices, led to moderate increases in knowledge and accurate risk perceptions, and a small increase in satisfaction with the decision-making process. When people used a decision aid, there was a moderate increase in feeling informed and a small increase in feeling clear about their personal values. Although there was a small (1.5 minute) increase in consultation length when a decision aid was used, when the decision aid was provided prior to the consultation, there was a slight decrease in consultation length. There was no difference in shared participation in decision-making; however, there was a moderate decrease in physician-controlled decision-making, and a small increase in participant-controlled decision-making. There was also a small decrease in decisional regret.

Table 5: Summary of outcomes and results from the systematic review.

OUTCOME	NO. OF RCTS REPORTING ON THE OUTCOME	DIRECTION AND SIZE OF THE EFFECT
Informed values – choice congruence Congruence between the chosen option and the informed person's values (141).	21	There was a moderate increase in informed values – choice congruence when decision aids were used, compared to usual care. For every 100 people who use decision aids with a health provider, 23 more will experience congruence between their chosen option and their values when making health screening or treatment decisions (the range is from 13 more to 36 more).
Knowledge The knowledge of the person using the decision aid about benefits/harms of the screening or treatment options. This was standardized on a scale from 0 (no knowledge) to 100 (perfect knowledge) (141).	107	Compared to usual care, there was a moderate increase in people's knowledge about the benefits/harms of screening or treatment options with the use of a decision aid.
Accurate risk perception How much the person understands the perceived probabilities of an outcome (141).	25	For every 100 people who use decision aids with a health provider, 26 more people will experience accurate risk perception when making health screening or treatment decisions (the range is 16 more to 38 more).

OUTCOME	NO. OF RCTS REPORTING ON THE OUTCOME	DIRECTION AND SIZE OF THE EFFECT
Decisional conflict – feeling uninformed subscale Person using the decision aid feels uninformed. This is standardized on a scale from 0 (informed) to 100 (uninformed) (141).	58	There was a moderate decrease in people feeling uninformed when a decision aid was used, compared to usual care.
Decisional conflict – unclear about personal values subscale Person using the decision aid feels unclear about their personal values. This is a standardized form on a scale from 0 (clear) to 100 (unclear) (141).	55	There was a small decrease in people feeling unclear about their personal values when a decision aid was used, compared to usual care.
Participation in decision-making: clinician- controlled Person using the decision aid indicates a passive role in decision-making, where the decision is primarily made by the clinician (141).	21	There is a moderate decrease in the number of people who play a passive role in making decisions when a decision aid was used, compared to usual care. For every 100 people who use decision aids with a health provider, 4 fewer people will experience a clinician-controlled decision-making process when making health screening or treatment decisions (the range is 7 fewer to 0 fewer).

OUTCOME	NO. OF RCTS REPORTING ON THE OUTCOME	DIRECTION AND SIZE OF THE EFFECT
Participation in decision-making: participant- controlled Person using the decision aid is actively involved in decision-making (141).	20	There is a small increase in the number of people who are actively involved in decision-making when a decision aid was used, compared to usual care. For every 100 people who use a decision aid with a health provider, 10 more people will experience participant-controlled participation in decision-making when making health screening or treatment decisions (the range is 2 more to 24 more).
Participation in decision-making: shared participation There was shared participation in the decision-making process between the person and provider (141).	23	There was no difference in shared participation between the person and provider in decision-making compared to usual care. For every 100 people who use decision aids with a health provider, 1 more individual will experience participant-clinician shared participation in decision making when making health screening or treatment decisions (the range is 4 fewer to 3 more).
Consultation length (time in minutes) Length of time the consultation lasted, as reported by the provider (141).	8 *Decision aid provided *during* consultation	There was a slight increase in consultation time when a decision aid was used, compared to usual care.
	5 *Decision aid used *to prepare for* consultation	There was a slight reduction in consultation time when a decision aid was used, compared to usual care.

OUTCOME	NO. OF RCTS REPORTING ON THE OUTCOME	DIRECTION AND SIZE OF THE EFFECT
Satisfaction in decision-making process Person reported satisfaction in decision-making process. Multiple scales were used to assess satisfaction, with higher scores indicating greater satisfaction (141).	12	There was a small increase in people's satisfaction in the decision-making process when decision aids were used compared to usual care.
Decision regret The amount of regret about the health screening or treatment decision(s) made that the person using the decision aid experienced. This was measured using a standardized scale with higher scores indicating lower satisfaction with the decision (141).	22	There was a small decrease in decision regret when people used a decision aid, compared to usual care.

There were no harms reported in the studies.

The overall certainty of the evidence for these outcomes was high. There were no concerns about study methodology (i.e., risk of bias), inconsistency, imprecision, indirectness or publication bias. The expert panel was confident that the desirable effects of using decision aids to facilitate involvement of people in decision-making outweighed the undesirable effects. There was reasonable confidence in the limited variability in the values and preferences for people.

For more detailed information on the impact of using decision aids to enhance participation in making health screening and health-care treatment options on the core outcomes, refer to the evidence profiles under the "methodology documents" tab on the BPG webpage.

Values and preferences

There were no values and/or preferences noted by the expert panel or identified in the systematic review.

Health equity

From the systematic review evidence

- Using decision aids can be beneficial for equity- deserving populations (e.g., those with limited health literacy, lower socioeconomic status, racial/ethnic minorities). When decision aids are written in plain language and tailored to people's unique information and support needs, decision aids result in greater knowledge improvements (142), providing people with access to information in a manner that enables them to determine whether the therapeutic choices align with their values and preferences (143,144). However, there is a need for more culturally relevant decision aids to engage equity-deserving populations (144,145).

From the expert panel

- Professional language translation support and/or culturally specific support may be required to use a decision aid.
- Decision aids may include care and treatment options for treatments/resources that are not readily available in rural areas or might not be affordable to the person. Efforts should be made to find equivalent, relevant and acceptable treatment options and resources.

Expert panel justification of recommendation

The expert panel noted that there are benefits for people who use decision aids with health providers to enhance their participation in making informed decisions about health screening and treatment options. No harms were reported in the literature. The certainty of the evidence is high. Therefore, the expert panel determined the strength of the recommendation to be strong.

Implementation tips

Implementation tips from the expert panel

For the health provider

- Health providers/teams play an important role in facilitating a shared decision-making process, and this is not replaced by the use of a decision aid alone.
- Decision aids may not be appropriate in certain circumstances, for example if there is a language barrier or cognitive impairment. If there is a language barrier, health providers can find out whether the decision aid is available in another language.
- For strategies to tailor decision aids for people with low health literacy and other equity-deserving populations, see **Supporting resources** below.
- The timing of when a decision aid is used may be provider/context dependent. For example, they can be reviewed by people before consultation with a health provider, or the person and health provider can review the decision aid together during consultation. By providing the decision aid prior to a visit, people will have time to reflect on their values, preferences and beliefs, and can identify questions and concerns that can be addressed by their health provider during the visit.
- Although the use of decision aids may increase the length of time health providers initially spend with people, the length of time spent during subsequent visits will likely decrease. The use of decision aids may facilitate explanations, education and discussions during the first encounter, so the patient is not left missing information or being concerned about making the "right" decision.

- People need sufficient time to make informed decisions about screening and treatment options; therefore, ensure individuals have the time and support they require to use the decision aid.
- Some people/cultures may believe that the health provider is the expert, leading them to prefer that the provider make decisions on their behalf. In these circumstances, health providers can explore the individual's values, beliefs and preferences and reasons for not wanting to make decisions about their options.
- If flexibility is allowed for people to change their decision(s) when using a decision aid, the health provider/team can follow up to ensure the person understands the benefits and harms of the updated decision and that the decision aligns with the person's needs and preferences.
- Follow-up after an initial treatment decision is made (and throughout the implementation period of the decision) should be done by the health provider/team. For example, if the person making the decision feels pressured by their chosen family's preferences, then the provider can follow up with the person when they are alone and ask if they are in agreement with the decision(s) made.
- Frontline staff have many competing priorities; therefore, implementation is a collaborative effort, and roles and responsibilities of each individual involved should be clearly communicated and explained.

Implementation context and details from the evidence

- To implement a decision aid the *Patient Decision Aids Research Group* from the Ottawa Hospital Research Institute suggests the following steps:
  - Identify the decisions to be made (from the perspective of people, providers and health services);
  - Find and review decision aid(s);
  - Identify barriers to using decision aids (e.g., is the barrier specific to the decision aid or specific to people/health providers?) and explore how to overcome these barriers;
  - Provide training and education for health providers to use decision aids and subsequently implement the decision aid; and
  - Monitor the use of decision aids, including person-related outcomes (146).
  - Health providers receive education on shared decision-making, risk communication, and some type of coaching (individual coaching for physicians) before using a decision aid tool in clinical trials (147–149).
  - Decision coaching is one method used to educate people on decision aids and develop their skills in thinking about various screening and health-care options, understanding and using the evidence that is presented, preparing them to have discussions with their health provider(s) and implementing their decisions (150).
  - To facilitate people-centred counselling using a decision aid about birth control options, health providers reported using the decision aid to improve how they initiated the counselling process, integrated people's preferences into the counselling discussion, facilitated participants knowledge uptake and informed their responses to specific questions related to the decision-making options (151).
  - Adoption of decision aids may temporarily increase and then decrease consultation time, as a provider's skill at using decision aids improves over time. With more opportunities to use decision aids and changes to workplace processes, clinicians become more adept with their use of decision aids as they implement them into their everyday practice (152,153).

Supporting resources

RESOURCE	DESCRIPTION
Muscat DM, Smith J, Mac O, Cadet T, Giguere A, Housten AJ, et al. Addressing health literacy in patient decision aids: An update from the International Patient Decision Aid Standards. Med Decis Making. 2021 Oct;41(7):848–69. DOI: 10.1177/0272989X211011101	▪ Outlines a variety of strategies to tailor decision aids for people with low health literacy and other equity-deserving populations ▪ Examples include: assessment of readability of decision aid; designing decision aids at a reading level of ≤ grade 8; following criteria outlined in the International Patient Decision Aid Standards (IPDAS).
National Institute for Health and Care Excellence (NICE). Patient decision aids [Internet]. Manchester (ENG): NICE; 2025. Available from: https://www.nice.org.uk/about/nice-communities/nice-and-the-public/making-decisions-about-your-care/patient-decision-aids	▪ Provides a library of patient decision aids, organized by condition. ▪ Provides a guide that outlines how patient decision aids are developed by NICE
The Ottawa Hospital Research Institute. Patient Decision Aids Research Group [Internet]. Ottawa (ON): The Ottawa Hospital; 2024 May 10. Available from: https://decisionaid.ohri.ca/index.html	▪ The Ottawa Hospital Research Unit houses a database of (patient) decision aids that meet the International Patient Decision Aids Standards (IPDAS). ▪ Searchable by using an A-to-Z inventory ▪ Available in multiple languages
The Ottawa Hospital Research Institute. Decision Guides (mostly for any decision) [Internet]. Ottawa (ON): The Ottawa Hospital Research Institute; 2025 May 2. Available from: https://decisionaid.ohri.ca/decguide.html	▪ Link to templates of personal decisional guides that can be downloaded by individuals and used to identify a decision, reflect on what they know about it, clarify what matters most, and plan next steps. ▪ The guides can be used for health or social related decision-making. ▪ Multiple languages available
The Ottawa Hospital Research Institute. Patient Decision Aids Research Group: Implementation toolkit [Internet]. Ottawa (ON): The Ottawa Hospital; 2022 October 19. Available from: https://decisionaid.ohri.ca/implement.html	▪ Implementation toolkit from the Decision Aids Research Group at the Ottawa Hospital Research Institute that supports implementation of decision aids into clinical practice

RESOURCE	DESCRIPTION
The Ottawa Hospital Research Institute. Decision coaching [Internet]. Ottawa (ON): The Ottawa Hospital; 2024 August 21. Available from: https://decisionaid.ohri.ca/coaching.html	▪ Resources to enhance the quality of decision coaching, including a script to standardize how coaching is provided to people, videos demonstrating decision coaching, guidance for effective communication skills, and a framework for decision coach-mediated shared decision-making.
YouTube n.d. https://www.youtube.com/watch?v=wH8M-WnPsEA&ab_channel=ACSQHC (accessed December 12, 2024). Available from: Shared decision making: patient decision aids	▪ Australian Commission on Safety and Quality in Health Care video outlining the purpose of decision aids and how they can be used to support shared decision-making

Plan of Care

GOOD PRACTICE STATEMENT 4.0: PLAN OF CARE

It is good practice for health and social service providers to collaboratively develop a plan of care with people that reflects their values, beliefs, goals, needs, attitudes, and preferences.

A plan of care is a people-centred health document used by health and/or social service providers to facilitate communication, reflect people's stated values, beliefs and preferences, meet people's short and long-term goals, and support holistic care across programs, organizations and sectors (154,155). It is an essential tool to easily convey information pertaining to people's clinical information, medication reconciliation, and any coordination between various health and service providers. Typically, elements of the plan of care include:

- person identifiers (e.g., preferred name, preferred pronouns, etc)
- medical and social history
- person's cultural needs
- the person's priorities/concerns, goals (e.g., what is most important right now), preferences in care, and an action plan related to the goals
- strengths or supports that can be built on
- who is on the care team (including chosen family, caregivers, others in non-professional roles), and what are the team's roles, responsibilities and goals
- health-care consent and advance care planning (e.g., who is the substitute decision maker)
- the conditions/issues and diagnoses affecting the person
- social determinants of health (e.g., income, employment, housing, food security, social network, health knowledge, etc.)
- medication reconciliation
- any education provided by the health and/or social service provider to people that pertains to their condition(s), treatment(s) and/or self-management (154,155)

See **Supporting resources** below for a link to a plan of care template developed by Ontario Health (formerly Health Quality Ontario).

The plan of care is developed in collaboration with providers and people (155). Through a co-created process that promotes mutual understanding, autonomy and shared responsibility for care, the person becomes a full and active participant in developing and monitoring the plan of care (154). This participation in shared decision-making (see **Good practice statement 2.0**) increases engagement and enables health and social service providers to gain a better understanding of the person's values and preferences with respect to life, health and health care (154). Therefore, it is good practice to develop and implement a plan of care with people and their chosen families that reflects the person's stated values, beliefs, goals, needs and preferences (36,117,156). The expert panel felt that it was necessary to communicate this good practice statement, but that it was not necessary to conduct a systematic review of the literature.

An example of the importance of developing and implementing a plan of care using a people-centred lens is care coordination. When coordinating care, a goal-directed and personalized care plan is created in collaboration with health and social service providers and the person receiving care. The care coordinator identifies the person's goals, values and preferences from the beginning and aligns resources and services accordingly (110,157). Understanding of family and/or caregiver involvement, including their role, capacity, abilities, and any challenge faced (or predicted to encounter) is also identified. Because care coordination can be provided over a long period of time, the plan of care becomes an essential living document to monitor progress (as identified from both the person and provider), identify gaps in care, re-assess the person's health and well-being (particularly after interventions are implemented), and continuously monitor and evaluate the effectiveness of the plan of care (157). For a detailed list of people-centred activities and elements that are integral to care coordination, see **Appendix E**.

Steps for implementing a plan of care and templates for creating a plan of care, can be found in the **Supporting resources**.

Implementation tips

Implementation tips from the expert panel

For the health and social service provider

- Developing a plan of care involves the person receiving care, their chosen family and/or caregiver(s) and all health and social service providers that are involved in the person's circle of care.
- It is important to take an individualized approach when creating a plan of care, and to recognize that some people will want to review their plan of care continuously, while others will not. Factors that influence a desire to review can include a new diagnosis, exacerbation of illness, pain, personality, dementia, and disease progression. Asking the person for their desired level of involvement, degree and frequency is essential. The level of involvement should be re-evaluated because an individual's decision may change over time.
- Some people may not want to share information or collaborate in the development of the plan of care, while others may not be able to (e.g., due to cognitive decline or altered levels of consciousness). It is important for health and social service providers to meet people where they are at and respect their desired level of involvement and/or their capabilities.
- Providers need to take the time to listen to and talk with the person about what they really want. It takes time for information to come out; however, by setting aside enough time at the beginning of the relationship to establish a therapeutic alliance (see **Good practice statement 1.0**), less time will be required for subsequent meetings.
- It is also essential to take the time to listen to and talk with families and/or caregiver(s) the person receiving care deems important, as they can provide unique knowledge about the needs and preferences of the person receiving care, and play a role in the implementation of the plan of care.
- Use the person's own description of their needs.
- It is important to use a strengths-based approach when developing a plan of care. Focus on the person's inherent strengths, recognize personal or community resources that can support their wellness and healing journey, and set and measure clear and achievable goals that align with the person's strengths, values, beliefs, goals and preferences (158).
- Plans of care can also include other elements, such as the person's hobbies or interests. This allows health and social service providers to obtain a more holistic view of the person, including what is important to them.
- Pay attention to non-verbal cues; it is not only about what the person says, but what they do not say.
- Use standardized processes and/or validated tools to create, review and update the plan of care, and to improve communication and coordination among health and social service providers across settings.

