

## Registered Nurses' Association of Ontario

### *People-Centred Care, 3<sup>rd</sup> edition: Methods*

September, 2025

This document presents an overview of the Registered Nurses' Association of Ontario (RNAO) guideline development process and methods. RNAO is unwavering in its commitment that every best practice guideline (BPG) be based on the best available evidence. The Grading of Recommendations Assessment, Development and Evaluation (GRADE) (1) has been implemented to provide a rigorous framework and meet international standards for guideline development. RNAO also 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 (2,3).

#### **Scoping the best practice guideline**

The scope defines what an RNAO BPG will and will not cover (see **Purpose and scope** in the full BPG). To determine the purpose and scope of this particular BPG, the RNAO best practice guideline development and research team conducted the following steps:

1. **A review of previous BPGs.** The following RNAO BPGs were reviewed: *Person and Family-Centred Care* (4), *Establishing Therapeutic Relationships* (5) and *Strengthening and Supporting Families through Expected and Unexpected Life events* (6). It was determined that these BPGs would be merged into the next edition guideline because of the overlapping clinical concepts.
2. **An environmental scan of guidelines.** Two guideline development methodologists searched an established list of websites for guidelines and other relevant content published between January 2014 and September 2021. The purpose of the guideline search was to gain an understanding of existing guidelines on people-centred care to identify opportunities to develop the purpose and scope of this BPG. The resulting list was compiled based on knowledge of evidence-based practice websites and recommendations from the literature. RNAO expert panel members were asked to suggest additional guidelines (see the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram online at <https://rnao.ca/bpg/guidelines/people-centred-care>). A PRISMA diagram is a diagram that depicts the flow of information throughout the different phases of a systematic review. It maps the number of articles identified, included and excluded (7). For more detailed information, please see the search strategy (found here: <https://rnao.ca/bpg/guidelines/people-centred-care>) for existing guidelines, including the list of websites searched and the inclusion criteria used.