- Document the plan of care as soon as possible in an electronic health record (if available), which is visible across professions and encounters.
- Note that depending on the health or social service organization, a plan of care might not be its own standalone document; rather, it is something that might be integrated within existing documentation.
- Make the plan of care readily available to the person/chosen family and the health and/or social service providers included in the circle of care.
- When information is transferred from one health or social service provider to another, ensure a clear hand-over process/standardized transfer of accountability.
- Ensure that information within the plan of care is effectively communicated among the person, chosen family/caregiver(s) and health and social service providers within the circle of care to avoid people having to re-share or re-communicate information that was already obtained.
- Similarly, health and social service providers need to advocate that a person's plan of care is adhered to as closely as possible (e.g., goals of care, wishes, etc.).
- Consider and document other agreements (e.g., Form 1) in the plans of care.

For the health and social service organization

- It is important for health and social service organizations to create a safe and caring environment that allows health and social service providers to truly get to know the person.
- Develop organizational structures and policies to support the implementation of collaborative care plans into practice, through electronic health records (when feasible), standardized assessment and documentation processes and education for health and social service providers about the importance of the plan of care.

Implementation tips from the literature

- The plan of care is a living document; it should be reviewed and updated on a regular basis, particularly when the person's status changes and/or they request to change it (155).
- Refer to the plan of care when managing and treating people. Any changes in treatment or a person's status should be documented (154).
- Every user of the plan of care (i.e., health and social service provider, organization) has the responsibility to obtain necessary consent from people before sharing information noted in the plan of care (154) or when consulting other providers (155). It should be standard procedure that consent forms are signed before information is released (154).

Supporting resources

RESOURCE	DESCRIPTION
Agency for Healthcare Research and Quality (AHRQ). Develop a shared care plan [Internet]. Rockville (MD): AHRQ; 2024. Available from: https://integrationacademy.ahrq.gov/products/playbooks/behavioral-health-and-primary-care/implementing-plan/develop-shared-care-plan	▪ Provides a description of what a shared care plan is, outlines tools to develop it, and provides guidance on how to implement the plan in practice.
Health Quality Ontario (HQO). Coordinated care plan user guide version 2.1 [Internet]. Toronto (ON): HQO; 2018, June 12. Available from: https://www.hqontario.ca/Portals/0/documents/qi/health-links/ccm-coordinated-care-plan-user-guide-v2.1-en.pdf	▪ Describes how the plan of care is intended to be used, and the purpose of each field. ▪ Includes thorough template with explanation and examples of each field.
NHS Tees, Esk and Wear Valleys NHS Foundation Trust. Co-creation framework: A shared document setting out co-creation and our values. Darlington (UK): NHS; December 2024. Available from: https://www.tewv.nhs.uk/wp-content/uploads/2025/03/Co-creation-framework-2025.pdf	▪ Provides an overview of what co-creation is and a framework for adopting a co-creation approach.
Registered Nurses' of Ontario (RNAO). Transitions in Care and Services [Internet]. Toronto (ON): RNAO; 2023. Available from: https://rnao.ca/bpg/guidelines/transitions-in-care	▪ Provides a good practice statement regarding collaborating with people and their support network to develop a care plan before, during and after a transition in care to ensure health information and care needs are transferred between health and social service providers accordingly. ▪ Provides implementation tips and supporting resources for creating and documenting plans of care.

Health-care environments: Noise and lights

RECOMMENDATION 2.0:

The expert panel suggests that people are provided with eye masks and/or earplugs as a sensory-minimizing strategy according to the needs and preferences of the person.

Strength of the recommendation: Conditional

Certainty of the evidence of effects: Very low

Discussion of evidence:

Physical environments of health-care settings may affect the health and comfort of people (159). Environmental stimuli, such as noise and light, may cause negative stress. The reaction to the stressor depends on the importance of the stressor to the person, duration of exposure and degree of control, demographics of the person, physiological characteristics, social aspects, and previous experiences and exposures (159). Health-care settings (e.g., hospitals) are complex buildings that include various specialty areas that support different functions (e.g., in-patient care, treatment, diagnostics, and supporting facilities) (159). With the movement towards a people-centred approach to care, the architectural design of health-care settings has also moved towards building health-care structures that promote health and well-being (160). Some examples of these include the use of nature, music, or lighting to decrease people's anxiety or increase sleep quality.

Health and social service providers may have different needs in physical health-care environments compared to people receiving care (e.g., health and social service providers need bright lighting to conduct physical assessments). Consequently, the needs of people receiving care may conflict with the needs of health and social service providers (159). Although it is important to consider the needs of health and social service providers within the physical health-care environment, health and social service providers must also consider what sensory-minimizing strategies can be used to decrease environmental stimuli that may cause stress to people receiving care.

For the purposes of this BPG, a sensory-minimizing strategy refers to a non-pharmacological method to decrease potential ambient stressors for people in health-care settings. An ambient stressor is a type of environmental stressor that is a continuous characteristic in the background of the physical environment (e.g., fluorescent lighting, noise from ventilator machines) (161). Many sensory-minimizing strategies are utilized in health-care settings. For the purposes of this guideline a decision was made, for feasibility reasons, to focus on examining the effectiveness of eye masks and earplugs. For this recommendation, the intervention of interest was sensory-minimizing strategies that address light or noise to facilitate people-centred care. The intervention was compared to usual care or no sensory-minimizing strategies.

Benefits and harms

There were four RCTs, one non-randomized control and two systematic reviews included for this recommendation (162–168). The types of interventions included eye masks and earplugs. These studies took place in the intensive care unit (ICU), neonatal ICU (NICU), cardiothoracic ICU, neurotrauma ICU, surgical ICU and cardiothoracic post-anesthetic care unit (PACU). The populations who received these interventions included adults and pre-term or very low birth weight infants. Even though the included studies were conducted in the ICU, NICU and PACU, the expert panel felt that it is likely that eye masks and earplugs can be used by people in other settings as well, when appropriate. For further details of the interventions noted in the literature, please refer to the **Implementation tips** below.

Table 6 provides a summary of the outcomes, as well as the effectiveness of eye masks and earplugs on those outcomes as reported across studies. Overall, eye masks and/or earplugs may improve total sleep time, delirium rates and systolic blood pressure for adults in the ICU, however there was inconsistency in whether eye masks and/or earplugs have an effect on diastolic blood pressure and heart rate for adults in the ICU. A modest improvement in height and weight and a small decrease in heart rate and blood pressure was found when earplugs were worn by preterm or very low birth weight infants in the NICU. It is uncertain if the use of eye masks and/or earplugs will reduce the length of stay in the adult ICU and NICU. For more detailed information regarding the impact of using sensory-minimizing strategies in specific health-care settings, and the quality assessment, effect size and certainty of the evidence for each prioritized outcome, refer to the evidence profiles under the "methodology documents" tab of the BPG webpage.

Table 6: Summary of outcomes and results from the systematic review.

INTERVENTION	NO. OF STUDIES	SETTING	OUTCOME	DIRECTION AND SIZE OF EFFECT
Earplugs and/or eye masks	1 Cochrane review (2 RCTs included) (162)	Adult ICU	Total sleep time (hours)	There was a small increase in sleep time when earplugs and/or eye masks are used, but the evidence is very uncertain.
Earplugs and/or eye masks	1 Cochrane review (2 RCTs) (162)	Adult ICU	Delirium Measured by Neelon and Champagne Confusion Scale and yes/no occurrence of delirium	There was a moderate decrease in the incidence of delirium when earplugs and/or eye masks are used. For every 100 people who receive an eye mask and/or ear plugs to mitigate light or sound in the ICU setting to facilitate people-centred care, 22 fewer people will experience delirium in the ICU (ranges from 30 fewer to 10 fewer).

INTERVENTION	NO. OF STUDIES	SETTING	OUTCOME	DIRECTION AND SIZE OF EFFECT
Earplugs and/or eye masks	2 RCTs (165,166)	Adult ICU and CICU	Heart Rate (beats per minute)	Although one study showed a moderate decrease in heart rate when people wore earplugs and/or eye masks, a second study showed a small increase in heart rate when earplugs and/or eye masks were used.
Earplugs and/or eye masks	2 RCTs (165,166)	Adult ICU and CICU	Systolic blood pressure (mmHg)	There was a moderate decrease in systolic blood pressure when people wore earplugs and/or eye masks at night.
Earplugs and/or eye masks	2 RCTs (165,166)	Adult ICU and CICU	Diastolic blood pressure (mmHg)	Although one study showed a small decrease in diastolic blood pressure when people wore earplugs and/ or eye masks, a second study showed a small increase in diastolic blood pressure.
Earplugs	1 non-randomized control (167)	Preterm infants in NICU	Heart rate (beats per minute)	There was a moderate decrease in heart rate when infants wore earplugs in the NICU.
Earplugs	1 non-randomized control (167)	Preterm infants in NICU	Systolic blood pressure (mmHg)	There was a small decrease in systolic blood pressure when infants wore earplugs in the NICU.

INTERVENTION	NO. OF STUDIES	SETTING	OUTCOME	DIRECTION AND SIZE OF EFFECT
Ear plugs	1 non-randomized control (167)	Preterm infants in NICU	Diastolic blood pressure (mmHg)	There was a small decrease in diastolic blood pressure when infants wore earplugs in the NICU.
Earplugs and/or eye masks	1 RCT (164)	Adult ICU	Length of stay in the ICU (hours)	There was a moderate increase in the length of stay in an adult ICU when earplugs and/or eye masks were used compared to usual care, but the evidence is very uncertain.
Earplugs	1 RCT (163)	Post anesthetic cardio-thoracic unit (C-PACU)	Length of stay (days)	There was a moderate decrease in the length of stay in the hospital following surgery compared to usual care, but the evidence is very uncertain.
Earplugs	1 Cochrane review (1 RCT) (168)	NICU	Length of stay in the NICU (days)	There was a moderate increase in the length of stay of infants who wore ear plugs in the NICU, compared to usual care, but the evidence is very uncertain.
Earplugs	1 RCT (163)	Post anesthetic cardio-thoracic unit (C-PACU)	Satisfaction with overall care Measured on a 1(excellent) to 5 (very poor) Likert scale	There was no difference in satisfaction with overall care reported among adults who wore earplugs compared to usual care, but the evidence is very uncertain.

INTERVENTION	NO. OF STUDIES	SETTING	OUTCOME	DIRECTION AND SIZE OF EFFECT
Earplugs	1 Cochrane review (1 RCT) (168)	Preterm or very low birth weight infants in the NICU	Height (cm)	There may be a small increase in height in 18-22 month-old (corrected age) infants who wear earplugs in the NICU, but the evidence is very uncertain.
Earplugs	1 Cochrane review (1 RCT) (168)	Preterm or very low birth weight infants in the NICU	Weight (g)	There may be a small increase in weight in 18-22 month-old (corrected age) infants who wear earplugs in the NICU, but the evidence is very uncertain.
Earplugs	1 Cochrane review (1 RCT) (168)	Pre-term or very low birth weight infants in the NICU	Weight (g) at 34 weeks post menstrual age	There may be a small increase in weight in pre-term or very low birth weight infants who wear earplugs, but the evidence is very uncertain.

No harms were reported in the literature.

The overall certainty of the evidence for earplugs and eye masks was rated as very low due to serious risk of bias for most studies, inconsistency in the direction of effect for three outcomes, and very serious to extremely serious imprecision for most studies. Because of this uncertainty, people should be given the option to choose if they would like a sensory-minimizing strategy, depending on their needs and preferences.

Values and preferences

From the systematic review evidence:

Values

- One study reported on the values people place on health outcomes derived from using sensory-minimizing strategies. The study noted that people sleeping in the post anesthetic cardiothoracic unit (C-PACU) setting with earplugs reported better quality of sleep in their own self-assessment compared to nurses objectively assessing people's sleep (according to polysomnographic findings, total sleep time, and number of awakenings). Therefore, evaluation of sleep quality by nurses may be inaccurate, and self-assessment of people's sleep quality is more reliable (163).

Health equity

From the systematic review evidence:

One study reported that earplugs and eye masks are inexpensive, easy-to-use nursing interventions that can be used in resource-limited settings (169).

Expert panel justification of recommendation

Despite the uncertainty in the evidence, the expert panel determined the strength of the recommendation to be conditional and noted that there may be benefits to using sensory-minimizing strategies, and no harms were reported. It is important to emphasize that people should be given the choice of sensory-minimizing strategy according to their preferences and individual sleep needs.

Implementation tips

Table 7: Implementation tips from the expert panel

CONSIDERATIONS	DETAILS
Using earplugs and/or eye masks	**For the health and social service provider** ▪ It is important to emphasize that people choose the type of sensory-minimizing strategies according to their preferences and individual sleep needs. ▪ Follow the manufacturer's instructions on how to properly wear earplugs and/or eye masks. ▪ Ensure that earplugs do not block all noises. People need to hear alarms or voices in case of emergencies (e.g., fire alarms or medical device alerts). ▪ Ensure that eye masks do not become tangled in tubing, such as oxygen tubing, intravenous tubing, electrode wires, etc. ▪ Vulnerable people (e.g., those with dementia, young children, those with developmental delays) who use earplugs may risk swallowing and/or choking on them. Observation is required. ▪ For people with a history of trauma, wearing eye masks may trigger distressing memories, especially if they associate such experiences with past traumatic events. ▪ For people with dementia, wearing eye masks may cause disorientation. The unfamiliar sensation or restricted vision can lead to increased confusion or anxiety. ▪ For people receiving treatment for acute psychosis or who have acute anxiety symptoms, offer earplugs and/or eye masks, but carefully monitor for adverse reactions.

CONSIDERATIONS	DETAILS
Using earplugs and/or eye masks (cont.)	▪ For people who cannot speak or require support to communicate, ensure there is a way for them to communicate if they wish to take off their eye mask and/or earplugs. Communication can include: ▫ nonverbal communication – body language, facial expressions, gestures or simple yes/no signals ▫ communication boards or picture cards ▫ assistive technology ▪ Health and social service providers can also consult with augmentative or alternative communication providers in these situations. **For health and social service organization** ▪ Health and social service organizations can have a variety of sensory-minimizing strategies available and offer them if people do not have their own and wish to use them. These can include eye coverings, ear muffs, headphones, etc. ▪ Earplugs and eye masks can be provided upon admission to the unit with an admission package. If that is not feasible, there can be a piece of paper saying that eye masks and/or ear plugs are available if people would like to have them.
Promoting healthy sound and lighting environments	▪ To avoid using earplugs and eye masks, health and social service providers and organizations can: ▪ Soundproof rooms: If possible, soundproof rooms through soft flooring materials, heavy curtains, sound-absorbing panels and/or acoustic ceiling tiles. ▪ Minimize unnecessary announcements and reduce noise levels from medical equipment: ▫ Reduce unnecessary or loud overhead paging and communicate with more localized paging systems or direct communication. ▫ Proper maintenance of equipment to prevent unnecessary mechanical noises (e.g., squeaky wheels, loud alarms), place equipment in hallways or nursing stations to limit noise in the patient care areas, turn off equipment if not needed, and set alarms to the appropriate parameters.

CONSIDERATIONS	DETAILS
Promoting healthy sound and lighting environments (cont.)	▪ Designate quiet hours and zones: Create designated quiet areas that people can access. Set specific periods during the day and night when noise is minimized. During these hours, health and social service providers can limit non-urgent tasks, reduce conversations, and ensure equipment noise is kept to a minimum (e.g., polishing floors in the early morning). ▪ Signage and guidelines: place signs in staff areas or hallways reminding everyone to be mindful of noise levels such as speaking at a lower volume and closing doors softly. Educate all staff on the importance of a quiet environment for recovery and well-being.
Home and community setting	▪ Health and social service providers are to remember that there may be ambient stressors that exist in the home or community setting; not all ambient stressors occur in the hospital or LTC facilities. E.g., bilevel-positive airway pressure (BiPAP) or continuous positive airway pressure (CPAP) machines will create ambient noise. Health and social service providers can suggest that people using a BiPAP or CPAP machine apply ear plugs to decrease noise if they cannot sleep well.

Table 8: Implementation context and details from the evidence

INTERVENTION	DETAILS FROM THE EVIDENCE
Earplugs and eye masks	▪ Earplugs and eye masks are typically used during regular night-time sleeping hours (162). ▪ Some people found using earplugs or eye masks uncomfortable; in these situations, health providers can offer alternatively designed earplugs or eye masks or can help people correctly apply them (162). ▪ Care may occur in multi-bed rooms within a health-care setting, resulting in more ambient noise. Earplugs can offer an easy solution to relieve people from elevated noise levels (163). ▪ There are different kinds of earplugs or eye masks. For example, single-use earplugs are made of paraffin wax, petroleum jelly and cotton wool. (163). ▪ Some types of earplugs may require teaching on how to shape the earplugs and insert them into the ear concha (162,170). ▪ When reporting on outcomes, such as quality of sleep, assessments should be obtained from both the person receiving care and the health /or social service provider.

Supporting resources

RESOURCE	DESCRIPTION
Hear Care Audiology. Safe ways to use earplugs while you sleep [Internet]. Kelowna (BC): Hear Care Audiology; 10 September, 2024. Available from: https://www.myhearcare.ca/hearing-loss-articles/safe-practices-for-using-earplugs-at-night/	▪ Provides information on how to correctly and safely use ear plugs, and how to choose the best earplugs.
National Institutes of Health. Hearing protection: How to use formable earplugs [video]. 16 December, 2019. Available from: https://www.youtube.com/watch?v=2eBpSctTXkY&ab_channel=NationalInstitutesofHealth%28NIH%29	▪ Video outlining how to correctly use foam (formable) earplugs

Virtual Care

GOOD PRACTICE STATEMENT 5.0: VIRTUAL CARE

Where virtual care can be offered as an alternative to in-person care, it is good practice for health and social service providers to determine appropriateness and modality based on people's care needs and preferences and to adjust as needs evolve.

People-centred care is fundamental to the care and services provided by health systems, organizations and interprofessional teams, and includes considering the person's unique needs and preferences (117). When people need or prefer to access health and social services virtually, it is good practice for health and social service organizations and providers to determine the appropriateness of **virtual care**[G] and the modality and to facilitate virtual care based on people's care needs and preferences. The expert panel felt that it was necessary to communicate this good practice statement, but that it was not necessary to conduct a systematic review of the literature. Virtual care refers to any interaction between people, health and social service providers and/or other members within the circle of care that occurs remotely, uses any form of communication or information technology, and aims to facilitate or maximize the quality and effectiveness of care (171). Virtual care can be either an approach to care or can refer to a single interaction that occurs between a provider and a person (172).

Different modalities can be used to participate in virtual care, including telephone (either landline or cellular), videoconferencing, or asynchronous communication (e.g., secure text messaging, emails, etc) (172). It is important to note that regardless of the modality used, organizations and health and social service providers need to ensure that the platforms are validated and meet appropriate security, privacy and confidentiality standards (173). To help organizations and providers identify virtual care solutions that are appropriate for clinical use and meet the standards, Ontario Health has created a list of verified vendor platforms (174).

To determine the appropriateness of virtual care and the modality to use, health and social service providers need to consider various factors. For example, the use of virtual care may depend on the unique clinical situation of the person, the capability of the provider, the capabilities and preferences of the person and/or their caregiver, and any guidance dictated by regulatory authorities (175). To align with the principles of people-centred care, the modality that people prefer should always be prioritized, unless there is a risk of harm (e.g., safety or breach of confidentiality) (175). For more details about the factors to consider, as well as the various modalities for virtual care, see Canada Health Infoway (2022) (175) *Providing safe and high-quality virtual care: A guide for new and experienced users.* A link can be found in the **Supporting resources** below.

Virtual care can support the continuum of care. For example, it has been found to support health-care needs remotely, streamline necessary health-care services, conserve medical resources, direct medical supplies on a priority basis, and provide telecommunication for visitor-person interactions (176). It can also enable improved chronic disease management, promote real-time person and provider engagement, and foster coordination between health-care teams (177). As a complement to in-person visits, virtual care can be instrumental in providing people-centred care. A 2023 systematic review assessed the impact of virtual care on people's experiences and outcomes during the COVID-19 pandemic (176). The authors found that virtual care was associated with positive person-reported responses, including:

- feelings of comfort while receiving care virtually
- feeling safe from COVID-19

- improved communication with health and social service providers
- convenience of virtual care
- saving time/money (i.e., transportation, traffic, gas and parking were minimized)
- improved access to care
- increased engagement in care
- comfort with technology/telehealth
- and not experiencing wait time delays (176)

Despite the benefits, some people did report feeling rushed during virtual appointments, disliked the lack of physical contact with the provider when a physical examination was required, reported technical challenges, and had difficulty trying to communicate symptoms or ask questions during a strict timeframe. Some also reported a preference for in-person care delivery (176). To ensure delivery of people-centred care, understanding the barriers or challenges of virtual care and how it can be optimized is crucial (176).

Barriers and challenges to virtual care also exist with respect to health equity and the social determinants of health. Not everyone has access to digital technologies or the knowledge and digital literacy skills to use technology to navigate virtual visits (177). Basic infrastructure can also be lacking in rural areas where broadband access is unreliable. Personal or private spaces where people can hold confidential conversations with health and social service providers may also not be feasible (177). Additional factors, such as language barriers, disabilities and cultural differences, can exacerbate the challenges people face when accessing or using virtual care (177). People should be provided with multiple options to connect with a health provider using a modality that is convenient and accessible to them, thereby not compromising the quality of care they receive.

Some of the aforementioned challenges are currently being addressed by providing people with locations in their community where they can access the required technology to engage in virtual care (e.g., community health centres), or providing the necessary technology through device-lending programs (178). To address issues with digital health literacy, education and support are being provided to people and providers, while non-digital access options (e.g., telephone, in-person) are being provided in addition to digital access options. The availability of translation services, along with technology platforms and information materials in various languages, also aims to improve access to virtual care in people's primary language (178).

Implementation tips

Implementation tips from the expert panel

For the health and social service provider

- In many settings virtual care is still a new practice. It is necessary to tailor this intervention to the setting, the context, the people receiving care, and the health and social service providers delivering care.
- Provide virtual care based on the needs and preferences of people, rather than the preferences of health and social service providers.
- Assess for the frequency of virtual care visits, taking into consideration the needs and preferences of people.
- Determine if people use digital technologies (e.g., personal cell phones, smart phone, smart watch, computer) in their daily life, as this can be an indication of their comfort level if and when they use virtual care technologies.

- Consider assessing for digital health literacy using a standardized tool (see **Supporting resources** below for access to available tools providers can use to assess people's digital health literacy).
- Consider having a trial period with virtual care technology, so people can identify and/or address any barriers they may encounter when using the technology.
- Consider health equity implications when using virtual care. For example, many people lack access to virtual technologies to engage in virtual care (e.g., limited data plans, limited internet, lack of devices, limited broadband service in remote areas).
- If there is a language barrier when using the virtual care platform, assess if the technology can be provided in another language or request a standardized translator if required.
- Conduct a comprehensive risk assessment when participating in a virtual care appointment. This is particularly relevant for equity-deserving populations, such as people living with mental health issues or substance use disorders. For example:
  - increased risk of intimate partner violence: give consideration to the heightened vulnerability of people who may experience domestic abuse or violence in their home environment, especially due to the lack of privacy during virtual care sessions.
  - crisis and escalation: anticipate scenarios when people may face a crisis or an escalation of their condition during a virtual care session. Accordingly, have access to the person's current address, phone number, and an emergency contact number to facilitate immediate response in case of emergencies.

For the health and social service organization

- Create policies and processes to ensure that privacy and risk assessments are embedded in virtual care interactions.
- To support equitable access, provide necessary tools and resources (e.g., internet connectivity, devices, digital literacy resources) to people or facilitate their access to these tools and resources.

Implementation tips from the literature

- Align the implementation of virtual care with national, territorial or provincial standards (e.g., Ontario Health standards) for virtual care and their approved platforms (173).
- Across most communities in Ontario, there are host Ontario Telemedicine Network (OTN) sites that are funded by Ontario Health to have Registered Nurses available to support appointments (178).
- Virtual care planning for equity-deserving populations should leverage community host sites available to support individuals who lack access to technology, who lack digital health literacy, who need help troubleshooting the virtual care platform, or simply require additional nursing support (178).
- The use of public libraries as telehealth hubs is being increasingly adopted, particularly in underserved and rural communities (179,180). Public libraries are often centrally located, easily accessible and offer resources (e.g., broadband internet service, computers, etc.) that individuals may not have access to at home (166). See **Supporting resources** below for the Health Canada's principle-based recommendations for equity with the goal of enhancing equitable access to virtual care.
- Send users a questionnaire to assess the experience of people and health and social service providers using virtual care technologies. These questionnaires should examine health outcomes related to virtual care (e.g., concerns

about quality of care, missed information, accessibility, appropriateness of care), and the experience of the provider (e.g., do they feel limited in their assessments?) (175).

- Health and social service providers need to assess the appropriateness for virtual care because certain circumstances may not be conducive to its use (173). For example, health and social service providers cannot assess or diagnose certain conditions in a virtual environment. However, situations typically suited for virtual care include:
  - assessment and treatment of mental health issues, skin issues, minor infections
  - sexual health care (e.g., screening/treatment for sexually transmitted infections)
  - well-child visits
  - prenatal care
  - travel medicine
  - assessment and treatment of conditions monitored with remote devices and/or laboratory tests
  - review of laboratory, imaging and consult reports
  - follow-up visits for chronic conditions
  - other assessments that do not require in-person physical examinations
  - triage to rule out concerns and determine appropriate modality/time frame for definitive diagnosis (175)

Supporting resources

RESOURCE	DESCRIPTION
Canada Health Infoway. *Providing safe and high-quality virtual care: A guide for new and experienced users. Clinician change virtual care toolkit. Version 1.* Toronto (ON): Canada Health Infoway; May 2022. Available from: https://www.infoway-inforoute.ca/en/component/edocman/6378-clinician-change-virtual-care-toolkit/view-document?Itemid=103	▪ Toolkit that provides information and resources to support health and social service providers deliver safe, high-quality virtual care. ▪ Includes sections on person and caregiver considerations when making decisions about using virtual care
Faux-Nightingale A, Philp F, Chadwick D, et al. (2022). Available tools to evaluate digital health literacy and engagement with eHealth resources: A scoping review. Heliyon [Internet]. 8(8), e10380. Available from: https://pubmed.ncbi.nlm.nih.gov/36090207/	▪ This scoping review assesses available tools that can be used by health and social service providers to evaluate digital health literacy.

RESOURCE	DESCRIPTION
Health Canada. Enhancing equitable access to virtual care in Canada: principle-based recommendations for equity. Ottawa (ON): Health Canada; 2022 March 30. Available from: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/bilateral-agreement-pan-canadian-virtual-care-priorities-covid-19/enhancing-access-principle-based-recommendations-equity.html	▪ A principle-based framework for equitable access to virtual care ▪ Provides guidance and recommendations on concrete actions various levels of government can take to ensure equity in virtual care
Healthcare Excellence Canada (HEC). Promising practices for enabling aging in place. Ottawa (ON): HEC; 2025. Available from: https://healthcareexcellence.ca/en/what-we-do/all-programs/enabling-aging-in-place/promising-practices-for-enabling-aging-in-place/	▪ Outlines 11 programs across Canada created to help older adults age in place (in the community) with formal supports ▪ The programs aim to: ▫ decrease barriers with system navigation ▫ decrease financial barriers ▫ increase responsiveness of services and health and social service providers ▫ increase access for specialized services ▫ create a connected community
National Institute for Health and Care Excellence (NICE). Behaviour change: digital and mobile health interventions [Internet]. NICE; 2020. Available from: https://www.nice.org.uk/guidance/NG183	▪ This guideline covers interventions that use a digital or mobile platform, including those delivered by text message, apps, wearable devices or the internet. ▪ Includes recommendations related to conducting an assessment prior to using digital and mobile health technologies
Norman CD, Skinner HA. eHEALS: The eHealth literacy scale. J Med Internet Res [Internet]. 2006; 8(4). Available from: https://pubmed.ncbi.nlm.nih.gov/17213046/	▪ The eHEALS is an eight-item measure of eHealth literacy developed to measure consumers' combined knowledge, comfort, and perceived skills at finding, evaluating, and applying electronic health information to health problems (Norman & Skinner, 2006). ▪ **Note:** this article is older than ten years but is considered a germinal article.

RESOURCE	DESCRIPTION
Registered Nurses' Association of Ontario (RNAO). Clinical practice in a digital health environment [Internet]. Toronto (ON): RNAO; 2024. Available from: https://rnao.ca/bpg/guidelines/clinical-practice-digital-health-enviornment	▪ RNAO Best Practice Guideline (BPG) ▪ Outlines best practice recommendations and good practice statements for nurses and members of the interprofessional team to maintain, advance and strengthen professional practice in a digital health environment. ▪ The BPG also recognizes that people receiving care are experts in their health and decision-making, and should be actively engaged as partners to improve health outcomes.
Yoon J, Lee M, Ahn JS, et al. Development and validation of digital health technology literacy assessment questionnaire. J Med Syst [Internet]. 2022; 46(13). Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC8784987/ *and* https://static-content.springer.com/esm/art%3A10.1007%2Fs10916-022-01800-8/MediaObjects/10916_2022_1800_MOESM2_ESM.pdf	▪ The Digital Health Technology Literacy Assessment Questionnaire (DHTL-AQ) is a reliable and valid instrument to measure digital health technology literacy. ▪ See supplementary file two located in the article link for the final version of the tool.

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 9**). The left-hand column of the table outlines the recommendation questions and outcomes, and the right-hand column outlines priority research areas identified by the expert panel based on the systematic reviews that were conducted for each question. Future studies conducted in these areas would provide further evidence to support high-quality and equitable support for people-centred care. The list is not exhaustive; other areas of research may be required.

Table 9: Priority research areas per recommendation question

RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
RECOMMENDATION QUESTION #1: **Should decision aids used by health providers and people to support shared decision-making about treatment and care be recommended or not?** **Outcomes:** ▪ people's participation in their care (involvement in decision making and options) ▪ provider/person outcomes: provider satisfaction with care (or decision aid), participant knowledge (about benefits/harms) and participant selection of a treatment/screening option that reflected what was most important to them ▪ provider care behaviours (establishing a therapeutic relationship respectful of people's preferences, culture etc.) ▪ organizational or system outcomes (satisfaction with overall care, length of stay, re-admission rates, adoption and sustainability (of decision aid use) ▪ harms (person/caregiver burden, provider burden) ▪ clinical (physiological) outcomes	▪ Research to identify strategies to facilitate the implementation of decision aids into everyday practice. ▪ Primary intervention studies that assess the use of decision aids in lower- or middle-income countries.

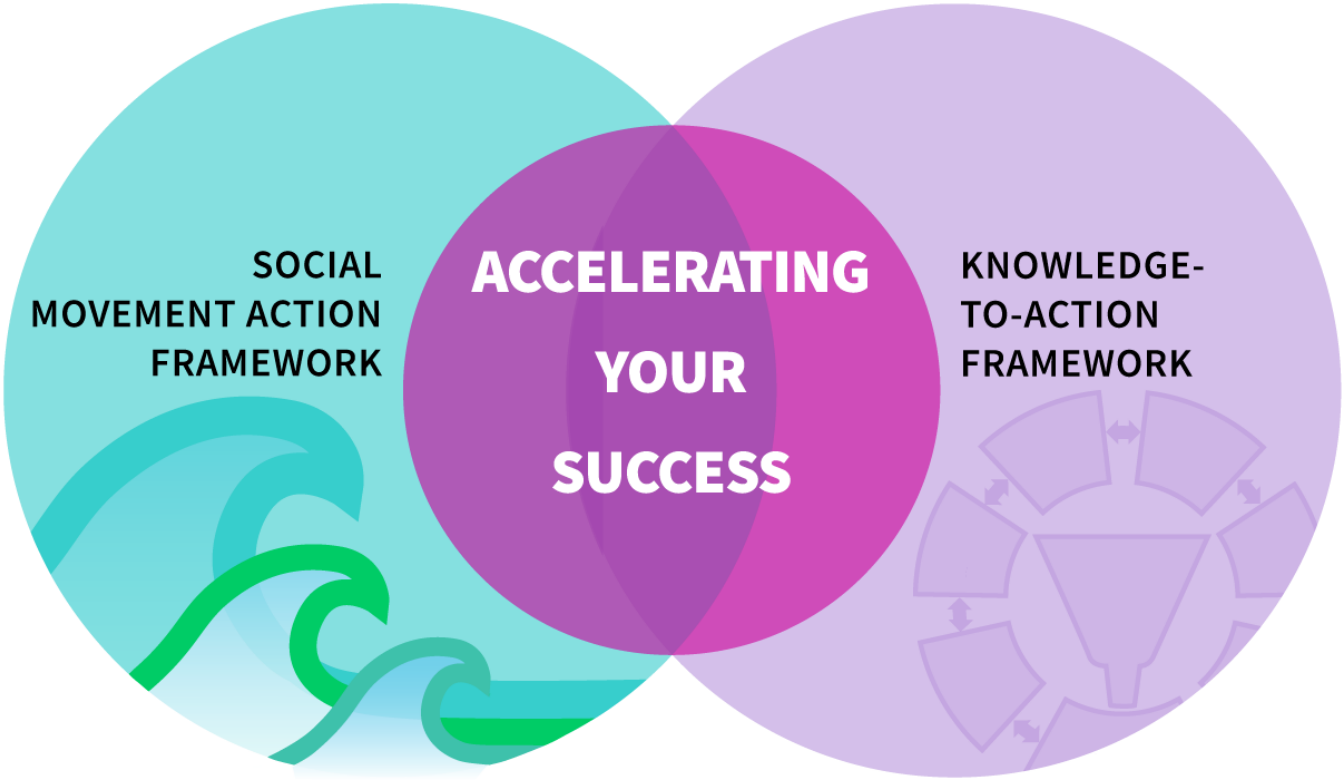
RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
RECOMMENDATION QUESTION #2: **Should sensory-minimizing strategies that address noise and light (used to facilitate people-centred care) be recommended or not?** **Outcomes:** ▪ person, family or caregiver/family satisfaction with sensory-minimizing strategies ▪ provider satisfaction ▪ provider knowledge ▪ physiologic measures ▪ satisfaction with overall care ▪ length of stay ▪ re-admission rates ▪ adoption and sustainability (of sensory-minimizing strategies) ▪ provider burden	▪ Studies that address the impact that lighting has on person and provider outcomes. ▪ Studies that address the impact of light therapy on person and provider outcomes. ▪ Studies that assess the impact of sound (e.g., maternal heartbeat) on person and provider outcomes. ▪ Studies that address the impact of sensory stimulation during periods of awakeness, particularly during periods of decision-making, on person outcomes.

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 (181). The Leading Change Toolkit (developed by RNAO in partnership with Healthcare Excellence Canada), provides evidence-informed processes for this (see **Appendix N**) (5).

The Leading Change Toolkit uses two complementary frameworks to guide evidence uptake and sustainability (see **Figure 3**). They can be used together to maximize and accelerate change.

Figure 3: The Leading Change Toolkit: Two complementary frameworks to accelerate your success



Source: Reprinted with permission from: Registered Nurses' Association of Ontario (RNAO), Healthcare Excellence Canada (HEC). Leading change toolkit [Internet]. 4th ed. Toronto (ON): RNAO; 2024. Available from: 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, inter-related 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.
- Others impacted by the change 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 people and organizations who are passionate about implementing evidence-based practices and mobilize others so together they improve care and health through the integration of competencies as defined by RNAO's Best Practice Champions Competency Framework. Champions include nurses and other health professionals from all roles and health sectors, students, advocates, people with lived experience, and caregivers.
2. **RNAO Clinical Pathways**™ [G] are digitized recommendations and good practice statements embedded into electronic medical records through a third-party software. Currently, these clinical pathways are available to all Canadian 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
- RNAO Clinical Pathways™: RNAO.ca/bpg/implementation/clinicalpathways
- RNAO BPSO®: RNAO.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: RNAO.ca/events

Appendix A: Glossary of terms

Best practice guidelines (BPG): "Best practice guidelines are systematically developed, evidence-based documents that include recommendations for nurses and the interprofessional team, educators, leaders, policy-makers and people 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" (182).

Best Practice Spotlight Organization® (BPSO): Health service or academic organization that has partnered formally with RNAO over a three-year time period with a goal of creating evidence-based practice cultures through the systematic implementation and outcome evaluation of multiple best practice guidelines (88). Upon successful completion of the first three-year time period, sites are recognized as designated. Following the pre-designation period, BPSOs are required to achieve deliverables and are redesignated on a biennial basis. The BPSO designation was launched in 2003 as a knowledge translation strategy. BPSOs have been established across all sectors with sites in Ontario and throughout the world.

Caregivers: An individual that provides physical, psychological and emotional support, as deemed important by the person receiving care. This care can include support in decision making, support with activities in daily living, care coordination and continuity of care. Caregivers can include family members, close friends or other individuals and are identified by people or their substitute decision maker (29). The terms "essential care partner" (29) or "care partner" are also commonly used in practice.

Chosen family: "A term used to refer to individuals who are related (biologically, emotionally, or legally) to and/or have close bonds (friendships, commitments, shared households and child rearing responsibilities, and romantic attachments) with the person accessing health and social services. A person's chosen family includes all those whom the person identifies as significant in his or her life (e.g., parents, caregivers, friends, substitute decision-makers, groups, communities, and populations). The person receiving care determines the importance and level of involvement of any of these individuals in their care based on [their] capacity" (22, 75).

Cultural awareness: One of the key components to realize cultural safety, it is about being cognizant of the differences and similarities between cultures (89).

Cultural competency: Occurs when people develop the knowledge, skills and attitudes for effectively and respectfully working with diverse people and decrease assumptions about others based on biases (89). It does not require the need to become experts in cultures that are different than one's own.

Cultural humility: One of the key components to realize cultural safety, it is a journey of self-reflection and learning and occurs when one listens without judgment and is open to learning from and about other people (89).

Cultural safety: Occurs when individuals respectfully engage in a manner that recognizes and aims to address power imbalances inherent across the health system. It involves health and social service professionals embracing a humble, self-aware approach to clinical practice, ensuring they act as respectful and open-minded collaborators in people-centred care rather than authoritative experts (17).

Cultural sensitivity: One of the key components to realize cultural safety, it is about being aware of and acknowledging how one's own culture impacts one's behaviours, knowledge and biases (89).

Co-creation: A collaborative activity whereby health and social service providers work together (on an even playing field) with people who have developed expertise from their experiences accessing health and social services (183). It is an approach to collaborative problem solving that engages diverse partners at all stages of a project working together towards a shared goal (i.e., from identifying what the problem is to the final stages of implementation) (184).

Decision aids: For the purpose of the BPG, decision aids are people-centred tools that support people in making informed health decisions. Decision aids identify the health-care decisions to be made, provide evidence-based information regarding screening or treatment options, provide information on the associated benefits and harms for each option and elucidate personal values and preferences (141). Decision aids can help guide people to make decisions when there is more than one option, including no change (141). Decision aids include a range of formats, such as paper-based, web-based, computer-based (or a combination of audio, computer and computer/web), video or scripts. Regardless of the format, the goal of a decision aid is to support and enhance consultations and discussions with health providers, not replace them (141). Decision aid tools are often also referred to as 'patient decision aids'.

Education statements: Standard statements created that would be applicable to all clinical BPGs to support evidence-based practice changes. These statements were created based on a rigorous thematic analysis of 26 education recommendations from eight different BPGs with diverse clinical topics and populations.

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 (185).

Evidence-to-Decision (EtD) frameworks: A table that helps guideline 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 being considered and increase transparency about the decision-making process in the development of recommendations (43).

Evidence profile: Allows presentation of key information about all relevant outcomes for a given health-care question (43). It presents information about the body of evidence (e.g. number of studies), the judgments about the underlying quality of evidence, key statistical results, and the quality of evidence rating for each outcome (43).

External reviewer: Individuals or groups who commit to reviewing and providing feedback on the draft RNAO best practice guideline prior to publication. External reviewers often include individuals or groups directly impacted by the guideline topic and recommendations (e.g. people accessing health services, people working in health or social service organizations or people with subject-matter expertise).

Equity-deserving populations: Groups of people who have been historically disadvantaged and underrepresented, including, but not limited to, women, visible minorities, Indigenous Peoples, people with disabilities, as well as members of the 2SLGBTQI+ community with diverse gender identities and sexual orientations. This term underscores that these communities are inherently entitled to the equity they have historically been denied (186).

Good practice statement: Good practice statements are directed primarily to nurses and the interprofessional teams that provide care to people 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 (37). These are believed to be so beneficial that summarizing the evidence would be a poor use of the expert panel's time and resources (37). 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 (37,38). Given the high level of certainty that the benefits derived from the good practice statement outweigh the harms, they are not based on a systematic review of the evidence, and they 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) (39). This does not diminish certainty in the evidence. While they are often supported by indirect evidence, there is a well-documented, clear and explicit rationale connecting the indirect evidence to the statement (37). 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 (37).

Grading of Recommendations Assessment, Development and Evaluation (GRADE): 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 (43).

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 (43).

Guiding principles: Overarching concepts that denote a philosophy, belief, value and/or standard of behaviour that nurses, members of the interprofessional team and health or social service organizations should apply to their practice when implementing recommendations and good practice statements.

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

Regulated health and social service provider: 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 (30). The Social Workers and Social Service Act 1998 provides a framework for regulating Social Workers and Social Service Workers (31).

Unregulated health or social service provider: 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 their roles and perform tasks that are determined by their employer. 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 (32).

Health and social service organizations: Any settings in which people receive care or services.

Health service organizations are organizations delivering health-care services to defined communities or populations. These include, but are not limited to, family health teams, home care organizations and hospitals (187).

Social service organizations are organizations that assist people with social issues, including (but not limited to) housing, domestic violence and substance use (187).

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" (188).

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 People as peoples of long settlement and connection to specific lands who practise unique traditions and retain social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they reside (189). Under the UN definition, Indigenous is generally understood to include the following: 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 (189).

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 (190).

Indirect evidence: As per GRADE methods, directness is judged based on the target population, intervention, and outcomes of interest (43). Evidence can be indirect if the populations differ from those of interest, the intervention tested differs from the intervention of interest, or the outcomes differ from those of primary interest (43).

Interprofessional team: A team comprised of multiple health and social service providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health and social services to people within, between and across health-care settings (33). Team members bring their unique perspectives and cooperate, coordinate and collaborate toward a common goal through shared decision-making (34) with the person accessing health and social services. Key interprofessional team members may include: nurses, general practitioners, physicians, dietitians, pharmacists, social workers, occupational therapists, physiotherapists, spiritual care practitioners, and other allied health professionals. It is important to emphasize that people and their chosen family and/or caregivers are at the centre of the interprofessional team as active participants.

Intersectionality: The study of intersecting social identities and related systems of oppression, domination or discrimination. In an intersectionality framework, categories of race, class, gender, sexuality, nation, disability and age are viewed as interrelated (93).

Meta-analysis: A systematic review that uses statistical methods to analyze and summarize the results of the included studies (191).

See systematic review

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 (30).

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 whether they are: (a) critical for decision making, (b) important but not critical for decision making, or (c) not important. The use of these outcomes helps make literature searches and systematic reviews more focused (43).

People: Replaces the terms "person", "patient," "client", "resident", "user", "consumer" used across health and social service organizations. The term is inclusive of caregivers, essential care partners, chosen families and communities. It refers to individual(s) with whom a health and/or social service provider has established a therapeutic relationship for the purpose of partnering for health.

People-centred care: "An approach to care that consciously adopts the perspectives of individuals, families and communities with the view that they are participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways" (12).

People-centred care focuses on the health needs and expectations of not just the person seeking care, but also their family, caregiver, community and society (11). Within this model, everyone involved in the care of the person (e.g., the person, doctor, nurses, chosen family, caregiver, social worker, spiritual care practitioners, etc.) contributes to the delivery of care and services (13).

People with lived experience: Members of the community who have first-hand experience and knowledge of the topic of interest either as a person, unpaid caregiver or advocate. People with lived experience are a diverse group with an array of backgrounds and experiences (187).

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

1. Patient or population that is being studied.
2. Intervention to be investigated.
3. Comparison or alternative intervention.
4. Outcome of interest (43).

Plan of care: A people-centred health document used by health and/or social service providers to facilitate communication, reflect the person's stated values, beliefs and preferences, meet the person's short and long-term goals, and support holistic care across programs, organizations and sectors (154,155). It is an essential tool to easily convey information pertaining to people's clinical information, medication reconciliation, and any coordination between various health and service providers.

Quantitative research: An approach to research that investigates phenomena with tools that produce statistical measurements/numerical data (192).

Quintiple aim: An internationally recognized framework for the delivery of health care that is centred around five overarching goals: (1) improving population health, (2) enhancing the experience of people receiving care, (3) controlling health-care costs, (4) improving the well-being of health and social service providers, and (5) establishing health equity (25).

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) (191).

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 (43).

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.

RNAO Clinical Pathways™: RNAO Clinical Pathways are a digitized version of RNAO's Best Practice Guidelines that can be embedded in an electronic health record system to promote evidence-based, people-centred care.

Shared decision-making: A joint process where health and social service providers work together with people receiving health and social care to reach a decision (35). This involves choosing tests and treatments based on evidence and on the person's individual preferences, beliefs and values (35).

The use of a shared decision-making process assists health and social service providers and people faced with making screening or treatment decisions about their health to understand the risks, benefits and possible consequences of various screening or treatment options through discussion and sharing of evidence-based information (35). A shared decision-making process can empower people to make informed decisions about medical treatment and care that is right for them and their personal needs and preferences (35). It is understood that some people may prefer not to take an active role in making decisions about their own health.

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 (193).

Strengths-based nursing and health care: The understanding of a person's challenges and limitations within a larger context that includes their inner and outer strengths, such as resilience, coping skills, family support or community resources (94). It is an approach to care that emphasizes the capabilities and resources of people, discovering the strengths that can empower people to take greater control over their health and wellness journey (94). Strengths-based nursing and health-care approach is based on four underlying foundations: 1) person-centred care, which focuses on a person's capabilities, resources, values and goals in order to understand them as a person beyond their illness or current deficit 2) empowerment, which acknowledges that people are resourceful and capable to participate in shared decision-making 3) relational practice, that fosters people-provider relationships that are collaborative and partnership-based, not hierarchical and 4) innate capacities, which focuses on building on what is working well for the individual (95).

Sustainable Development Goals (SDG): Adopted by the United Nations in 2015, the Sustainable Development Goals (SDG) are a universal and urgent call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030 (27).

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 (191).

See meta-analysis

Therapeutic relationship: A purposeful, goal-directed relationship between the health and social service provider and the person accessing the health system for care and treatment that is grounded in an interpersonal process directed at advancing the best interest and outcome of the person (23,36).

Trauma-informed approach to care: A trauma-informed approach to care is a framework that emphasizes physical, psychological and emotional safety with the goal to empower people in their recovery. When adopting a trauma-informed approach to care, the aim is to not only understand the whole person, but to also be cognizant of how the impact of trauma and how people's lived experiences of trauma shape health status and behaviours (90).

Virtual care: Any interaction between people, health and social service providers and/or other members within the circle of care that occurs remotely, uses any form of communication or information technology, and aims to facilitate or maximize the quality and effectiveness of care (171). Virtual care can be either an approach to care or can refer to a single interaction that occurs between a provider and a person (172).

Appendix B: RNAO guidelines and resources that align with this guideline

The following are some topics and suggested RNAO guidelines and resources from other organizations that align with this best practice guideline.

TOPIC	RESOURCE(S)
Implementation science, implementation frameworks and resources	▪ Registered Nurses' Association of Ontario (RNAO), Healthcare Excellence Canada (HEC). Leading change toolkit [Internet] (4th ed.). Toronto (ON): RNAO; 2024. Available from: https://www.RNAO.ca/leading-change-toolkit
Palliative care	▪ Registered Nurses' Association of Ontario (RNAO). *A palliative approach to care in the last 12 months of life.* Toronto (ON): RNAO; 2020. Available from: https://rnao.ca/bpg/guidelines/palliative-approach-care-last-12-months-life
Transitions in care and services	▪ Registered Nurses' Association of Ontario (RNAO). *Transitions in care and services.* Toronto (ON): RNAO; 2023. Available from: https://RNAO.ca/bpg/guidelines/transitions-in-care

Appendix C: 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 period, as all clinical BPGs published within this period are based on a systematic review of the literature. It examined 26 education recommendations from eight 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 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 RNAO BPGs were analyzed:

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

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, dieticians 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 (194). 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 goal of enhancing the health outcomes of people.

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 (195).
   - 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 people (195).

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 (196). 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 informs the recommendations (195).
   - **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 the following: 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 (195).

- **Simulation:** High-quality digital simulation within skills lab settings can ease the uncertainty of students related to clinical practice and also increase skill acquisition, self-confidence and satisfaction. Faculty trained in pedagogy can use simulation to teach students content related to safe and effective people-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 (195).
- **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 (195).
- **Access to BPG-related resources:** Educators can promote and facilitate access to BPG-related links and resources (195).
- **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 (195).
- **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 (197). 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)
- *Person- and Family-centred Care* (2015)
- *Engaging Clients Who Use Substances* (2015)
- *Preventing and Addressing Abuse and Neglect of Older Adults: Person-centred, Collaborative, System-wide Approaches* (2014)

- *Primary Prevention of Childhood Obesity, Second Edition* (2014)
- *Delirium, Dementia and Depression in Older Adults: Assessment and Care, Second Edition* (2016)
- *Working with Families to Promote Safe Sleep in Infants 0–12 Months of Age* (2014)

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 (198). 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 that adults:

- have an awareness of learning needs/goals
- are self-directed and autonomous
- value and utilize prior life experiences
- have a readiness to learn
- are motivated to learn
- are presented knowledge and skills in the context of practical, real-life situations (199)

Furthermore, education and training should be appropriate to the health and 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 (200,201).
- **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 slide presentations and videos that integrate relevant BPGs/recommendations. RNAO's Best Practice Champions Workshop and BPG Clinical Institutes are examples of programs that provide education on how to implement BPGs within practice settings (88).
- **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; and
  - sharing knowledge and lessons learned from reviewing guidelines with the accreditation committee (202,203).

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 (204). 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 (205) 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 (5) 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 the following:

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

Appendix D: Scoping review: Collaborative communication approaches and strategies relevant to people-centred care

Using the Arksey and O'Malley Framework (203), a scoping review was conducted to explore the current trends of collaborative communication strategies used within the context of people-centred care. It is important to recognize that a scoping review does not provide recommendations for practice or inform clinical guidelines (204). Rather, the scoping review provides an overview of approaches and strategies found in the existing literature that may be useful and applicable in practice. For a detailed description of the steps taken to conduct the scoping review, refer to supplementary materials under the "methodology documents" tab on the BPG webpage.

In total, 84 articles were included in this review. The most common types of studies were systematic reviews and/or **meta-analyses**[G] (n=38) and literature reviews or discussion papers (n=28). In addition, nine were non-randomized control studies, four were randomized control studies, three were guiding frameworks, one was an evidence-based/consensus guideline and one was a qualitative study. The articles were from 19 countries with most originating from the United States of America (43%), Australia (9%), the United Kingdom (9%) or had an international contribution (9%). There were five (6%) articles originating from Canada. Approaches and strategies include guides for prompting discussions between people or surrogates and their treating clinicians, theoretical approaches to communication (e.g. motivational interviewing), and acronyms outlining the key components of protocols or frameworks for optimizing interactions between people and their provider(s). The approaches and strategies have been -designed for use in different sectors (e.g., tertiary care, community settings) and with different patient populations (e.g., those experiencing diabetic complications, dementia, and acute kidney injury at end-of-life).

Table 10 depicts the types of collaborative communication approaches and strategies relevant to people-centred care along with a brief description that end users can further explore when referring to the corresponding citation. A systematic review was not conducted and an assessment to determine the quality of evidence was not made; as such, the table does not provide information about the effectiveness of each strategy. RNAO is not recommending one approach and/or strategy over another.

Table 10: Collaborative communication approaches and strategies relevant to people-centred care

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
Advance Care Planning Linguistics	The following are phrases that health and social service providers may find useful when communicating with people receiving care throughout the course of kidney disease and during end-of-life. **DISCUSS Advance Care Planning (ACP)** ▪ I want to understand how you would like us to care for you if you got sicker. ▪ What would you like us to prioritize? ▪ Talking about how to take care of you now can help your family know what would be important if you were too sick to tell us. ▪ Are you willing to talk about this with me? It is important for us to be able to respect your wishes about your health care if you were very sick. ▪ Have you discussed this with someone? ▪ Would it be ok if we talked about how you would like to be cared for if your health worsened? ▪ Are there situations you would like to avoid if you became very sick? ▪ Getting to know what is important to you will help us take better care of you. ▪ How do you like to make decisions about your health care? **NORMALIZE ACP** ▪ These conversations are an important part of the care for every person experiencing dialysis. ▪ Many people find these conversations difficult, that is normal. ▪ I want you to know that you can talk to me about your preferences. **ACP is a PROCESS** ▪ Over the course of your time on dialysis, talking about this will help me understand your preferences. ▪ If there is family that helps you make decisions, it can be useful to involve them in these discussions. ▪ I would like to have an ongoing conversation about these topics. ▪ Getting to understand your priorities is a process.	Nephrology	(206)
Augmentative and Alternative Communication (low technology)	▪ People with preserved cognition and fine motor abilities can use pen and paper to freely write. ▪ When people have fine motor abilities but are unable to write, communication boards (alphabet/images/phrases/symbols) are available. These boards consist of icons and pictures representing basic needs. Alphabet and symbol charts allow the person to point toward individual letters/symbols to form words and/or expressions. Other examples include: gestures, facial expression, body language, and sign language.	Critical Care	(207–209)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
Augmentative and Alternative Communication (high technology)	▪ The "ICU Patient Communicator" application facilitates communication with the use of a handheld device. ▪ The application allows people to select from several icons with the titles "I have pain," "I need," "I feel," and "I want to see." ▪ Once an icon is selected, a drop-down menu or body image appears, which allows the person to select specific messages or point toward a body area of pain. ▪ The application also includes a language translator, an option to record a daily diary, and resources for the person and family members, such as the "ICU Stay Booklet." ▪ Speech-generating devices or voice-output communication aids are handheld devices that allow people to touch a word or picture icon to generate prerecorded messages. ▪ The "mHealth" is a team-developed, people-centred, and nurse-led communication computer application. The content of the application includes: □ Body graphic for indication of pain location. □ A menu about less acute pain. □ A prompt for requests related to basic needs such as repositioning, water, or a need to void, a request to see people, including family members, partners, and spiritual care practitioners. □ A free-text section that allows people to create their own menu for specific needs, questions, or requests and includes a predictive engine (much like a smartphone). ▪ Other computer communication systems contain databases that include the possibility to provide free text, select letters to form phrases, or select icons with actions, symbols, or preformed messages. ▪ The user may combine options to deliver messages, which can be read or amplified by voice synthesizers. The system allows Internet connectivity and utilization of email, social media, and other usual computer functions. ▪ Navigation through these devices is possible by buttons, mouse clicking, touch screen, or infrared eye-blink detector. ▪ More sophisticated systems incorporate an eye-tracking device, which allows gaze control of the system, not relying on motor ability. ▪ For wearable personal communication devices that function without a screen: □ Head-mounted infrared camera tracks eye movements and sends information to a small processing unit that translates movements into communication. □ People can select from a menu that includes "words and phrases," "application," "alphabet," "rest mode," and "settings." Once the message is selected, the device includes audio feedback to the user, and prior communication is transmitted to the output speaker or the connected Bluetooth device. □ Notably, the user can sleep with the device, and it becomes immediately available upon waking.	Critical Care	(207,208,210–213)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
Communication and Therapeutic Relational Connection	▪ Interpersonal communication skills include the ability to assess a persons' verbal and nonverbal cues, including understanding emotional expressions and feelings and responding to these cues with empathy. ▪ Verbal communication includes behavioural skills, timing, clinical conversation, and nonverbal communication includes eye contact, visual cues, and empathetic gestures. ▪ There is a need for bidirectional responsiveness with interpersonal communication where people together with the provider rely on cues from one another to communicate. ▪ Bidirectional responsiveness within telehealth provides the opportunity for real-time feedback and adaptivity for people and the provider as is common during in-person communication.	Telehealth and therapeutic relational connection	(105)
Communication Domains in Palliative Care	▪ Fostering a people-centred relationship, discussing serious news, dealing with emotions, eliciting values, preparing for the future, making decisions about goals of care and involving family/supports.	Palliative care	(214)
Communication Strategies for Residents with Hearing Impairment	▪ Gain attention by beginning a conversation using the resident's name; if the resident is not facing you, consider alerting them by gently touching their hand, arm or shoulder. ▪ Face the resident and spotlight your face, improve lighting on your face if possible. ▪ Do not speak directly into the resident's ear; do not chew gum or cover your mouth when speaking. ▪ Reduce background noise. ▪ Speak clearly at a moderate pace - do not shout (i.e., speak clearly and slowly, pausing occasionally to help the resident keep up with the word flow). ▪ Use simple language and allow time for the resident to respond (i.e., when it is too difficult to listen, some residents agree with everything, even when they do not understand what is being said - use gestures if you need to clarify a statement or question). ▪ Pronounce words clearly for residents who lip-read.	Residential care; LTC	(215,216)
Communication with Older Adolescents and Young Adults (AYA)	▪ Adolescents talk more to family and friends about their preferences for care than to their providers. ▪ AYAs prefer that providers raise these issues with them, rather than the other way around. ▪ Methods and example phrases for engaging AYA in conversations around diagnosis, prognosis, and ACP are listed in Snaman et al. (217). ▪ For example, offer the opportunity for the AYA to be involved in the conversation: "We have some new findings about your disease. Would you like to be a part of this conversation right now? Or are there things you would rather we talk to your parents about first?". ▪ Other communication strategies for AYA are the use of children's books (i.e., bibliotherapy) to normalize the experiences of death, facilitate communication around end-of-life, and provide language for parents to explain death, taking into consideration the child's cognitive and emotional development and level of understanding.	Palliative oncology	(217)
Conceptual Framework of Effective Listening in Healthcare Conversations	▪ Relationships are seen among a set of constructs, including engaged listening, awareness, people-centred perspective in the relational space which occurs in the moment and over time.	Rehabilitation care	(218)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
Conceptual Framework for Preferred Communication Strategies	▪ **Disclosure-facilitating** is achieved using open-ended questions/formulations, gaze and nodding as conversation continuers, and asking about lifestyle. ▪ **Rapport-building** involves being friendly, respectful, listening, humor, tailoring, and using a specific approach and format that is acceptable to the individual. ▪ **Being empathic** involves identifying and attending to emotional matters, encouraging, not judging. ▪ **Being collaborative** involves finding common ground, and engaging in shared decision-making. ▪ **Professional accountability**. ▪ **Informative communication** involves providing education and information reconciling the person's perspectives, developing person-centred insights, and reconciling information from verbal and nonverbal (e.g., postures/movements, pain behaviours) communication cues during presentations of pain. ▪ **Agenda-setting** requires providers to organize and guide conversations to prioritize selected topics or tasks during an interpersonal encounter that may be constrained by time; this can include shifting topics, closing down a topic of conversation, or ensuring that the topics gets covered before the end of a visit. ▪ **Meta-communication** is communicating about communication, for example, 'If pain could talk, what would it say?' An aspect of meta-communication is when people and the provider together reflect, giving new perspectives on the experience of pain.	Physical Therapists in Chronic Pain Rehabilitation	(219)
Decision-making and people with autism spectrum disorder (ASD)	▪ Allow extended and adequate processing time, preferably in an environment that is quiet, calm, and with as little distraction as possible. ▪ Information should be clear and concise, emphasizing medical information, and avoiding emotion/value-laden, open-ended questions. ▪ Information should be presented in written form as well as orally to accommodate people with autism spectrum disorder (ASD) who often process information more accurately when it is given visually. ▪ Ask specific questions that reflect relevant short, moderate or long term goals. ▪ More information and examples for adapting existing conversation guides to meet the communication needs of people with ASD are found in Satkoske et al. (220).	Autism spectrum disorder	(220)
Empathetic Communication	Examples of provider attributes needed in empathetic communication are: ▪ A warm attitude, especially in voice, tone, and careful listening without looking at one's notes or computer. ▪ An ability to demonstrate emotional skills: identifying emotions, understanding emotions (those of the person but also one's own emotions as the messenger of bad news and the witness of upsetting emotions), regulation of emotions and facilitation of a person's expression of emotions.	Palliative care; people undergoing radiation therapy; home care	(221–223)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
Evidence-based strategies for managing complex/ challenging situations	Examples of wording and behaviours to manage communication with challenging or complex situations are available in Laidsaar-Powell et al. (2018) related to the following areas: ▪ Facilitating the presence of multiple family caregivers during consultations □ "We can fit 2 or 3 family members into the consultation room. [Person's name], are you ok to decide who will come in with you?" ▪ Managing family requests for non-disclosure of information to the person □ "I respect that you are wanting to protect your loved one." ▪ Family acting as interpreters for a person with limited English proficiency and/or severe hearing impairments □ "As we are going to be discussing the results of your next scan and the next steps for your treatment at our next meeting, it would be helpful if I arranged for a professional interpreter to attend the consultation". ▪ Conflicting preferences between the person and their family □ "It seems that you both want to be happy as a family and enjoy life together, but [the person's name] wants quality of life and [family caregiver] wants more time." ▪ Managing dominant, controlling, or coercive family caregivers ▪ Aggressive family caregivers. ▪ Family conflict/dysfunction or abuse	Oncology care settings	(224)
"Elicit-provide-elicit"	▪ A skill often used in motivational interviewing. ▪ It can be used to ask people for permission to integrate stress management (and/or the management of fear, anxiety, and behavioural factors) into the treatment program, ▪ First, ask the person about their thoughts on the role of stress in their daily pain experience (elicit). ▪ Second, ask permission to explain why stress influences pain and how coping skills may be used to address those stressors (provide). ▪ Third, ask about their thoughts on this new information (elicit).	Chronic pain; primary care	(225,226)
EMPATIA Communication Guide	▪ This guide is sub-divided into seven steps to facilitate communication of neuromuscular diseases: Empathy, Message, Prognosis, Acknowledgment, Time, Individualization, and Autonomy.	Neuromuscular disease	(227)
Jumpstart Guide	▪ This guide was designed to prompt discussions about goals-of-care between the person or surrogate and their treating clinicians. ▪ The person completes a set of items in a baseline questionnaire that assesses individual preferences for goals-of-care communication, barriers to and facilitators of such communication, and treatment preferences for cardiopulmonary resuscitation. ▪ The Jumpstart Guide holds a summary of the person's or surrogate's responses and based on these responses, provides person-specific prompts for conducting goals-of-care discussions with the person or surrogate.	Adults with chronic life-limiting illness	(228)
Life Story Book	▪ Facilitates person-centred care by incorporating the main principles and philosophy of personhood in dementia care ▪ The Life Story Book focuses on enabling people with dementia to share and talk about their life stories and experiences	Dementia care	(229)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
Linguistic Communication Strategies	▪ The following are essential linguistic communication strategies for dementia and LTC settings: ▫ ensure that any sensory impairments are addressed (e.g. hearing and vision) ▫ reduce background noise ▫ face the person when speaking with your lips at the same level as theirs ▫ speak clearly, be aware of the presence of an unfamiliar accent or dialect ▫ pay close attention to sentence structure and length when conveying information ▫ allow time for the person to listen and respond ▫ pose different types of questions according to conversational goals ▫ use active listening techniques, such as eye contact and open-ended questions ▫ offer visual choices if the person is having difficulty making verbal choices ▫ use gestures, pictures, and objects as well as words to express your meaning ▫ prompt the person to stay on the topic of the conversation ▫ use repetition or paraphrasing to facilitate comprehension ▫ avoid patronizing speech, such as baby-talk or elderspeak ▫ maintain a positive tone ▫ avoid speaking too slowly to facilitate retention of information ▫ monitor and control non-verbal behaviour ▪ Avoid features of elderspeak, which include the use of very short sentences; slow speech, but elevated pitch; simple vocabulary and grammar; use of intimate words such as "good boy/girl" "sweetie" or "honey"; use of collective/plural pronouns (represented in italics), such as "Are we ready for our bath?". ▪ There is a training model to reduce elderspeak entitled: Changing Talk to Reduce Resistiveness to Dementia Care (CHAT) (230,231).	Dementia care; LTC	(230,231)
Linguistic Markers of Shared Decision Making	▪ In shared decision-making, providers support people to come to understand their preferences and make informed decisions. ▪ Linguistic markers: people perceive greater provider shared decision-making when providers use more first-person singular pronouns ("I think"), more cognitive process words indexing causation (e.g., because) and differentiation (e.g., but), more clout words (i.e, convey power/authority), and less cognitive process words indexing insights (e.g., think, know).	Medical care; LTC residential facility; treatment recommendation and antibiotic stewardship	(232–235)
Linguistic Markers of Compassionate Care	▪ The goal of compassionate care is to address people's need for relationships through attentiveness to the person's feelings and experiences. ▪ Linguistic markers: when providers use affiliation words, such as "together" or "let's", perceptions of compassionate care increase. ▪ Providers' use of affiliation words has the potential to promote a belief that their feelings and experiences are cared about and attended to, leading to a sense of compassionate care from providers.	Treatment recommendation and antibiotic stewardship	(235)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
Motivational Interviewing (MI)	▪ MI is a person-centred conversation and counseling style that aims to provide behavioural change through person discovery and resolution of indecision. ▪ MI also encourages elaboration of the person's need for change rather than simply counseling or providing information for people to find their own intrinsic motivation. ▪ Below are some helpful tips for using MI: □ Encourage clients to express their own views and make decisions that best suit their motivation □ Engage in an empathic, collaborative, non-judgmental manner using open questions and reflections to motivate change, evoke the person's perspectives and support autonomy following the OARS (Open questions/ Affirmation/Reflective listening/Summarizing) method.	adolescent care; end-of-life care; pediatric care; nephrology; blood sugar control, diet, physical activity, and depression; counselling for hormone therapy; coronary care	(225,226,236–250)
Online people–provider communication	▪ The use of electronic means of communication (e.g., e-mail, social media, and individualized electronic portal) between people and health-providers.		(251)
People-centred communication in end-of-life care	▪ Four elements of people-centred communication: 1. Engage the person in consultations. 2. Respond to the person's emotions. 3. Inform the person about choices related to treatment and prognosis. 4. Frame information in a balanced (unbiased) way. ▪ Use problem listing, including drawing out relatives' perspectives related to the deterioration of their loved ones. ▪ The practice of highlighting deterioration is a collaborative communication strategy that could be used by other health and/or social care providers to meet these recommendations. ▪ Other common communicative practices for receiving detailed information with family members include repetition, pacing & staging, and highlighting continuing care. ▪ Use simple, direct language and honesty.	End-of-life care	(252,253)
People-centred Outcomes Research Institute (PCOR) in format of pocket card	▪ A standard communication pocket card for team members who will be present at a family meeting. ▪ The pocket card identifies and provides example statements related to the pre-meeting with the team, introduction of the team, assessing the family's understanding, empathizing with emotions, identification of priorities, alerting to use of plain language, and documentation and updates.	Intensive care	(254)
Personal Passport	▪ Provides staff with information important to the person and enables tailored interventions to be more personalized. ▪ The collection of basic information and small details including 'if the person likes sugar in their tea' is central to the provision of good people-centred care and getting to know the person.	Hospital and acute care	(255)
Phenomenological Approach to Communication	▪ People reflect upon and stay with thoughts and feelings which otherwise tend to either not surface in health-care communication or are quickly passed over. ▪ This communication training offers a basic yet fundamental communication skill which can be taught to general-level registered nurses.	Not specified	(256)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
Professional Interpreters	▪ Professional interpreters – including bilingual providers – compared to interpreter services provided by video, look promising and potentially cost-effective in assisting with parental health literacy and compliance. ▪ Additionally, the capacity to influence parental health literacy or understanding of diagnosis was higher with professional interpreters, albeit lower using telephone modality. ▪ In-person and video modalities promote the use and acknowledgement of non-verbal communication (e.g. subtle nuances or changes in body language).	Hospitalized children from migrant and refugee families; radiology department	(257,258)
Prognostic Communication	▪ Use explicit, rather than imprecise, prognostic information. ▪ Instead of stressing the best-case scenario, inducing the person's overestimation of life expectancy, also discuss typical and worst-case scenarios. ▪ Provide reassurance about non-abandonment and support while communicating life expectancy. ▪ Expert, positive, and collaborative behaviour during prognostic communication promotes hope. ▪ Oncologists are advised to address other sources of hope as well, rather than just medical information, like faith, inner peace, dignity, meaningful life events, relationships, or humour.	Palliative oncology	(259)
Question Prompt Lists (QPL)	▪ QPLs enable people to voice concerns and uncertainties by asking questions, prompting person-clinician discussion about any topic relevant to a particular condition or health concern of importance to the person (not only decisions about treatment or management). ▪ Formats include single-page handouts, booklets, pamphlets, or multi-page QPLs.	Health care; telehealth; oncology; peri-operative care	(260–267)
Relational Communication Strategies	▪ Know the person, their personality and how they best communicate; their life history and what is meaningful to them. ▪ Respect what the person brings to the conversation and interaction. ▪ Be aware and avoid ageist assumptions and stereotypes. ▪ Conduct an individual assessment of cognitive and communication abilities; ▪ Focus on the abilities of the person and support continued use of these abilities. ▪ Support people to speak for themselves. ▪ Express understanding and compassion to help address emotional responses. ▪ Include the person in the conversation even if verbal communication skills are impaired. ▪ Individualize care by seeking information about the person's values and preferences. ▪ Engage in shared decision-making when possible and desired. ▪ Strike a balance between respecting autonomy and active participation in care. ▪ Whenever possible, speak in the same language as the person. ▪ Address both task-related and emotionally-related aspects of conversation and care. ▪ Recognize that you as a health or social service provider have a role in making the conversation successful.	Dementia care	(230)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
Serious Illness Conversation Guide (SICG)	▪ **Understanding:** elicit the person's current understanding of their illness. ▪ **Information preferences:** determine the extent of information the person would like to know. Share the prognosis with information aligned to the person's preferences. ▪ **Goals:** elicit the person's most important goals, particularly if his/her condition worsens. ▪ **Fears/worries:** determine the person's concerns about the future pertaining to his/her health. ▪ **Function:** determine the person's most valued abilities and those they feel they cannot live without. ▪ **Trade-offs:** in the event of worsening illness, determine the level of medical intervention the person is willing to pursue to extend their life. ▪ **Family:** elicit the person's view of their family's perception of the illness and the person's wishes. Determine the extent to which the person desires the family's involvement.	Oncology	(268–270)
Strengths-Based Messages and Active Listening	▪ Collaborative and open communication (between eye care providers and people) can provide a basis to identify challenges and concerns among people with glaucoma who are experiencing inconsistencies with applying their eye drops. ▪ Create an atmosphere where people can discuss their challenges with treatment recommendations, without judgment or fear. ▪ Listening to an individual's stories promotes a partnership between the person and provider to address unique barriers and achieve mutually agreed upon goals without fear, guilt, or criticism.	Ophthalmology; Radiology	(257,271)
Teach-Back Method	▪ Involves 3 very distinct steps: 1. Teach the family 2. Ask the family to repeat what they understand 3. Provide clarification	NICU	(272)
Therapeutic Listening	▪ At its core, therapeutic listening involves active participation from the listener and relies on empathy to try to understand the perspective of the other person (Stewart, 1983).	Anxiety levels in the immediate post-operative period	(273)
Therapeutic 'Untruths'	▪ Involves responding in an empathetic way to a person's behaviour without correcting them. ▪ The listener comments on the feeling state of the person. For example, if a resident expresses a wish to leave to go to work, the nurse might say: 'It sounds like you're really missing work. What is it that you miss the most?' ▪ The provider will try to respond to the distressed person in as kind a way as possible.	Residential care	(274)
Three-Talk-Model	▪ **TEAM TALK:** includes, person-centred education, discussing options available, developing a working partnership, understanding the person's priorities and goals. ▪ **DECISION TALK:** includes establishing the person's preferences, working collaboratively towards a preference-based decision, and allowing for the opportunity to evaluate the decision. ▪ **OPTION TALK:** includes having options described in detail, describing trade-off between benefits and harms for each option, and giving the person time to determine which option aligns most closely to their priorities.	Advanced kidney disease; medical appointments; high-stakes, crisis situations	(270,275–277)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
Two approaches identified for delivering serious news	▪ "Warning Shot" which consists of setting up the person for hearing serious news. For example, "I have some serious news to share with you. Is it OK for me to share?" ▪ "Headline" which consists of forecasting the content of information to be shared. For example, "Your labs and imaging results came back. Unfortunately, they suggest your cancer has gotten worse". ▪ Between the two methods, research shows no difference in overall psychological distress or recall. ▪ After disclosing serious news, clinicians can ask candid, open-ended questions about what is important to the person using Ask-Tell-Ask. ▪ Examples of open-ended questions and suggestions to manage challenging scenarios are available (278).	Critical care	(278)
Video Remote Interpreting (VRI)	▪ Can involve all participants being physically present in one location and the interpreter is in a separate, remote location or can be used when all participants are in separate locations (such as a virtual call) and the interpreter is also at a different location.	Hearing impairment	(279)
ACRONYMS DESCRIBING FRAMEWORKS, MODELS AND PROTOCOLS			
ABCDE protocol	**A**dvanced preparation. **B**uild a relationship and therapeutic environment. **C**ommunicate adequately. **D**eal or manage the reactions of the person and the family. **E**ncourage and validate emotions.	Communicating bad news	(280)
COMFORT Curriculum	▪ COMFORT is an acronym that stands for seven communication modules: communication, orientation and options, mindful communication, family, openings, relating, and team. Wittenberg et al. (275) adapted these modules to create communication strategies for quality palliative care nursing that focus on: ◻ **C**ommunication: being with and relating to others while honoring people's voice and lived experience. The nurse will deliberately acknowledge and elaborate on the illness within the context of the person's life story. ◻ **O**rientation and Options: Oncology nurses bridge the divide between the language of medicine and the language of everyday life. They do this by helping people and their families understand health within the context of daily living, translating medical words by using metaphors and adjectives, and conveying to the team what the person and family understand and do not understand. ◻ **M**indful communication: reducing self-talk, avoiding judgment about the person and family or how an interaction will proceed, and the ability to adapt to changes in the interaction. A nurse can be in the moment with person and family by avoiding pre-determined scripts and engaging in mindful self-monitoring of the inner experience. ◻ **R**elating: relating involves being aware of the person's/family member's understanding of the disease and its probable course and being willing to meet people and families where they are in accepting the change brought by serious illness. In relating to a person and family, nurses should recognize that medical information such as prognosis and treatment options may need to be repeated numerous times to help them reach awareness and understanding.	Palliative care nursing	(281)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
OARS (Based on fundamental principles of motivational interviewing)	**O**pen-ended questions: these questions are used to elicit individualized information from people and typically begin with "How" or "What," or a request for a person's description of something, e.g., "Tell me about...". **A**ffirmations: these reassuring statements are used to acknowledge and encourage positive health behaviours that people are already practicing. **R**eflections: aimed at making people think about what they are doing, these help to prompt further discussion from people and clarify what their intentions are. **S**ummary: this communication element reiterates the interviewer as an active and empathetic listener and sets the stage for behavioural change.	Obstetrics and Gynecology; fast-paced health care settings	(282,283)
SPIKES protocol	**S**etting up the interview: arrange for a setting of privacy, prevent interruptions, sit down and make eye contact, and include significant others. **P**erception: assess the person's understanding of their health situation by asking open-ended questions to tailor the information to be provided. **I**nvitation: discuss how they would like to receive information and how much. **K**nowledge: provide information in accordance with the person's wishes that will help them understand their situation and make informed decisions. **E**motions: using communication tools such as observing for cues of emotional distress, responding with statements of empathy and recognition of emotions, and allowing periods of silence for processing of information. **S**trategy and summary: a care plan is made in accordance with the values and wishes of the person.	Cancer care	(269,270,280)
SPIKES protocol (child adapted)	▪ Health providers may use activities and tools to support the child in safely engaging and participating in the treatment processes. ▪ The proposed child-adapted SPIKES model involves establishing a relationship, assessing the person's perceptions, obtaining the person's invitation, providing knowledge and information to the person, addressing emotions, implementing a procedure when relevant. ▪ The strategies discussed are intended for use with infants and toddlers (0-18 months), preschool age (2-6 years), school age (7-12 years), adolescence (13-18 years).	Child-centered	(284)
SURETY Non-Verbal Communication Model	**S** – Sit at an angle to the client (creates a non-confrontational arrangement) **U** – Uncross legs and arms (communicates we are open and receptive) **R** – Relax (adopt a natural position) **E** – Eye contact (communicates respect and attention, without staring at the other person) **T** – Touch (respectful use of touch can communicate empathy although cultural sensitivity is required) **Y** – Your intuition (remembering that every interaction is unique, and each situation should be assessed individually) From Jack et al. (215).	Psychiatry; cancer care; hospital setting	(221, 258, 285, 286)

TYPES OF COLLABORATIVE COMMUNICATION	DESCRIPTION	EXAMPLES of SETTING or CONTEXT	REFERENCE
VIPS Framework	**V**alue the person ▪ Value for each person regardless of age, cognitive ability, or condition is a fundamental tenet of people-centred dementia care philosophy. ▪ Promote citizenship rights and entitlements regardless of age or cognitive impairment and eliminate discriminatory practice. - Attend to both a person's relational needs and physical care needs. **I**ndividual approach and care ▪ Treating a person with dementia as a unique individual with distinctive care needs is essential in the people-centred care framework. ▪ Appreciate that all people have a unique history and personality, physical and mental health, and social and economic resources, and that these will affect their response to dementia. ▪ Understand that as the impairment of verbal communication skills accompanies the progression of dementia, individuals often communicate their needs via outward behaviours and non-verbal responses. **P**erspective ▪ Look at the world from the perspective of the person with dementia. ▪ Recognize that each person's experience has its own psychological validity, that people with dementia act from this perspective. **S**upportive social environment ▪ Creating an environment that promotes emotional well-being, trust, and security. ▪ Encouraging family involvement, teamwork, and a culture of compassion.	Dementia care	(230)

Appendix E: The components and activities performed by health and social service providers in care coordination that support the delivery of people-centred care

Using a two-step mixed methods approach, an interdisciplinary research team (EPOCK team) developed an evidence-based reference framework for care coordination, focusing on micro-level (clinical) activities delivered to people receiving care (287). In the first step, a scoping review of reviews was conducted to explore the impact of care coordination interventions and their key components. In the second step, a total of nine experts (including a "patient expert") were assembled and a nominal group technique implemented to select and prioritize activities of care coordination that were most relevant and applicable (287). The nominal group technique included: 1) group discussion to reach consensus on the activity items identified by the scoping review, 2) independent rating of each activity item, and 3) discussion of results, along with rewording and re-grouping of activities.

Three overarching characterizations of care coordination were identified, each consisting of several activities and elements. The first overarching characterization was "organization of care". Care coordination activities within this component of the framework included:

- case identification: all activities that identify people who need coordination of care through the pathway. Examples include identifying people with complex needs and identifying people that are not in contact with health or social care services (287).
- provider identification: activities that identify health and/or social service providers that may be involved in the care of the person. Examples include outlining the roles and responsibilities of each partner and their competencies, identifying any resources that may be required (e.g., structural, financial, devices), assessing the level of engagement of the person receiving care and family/caregiver(s) they deem to be important (287).
- care planning: activities that define the care plan and monitor for implementation. Examples include creating individualized plans of care with the person receiving care as well as health and social service providers, family/caregiver(s) identified by the person; planning the interventions for the person receiving care and ensuring the effective planning and implementation of the interventions (287).
- navigation: activities that connect care providers and/or refer people to the appropriate services. Examples include liaising with all partners who are involved in the care of the person to facilitate appropriate access to health and social services and supporting persons receiving care in accessing those services, ensuring effective transitions throughout the continuum of care and anticipating any barriers to care that might arise (287).

The second overarching characterization of care coordination identified was "care activities". Care coordination within this component of the framework included:

- collaboration with the person receiving care: activities that focus on the relationship between the person receiving care and the care coordinator, such as establishing a therapeutic alliance(287).

- comprehensive needs assessment and monitoring: activities that focus on initial and ongoing assessments of people's health and social needs. Examples include: assessing people's capacity for shared decision-making; gaining a comprehensive understanding of the needs of people and their families/caregivers, including health, social and spiritual care needs; assessing people's preferences, expectations and resources; assessing family's and caregivers' personal and environmental situations; monitoring for symptoms and screening for comorbidities; evaluating the quality, effectiveness and efficiency of the care provided (287).
- education and information for the person receiving care and their caregiver: activities focus on empowering people to gain greater control over their decisions and actions. Examples include providing people and their family/caregiver(s) with information about their illness, assessing health literacy and educational needs, monitoring and supporting adherence to treatment, supporting people and their family/caregiver(s) if needs are expressed (287).

The third overarching characterization of care coordination identified was "facilitation activities". Care coordination within this component of the framework included:

- communication and information sharing: refers to formal and informal communication between health and social service providers, such as relaying any information that is identified, collected and recorded from people receiving care (287).
- professional training and education: refers to all activities related to the collection and recording of medical information. Examples include assisting and informing the care team concerning necessary care and its coordination, providing knowledge (know-how and experiential) required for appropriate care to the care team and identifying any required training needs (287).
- quality procedures: refers to activities related to the exchange and interpretation of information. Examples include supporting the care team in the use of evidence-based guidelines, participating in audits, and assessing and analyzing the experiences of people during care coordination (287).

The activities in this framework can be used by health and social service providers to guide care coordination practice by informing job roles training programs, to develop performance indicators, digital tools, and for comparing care coordination across contexts (287).

Appendix F: Communication support frameworks

This tool provides three frameworks to support communication, including: acknowledging and attending to emotion, empathic communication, and assessing and understanding of information.

Communication Support Frameworks

N-U-R-S-E-S

A framework for acknowledging and attending to emotion

Dealing with emotion is often necessary for effectively discussing serious illness decisions. When patients express strong emotion, it is helpful to actively listen even if the situation cannot be "fixed."

Name — Acknowledges an emotion. (Anger, sadness, frustration) "It sounds like you are frustrated/sad/upset," then pause.

Understand — Acknowledges the emotion or situation. Stop short of "I understand how you feel." For example, "I can't imagine what you are going through," or "This helps me understand what you are thinking."

Respect — Expressions of praise or gratitude about things the patient and family are doing. "I really appreciate and can see you have been working hard to follow the instructions," or "You have been so strong throughout this difficult time."

Support — Expresses support and affirms non-abandonment. "We will do everything we can to support you through this process." or "I will do my best to make sure you have what you need."

Explore — Asking a focused question from a place of curiosity. "Could you say more about what you mean when you say….?"

Silence — Using silence intentionally to show presence.

WISH-WORRY-WONDER

July 2020

A framework for empathic communication

I wish ….. I worry….. I wonder statements

KEY IDEAS

"I wish" allows for aligning with the patient's hopes.

"I worry" allows for being truthful while sensitive.

"I wonder" is a subtle way to make a recommendation.

Align with patient hopes, acknowledge concerns, and then propose a way to move forward:

"I *wish* we could slow down or stop the growth of your cancer and I promise that I will continue to look for options that could work for you. I *worry* that you and your family won't be prepared if things don't go as we hope. I *wonder* if we can discuss a different plan today."

ASK-TELL-ASK

A framework for assessing the understanding of information

Ask What they know and what they want to know. (Ex. "What is your understanding of...")

Tell Provide a few short sentences using simple language to fill in the gaps. (Ex. "Here's what the tests show...")

Ask them to repeat back what was just explained in their own words. (Ex. "If you were to go home and relay this information to your sister, what would you tell her?")

Reprinted with permission from: Comprehensive Advanced Palliative Care Education (CAPCE) Program. Communication Support Frameworks [Internet]. London (ON): Palliative Pain & Symptom Management Consultation Program Southwestern Ontario; 2020 July. Available from https://www.palliativecareswo.ca/docs/Communication-Support-Tools-Framework.pdf

Appendix G: Talk clinical debriefing tool

This tool provides a guide for clinical teams to reflect on learning events and promotes a culture of learning and patient safety.

T **Step 1: Target**
What shall we discuss to improve patient care?
Share your perspective.

A **Step 2: Analysis**
Explore your agreed target, if appropriate consider:
1. What helped or hindered...
   communication / decision making / situational awareness?
2. How can we repeat successful performances or improve?

L **Step 3: Learning Points**
What can the team learn from the experience?

K **Step 4: Key Actions**
What can we do to improve and maintain patient safety?
Who will take responsibility for actions? Who will follow up?

Reprinted with permission from: Diaz-Navarro C, Armijo-Rivera S, Prudenico-Palomino C, Velazcoo-Gonzalez J, Castro P. et al. (2024). Evaluation of TALK© training for interprofessional clinical debriefing in Latin America. *Archives of Medical Research 55*(7), p103060. Available from: doi.org/10.1016/j.arcmed.2024.103060, and Diaz-Navarro C, Leon-Castelao E, Hadfield A, Pierce S, Szyld D. (2021). Clinical debriefing: TALK© to learn and improve together in healthcare environments. *Trends in Anaesthesia and Critical Care 40*, p4-8. Available from: https://doi.org/10.1016/j.tacc.2021.07.004, and Diaz-Navarro C, Enjo-Perez I, Leon-Castelao E, Hadfield A, Nicolas-Arfelis JM. Implementation of the TALK© clinical self-debriefing tool in operating theatres: a single-centre interventional study. *Brit J of Anaesthesia 133*(4), p853-861. Available from: https://doi.org/10.1016/j.bja.2024.05.044.

Appendix H: Sample questions to consider when implementing a trauma-informed approach across an organization

For organizations who would like to implement a trauma-informed approach to care, this appendix provides sample questions to consider across 10 implementation domains.

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

KEY PRINCIPLES					
Safety	**Trustworthiness and Transparency**	**Peer Support**	**Collaboration and Mutuality**	**Empowerment, Voice, and Choice**	**Cultural, Historical, and Gender Issues**
10 IMPLEMENTATION DOMAINS					
Governance and Leadership	• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? • How do the agency's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?				
Policy	• How do the agency's written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? • How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?				

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Physical Environment	• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this? • How has the agency provided space that both staff and people receiving services can use to practice self-care? • How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).
Engagement and Involvement	• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? • How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information? • How is transparency and trust among staff and clients promoted? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross Sector Collaboration	• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?
Screening, Assessment, Treatment Services	• Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? • Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? • How are peer supports integrated into the service delivery approach? • How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women? • Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding? • How are these trauma-specific practices incorporated into the organization's ongoing operations?

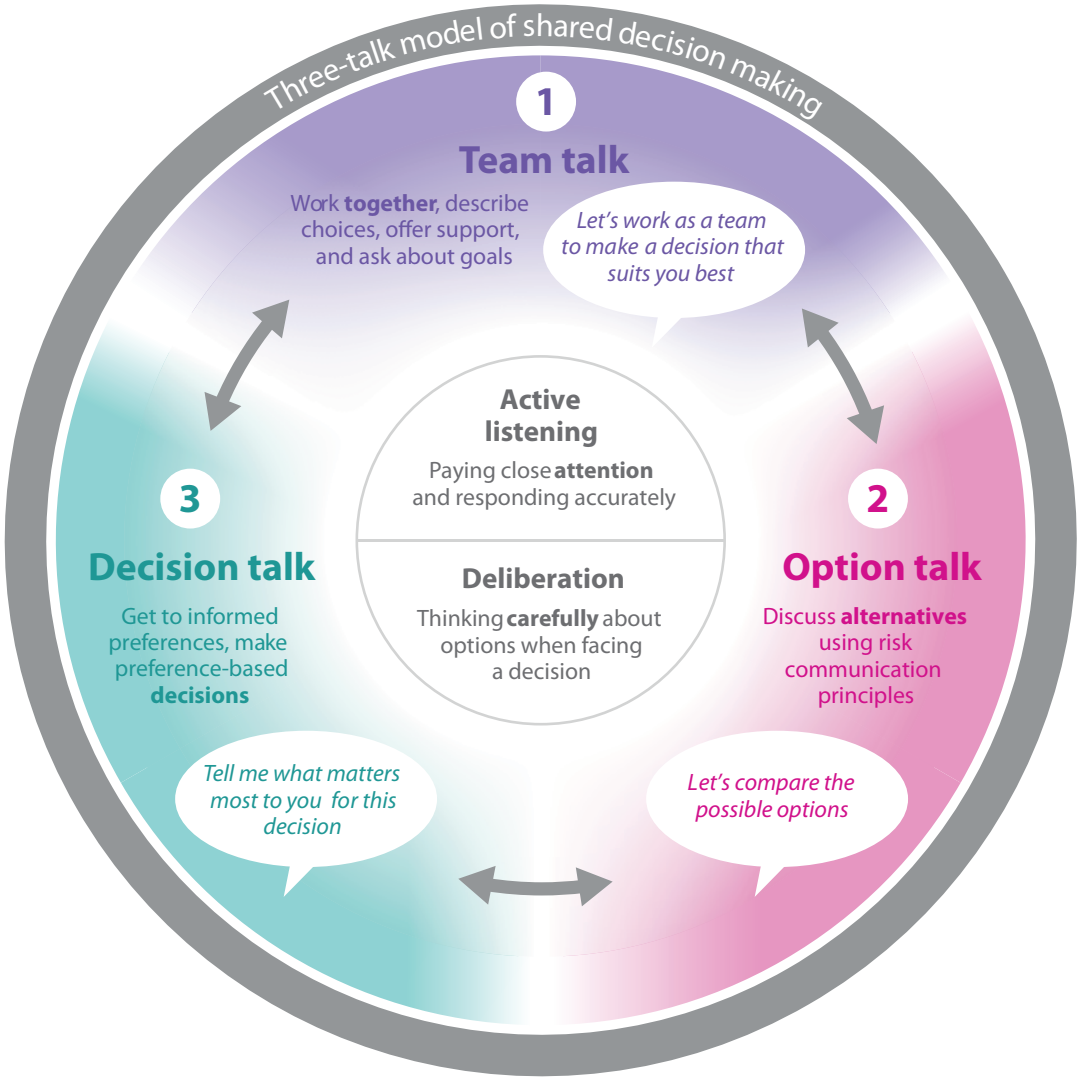
SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Training and Workforce Development	• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors. • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?
Progress Monitoring and Quality Assurance	• Is there a system in place that monitors the agency's progress in being trauma-informed? • Does the agency solicit feedback from both staff and individuals receiving services? • What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency? • How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? • What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?
Financing	• How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?
Evaluation	• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

Reprinted with permission from: Substance Abuse and Mental Health Services Administration (SAMHSA). Practical guide for implementing a trauma-informed approach. SAMHSA Publication No. PEP23-06-05-005. Rockville (MD): National Mental Health and Substance Use Policy Laboratory; 2023. Available from: https://library.samhsa.gov/sites/default/files/pep23-06-05-005.pdf

Appendix I: Three-talk model for shared decision-making

This model provides conversational steps that emphasize collaboration and deliberation throughout the decision-making process with people receiving care.



Reprinted with permission from: Elwyn G, Durand ME, Song J, et al. (2017). A three-talk model for shared decision making: multistage consultation process. BMJ, 359: j4891. doi: 10.1136/bmj.j4891.

Appendix J: Serious illness conversation guide

The Serious Illness Conversation Guide provides examples of prompts that can be used when speaking with people about their goals and values, initiating conversations with people receiving care, assessing people's understanding of their illness and informaiton preferences, sharing prognoses with people, exploring key topic areas, and ending the conversation.

Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

SET UP

"I would like to **talk together** about what's happening with your health and **what matters to you. Would this be ok?"**

ASSESS

"To make sure I share information that's helpful to you, can you tell me **your understanding** of what's happening with your health now?"

"How much **information about what might be ahead** with your health would be helpful to discuss today?"

SHARE

"Can I share my understanding of what may be ahead with your health?"

Uncertain: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time, and we will work toward that goal. **It's also possible that you could get sick quickly**, and I think it is important that **we prepare** for that."
OR
Time: "I **wish** this was not the case. I am **worried** that time may be as short as *(express a range, e.g. days to weeks, weeks to months, months to a year).*"
OR
Function: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time, and we will work toward that goal. **It's also possible that it may get harder to do things** because of your illness, and I think it is important that we prepare for that."

Pause: Allow silence. Validate and explore emotions.

EXPLORE

"If your health was to get worse, what are your **most important goals**?"

"What are your biggest **worries**?"

"What **gives you strength** as you think about the future?"

"What **activities** bring joy and meaning to your life?"

"If your illness was to get worse, **how much would you be willing to go through** for the possibility of more time?"

"How much do the **people closest to you know** about your priorities and wishes for your care?"

"Having talked about all of this, **what are your hopes** for your health?

CLOSE

"I'm hearing you say that ___ **is really important to you** and that you are **hoping for** ___. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your **care reflects what's important to you. How does this plan seem to you?"**

"I will do everything I can to support you through this and to make sure you get the **best care possible."**

SI-CG 2023-05-18

ARIADNE LABS

Source: Reprinted with permission from: Ariadne Labs: A Joint Center for Health Systems Innovation between Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health, in collaboration with Dana-Farber Cancer Institute. Serious Illness Conversation Guide: Welcome to our updated guide. 2023 May. Available from: https://www.ariadnelabs.org/wp-content/uploads/2023/05/Serious-Illness-Conversation-Guide.2023-05-18.pdf

Appendix K: PAUSE Talking map for early goals of care conversations

The PAUSE Talking map provides examples statements or questions that health and/or social service providers can adapt when having "early" goals of care conversations with people. "Early" refers to when the clinical decision is not imminent.

PAUSE Talking Map
To us, an 'early' goals of care conversation is one where a clinical decision is not imminent. For that, use the PAUSE talking map.

PAUSE

GOALS OF CARE, EARLY IN THE ILLNESS

STEP	WHAT YOU SAY OR DO
PAUSE, make the time	***"There is something I'd like to put on our agenda today."*** Take a moment to introduce the topic.
ASK permission and explain why.	***"I would like your opinion on something. Occasionally one of my patients gets sick suddenly and I can't talk to them."*** *"Then I worry that I can't provide the best care for them."* *"For example, one of my patients told me that they would never want to be a vegetable. That's very important for me to know, even when that person is far from being that sick."* *"What do you think about that?"*
UNDERSTAND big picture values.	***"Have you ever heard about advance directives or living wills?"*** *"If the disease was getting worse and might take your life, what would be most important to you?"* *"Some people think that we should focus on comfort, others say adding days to your life is the most important. What do you think?"*
SUGGEST choosing a surrogate.	***"Have you ever thought about who would be the best person to make medical decisions if you were too sick to make them yourself?"***
EXPECT emotion respond empathically.	***"I can see this is making you feel concerned." [names the emotion]*** *"What I am hearing you say is you want to keep fighting."* [Reflects the patient's words back]

Reprinted with permission from: Vital Talk. Pause talking map: Goals of care, early in the illness [Internet]. [place unknown]: Vital Talk; [date unknown]. Available from: https://www.vitaltalk.org/guides/pause-talking-map/

Appendix L: What matters to me: A workbook for better health care (for people accessing health and social services)

The "What Matters to Me" Workbook is for people with a serious illness prepare to speak with their health-care team about what is most important to them. Instructions on how to complete the following pages, as well as information for next steps can be found in the full resource, available here: https://theconversationproject.org/wp-content/uploads/2020/12/WhatMattersToMeWorkbook.pdf

My Health

- What is your understanding of what's happening with your health now?

- How much information about what might be ahead with your health would you like from your health care team?

About Me

- MY GOOD DAYS • What does a good day look like for you?

  Here are some things I like to do on a good day:

  EXAMPLES

  Get up and dressed • Play with my cat • Make a phone call • Watch TV • Have coffee with a friend

- MY HARD DAYS • What does a hard day look like for you?

  These are the toughest things for me to deal with on a hard day:

  EXAMPLES

  Can't get out of bed • In a lot of discomfort • No appetite • Don't feel like talking to anyone

- MY GOALS • If your health gets worse, what are your most important goals?

  These are some things I would like to be able to do in the future:

  EXAMPLES

  Take my dog for a walk • Attend my child's wedding • Feel well enough to go to church • Talk to my grandchildren when they come to visit

My Care

Everyone has their own preferences about the kind of care they do and don't want to receive. Use the scales below to think about what you want at this time.
Note: These scales represent a range of feelings; there are no right or wrong answers.

- Answer where you are right now. For each scale below, think about what you want now. Revisit your answers in the future, as they may change over time.
- Use your answers as conversation starters. Your answers can be a good starting point to talk with others about why you answered the way you did.

As a patient, I'd like to know…

○	○	○	○	○
Only the basics about my condition and my treatment				All the details about my condition and my treatment

When there is a medical decision to be made, I would like…

○	○	○	○	○
My health care team to make all the decisions				To have a say in decisions whenever possible

What are your concerns about medical treatments?

○	○	○	○	○
I worry that I won't get enough care				I worry that I'll get too much care

How much medical treatment are you willing to go through for the possibility of gaining more time?

○	○	○	○	○
Nothing: I don't want any more medical treatments				Everything: I want to try any medical treatments possible

If your health situation worsens, where do you want to be?

○	○	○	○	○
I strongly prefer to be in a health care facility				I strongly prefer to be at home, if possible

When it comes to sharing information about my illness with others…

○	○	○	○	○
I don't want those close to me to know all the details				I do want those close to me to know all the details

ABOUT ME • What would you like your health care team to know about you?

Something basic or practical:

EXAMPLES

My faith is very important to me • I live alone and need to be able to care for myself • I remember things better when they are written down

MY FEARS AND WORRIES • What are your biggest worries?

These are the main things I worry about:

EXAMPLES

I don't want to be in pain • I'm worried that I won't be able to get the care I want • I don't want to feel stuck someplace where no one will visit me • I worry about the cost of my care • What if I need more care than my caregivers can provide?

MY STRENGTHS • As you think about the future, what gives you strength?

These are my main sources of strength in difficult times:

EXAMPLES

My friends • My family • My faith • My garden • Myself ("I just do it")

MY ABILITIES • What activities bring joy and meaning to your life?

I want to keep going as long as I can…

EXAMPLES

As long as I can at least sit up on the bed and occasionally talk to my grandchildren • As long as I can eat ice cream and watch football on TV • As long as I can recognize my loved ones • As long as my heart is beating, even though I'm not conscious

MY HOPES • What are your hopes for your health?

Here's what I want to make sure DOES happen:

EXAMPLES

I want to stay as independent as possible • I want to get back home • I want my doctors to do absolutely everything they can to keep me alive • I want everybody to respect my wishes if I say I want to switch to comfort care only

And here's what I want to make sure DOES NOT happen:

EXAMPLES

I don't want to become a burden on my family • I don't want to be alone • I don't want to end up in the ICU on a lot of machines • I don't want to be in pain

Is there anything else you want to make sure your family, friends, and health care team know about your hopes for care?

MY QUESTIONS • What questions do you want to ask your health care team?

EXAMPLES

How will you work with me over the coming months? • What treatment options are available for me at this point — and what are the chances they'll work? • What can I expect if I decide I don't want more curative treatment? • If I get sicker, what can you do to help me stay comfortable? • What are the best-case and worst-case scenarios?

My People

- Are there key people who will be involved in your care (family members, friends, faith leaders, others)? For each person you list, be sure to include their phone number and relationship to you.

- How much do they know about your hopes and preferences? What role do you want them to have in decision making? When might you be able to talk to them about your wishes?

- Which person would you want to make medical decisions on your behalf if you're not able to? This person is often called your health care proxy, agent, or surrogate. See the Guide to Choosing a Health Care Proxy for help.

Name, phone number, relationship to me

I have talked with this person about what matters most to me. ◯ Yes ◯ No

I have filled out an official form naming this person as my health care proxy. ◯ Yes ◯ No

I have checked to make sure my health care team has a copy of the official proxy form. ◯ Yes ◯ No

My Health Care Team

Who are the key clinicians involved in your care?

	Name	Phone
My primary care provider		
My social worker		
My main specialist		
Other		

Source: Reprinted with permission from: Ariadne Labs and the Conversation Project, an initiative of the Institute of Healthcare Improvement (IHI). What matters to me: A workbook for people with serious illness [Internet]. [place unknown]; 2021. Available from: https://theconversationproject.org/wp-content/uploads/2020/12/WhatMattersToMeWorkbook.pdf

Appendix M: Decision guide template

A decision guide that can be used by people receiving care to identify any health and/or social decision and subsequently guide them through a series of steps that elicit thoughts about what is known about the decision, what matters most to them, and to plan next steps. The decision guide can also be used by health providers when guiding people in informed decision-making.

Ottawa Personal Decision Guide
For People Making Health or Social Decisions

❶ Clarify your decision.

What decision do you face?		
What are your reasons for making this decision?		
When do you need to make a choice?		
How far along are you with making a choice?	Not thought about it Thinking about it	Close to choosing Made a choice

❷ Explore your decision.

Knowledge
List the options and benefits and risks you know.

Values
Rate each benefit and risk using stars (★) to show how much each one matters to you.

Certainty
Choose the option with the benefits that matter most to you. Avoid the options with the risks that matter most to you.

	Reasons to Choose this Option Benefits / Advantages / Pros	How much it matters to you: 0★ not at all 5★ a great deal	**Reasons to Avoid this Option** Risks / Disadvantages / Cons	How much it matters to you: 0★ not at all 5★ a great deal
Option #1				
Option #2				
Option #3				

Which option do you prefer?	Option #1		Option #2		Option #3	Unsure

Support

Who else is involved?						
Which option do they prefer?						
Is this person pressuring you?	Yes	No	Yes	No	Yes	No
How can they support you?						

What role do you prefer in making the choice?	Share the decision with… Decide myself after hearing views of… Someone else decides…

❸ Identify your decision making needs.			Adapted from The SURE Test © 2008 O'Connor & Légaré.
	Knowledge	Do you know the benefits and risks of each option?	Yes No
	Values	Are you clear about which benefits and risks matter most to you?	Yes No
	Support	Do you have enough support and advice to make a choice?	Yes No
	Certainty	Do you feel sure about the best choice for you?	Yes No

If you answer 'no' to any question, you can work through steps two ❷ and four ❹, focusing on your needs.
People who answer "No" to one or more of these questions are more likely to delay their decision, change their mind, feel regret about their choice or blame others for bad outcomes.

❹ Plan the next steps based on your needs.		
Decision making needs	✓	**Things you could try**
Knowledge If you feel you do NOT have enough facts		Find out more about the options and the chances of the benefits and risks. List your questions. List where to find the answers (e.g. library, health professionals, counsellors):
Values If you are NOT sure which benefits and risks matter most to you		Review the stars in step two ❷ to see what matters most to you. Find people who know what it is like to experience the benefits and risks. Talk to others who have made the decision. Read stories of what mattered most to others. Discuss with others what matters most to you.
Support If you feel you do NOT have enough support		Discuss your options with a trusted person (e.g. health professional, counsellor, family, friends). Find help to support your choice (e.g. funds, transport, child care).
If you feel PRESSURE from others to make a specific choice		Focus on the views of others who matter most. Share your guide with others. Ask others to fill in this guide. (See where you agree. If you disagree on facts, get more information. If you disagree on what matters most, consider the other person's views. Take turns to listen to what the other person says matters most to them.) Find a person to help you and others involved.
Certainty If you feel UNSURE about the best choice for you		Work through steps two ❷ and four ❹, focusing on your needs.
Other factors making the decision DIFFICULT		List anything else you could try:

Source: Reprinted with permission from: O'Connor A, Stacey D, Jacobsen MJ. Ottawa personal decision guide. Ottawa (ON): Ottawa Hospital Research Institute & University of Ottawa, Canada; 2015. Available from: https://decisionaid.ohri.ca/docs/das/OPDG.pdf

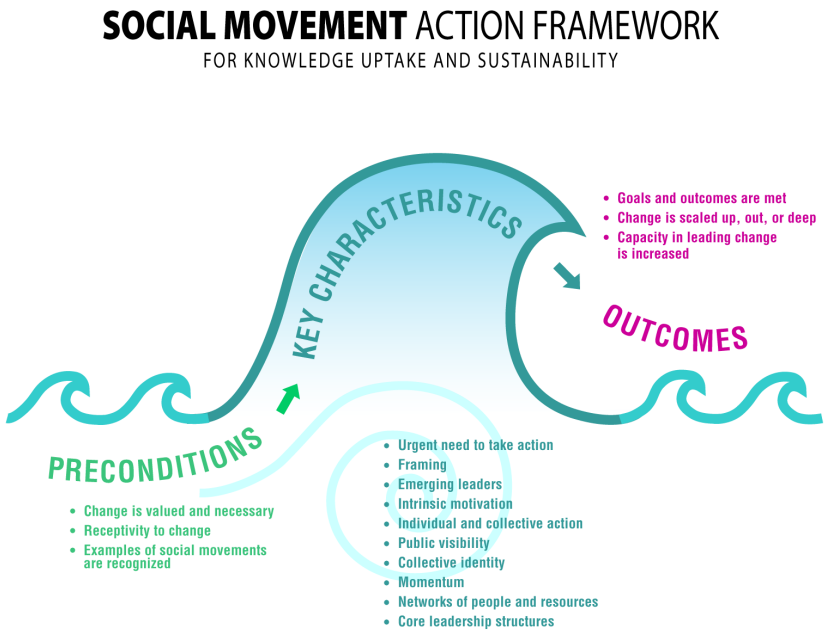
Appendix N: Description of the Leading Change Toolkit

BPGs can only be successfully implemented and sustained if planning, resources, organizational and administrative supports are adequate and 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, people advocates, social movement activists and administrators has developed the Leading Change Toolkit (5) . 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-care 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) (3,4) – for change agents and change teams leading the implementation and sustainability of BPGs. Both frameworks outline the concept of implementation and its inter-related 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**[G] 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) (1,288). The three categories and elements of the SMA Framework are shown in **Figure 4**.

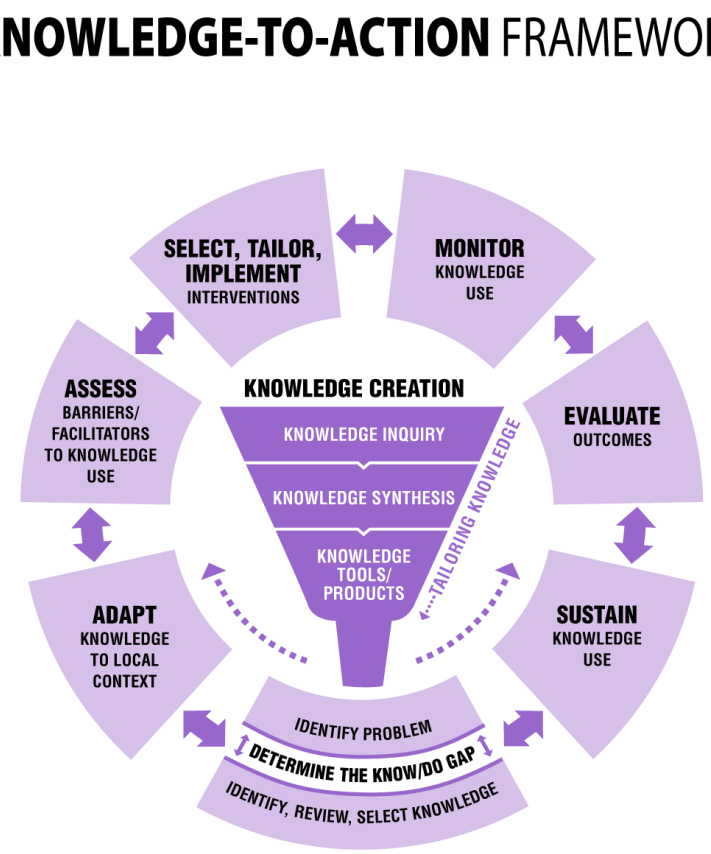
Figure 4: Social movement action framework



Source: Reprinted with permission from: Grinspun D, Wallace K, Li SA, 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. and Grinspun D, Wallace K, Li SA, et al. Leading change through social movement. Registered Nurse Journal. 2020. Spring:32(1).

The KTA Framework is a planned cyclical approach to change that integrates two related components: the knowledge creation 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 5** (5).

Figure 5: 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 and Sraus SE, Tetroe J, Graham ID. (2013). Introduction Knowledge translation: What it is and what it isn't. In SE Straus, J Tetroe, ID Graham (Eds.), Knowledge Translation in Health Care, https://onlinelibrary.wiley.com/doi/10.1002/9781118413555.ch01

Implementing and sustaining BPGs to effect successful practice changes and positive health outcomes for people, providers, organizations and systems is a complex undertaking. The Leading Change Toolkit is a foundational implementation resource for leading this process.

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As a component of the guideline development process, feedback was obtained from participants across a wide range of health and social service organizations, academic institutions, practice areas and sectors. Participants include nurses and members of the interprofessional team, educators, students, individuals with lived experience, knowledgeable administrators and funders of health and social services. **External reviewers**[G] representing diverse perspectives were also solicited for their feedback. RNAO wishes to acknowledge the following individuals for their contribution in reviewing this BPG. External reviewers have given consent to the publication of their names and relevant information in this BPG.

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Endorsements

Healthcare Excellence Canada / Excellence en santé Canada

Ottawa, September 2nd, 2025

Doris Grinspun
Chief Executive Officer and Founder of the Best Practices Guidelines Program
Registered Nurses' Association of Ontario

Dear Doris,

Hereby, on behalf of Healthcare Excellence Canada (HEC), I am delighted to inform you that we support the principles underlying the content developed in your Best Practice Guidelines (BPG) on "People Centered Care". This BPG recognizes the critical importance of learning about and from people accessing health services, developing an authentic relationship with people and co-designing plans of care that emphasize the values and preferences, needs and desires of people. Those principles embedded in your BPG align with HEC's values of fostering inclusive and equitable care and establishing meaningful partnerships with various groups (ex.: people and their families, healthcare providers) to influence a future where safe and high-quality healthcare is available for all people across the country.

As our respective work has in common shared values, we also invite you to stay connected with us. HEC is currently working at launching publicly, in March 2026, as part of Care Forward , self paced training learning modules on Rethinking Patient Safety, Engagement-capable environments, Cultural Safety, and the Health Equity Framework. All that material will be accessible on web at no cost for everyone who is interested in those topics, as the foundations of healthcare excellence.

Should you have any questions on those four foundations of healthcare excellence, we invite you to contact Carol Fancott, Director, Patient safety, equity, and engagement at carol.fancott@hec-esc.ca

Warm regards,

Jérôme Ouellet, R. N., Ph. D.
Director, Leadership Programs

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THE ONTARIO caregiver ORGANIZATION

September 3, 2025

Dr. Doris Grinspun, RN, BScN, MSN, PhD, LLD (hon), Dr (hc), DHC, DHC, FAAN, FCAN, O.ONT.
Chief Executive Officer and Founder of the Best Practices Guidelines Program
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Dear Dr. Grinspun,

The Ontario Caregiver Organization is pleased to offer our support for and endorsement of the Registered Nurses' Association of Ontario's (RNAO) best practice guideline – *People-Centred Care, Third Edition*.

At The Ontario Caregiver Organization, we are dedicated to supporting the more than 4 million caregivers across the province who provide physical and emotional support to family members, friends, and loved ones. The principles outlined in the third edition of the *People-Centred Care* guideline align closely with our focus on improving the lives of caregivers and ensuring they are recognized and empowered as essential partners in care. This guideline promotes a holistic, respectful, and inclusive approach to care that acknowledges the unique needs, values, and preferences of individuals and their caregivers.

We believe this BPG is an invaluable resource for nurses and other health and social service providers. It provides evidence-based strategies that foster collaboration, enhance communication, and improve outcomes for those receiving care and those who support them. By embedding people-centred care into practice, we can collectively build a more compassionate and responsive health system.

We congratulate the RNAO on their leadership and commitment to promoting guidelines that embody the principles of people-centred care.

Sincerely,

Amy Coupal
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Notes

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This project is funded by the Government of Ontario.

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ISBN 978-1-926944-89-0

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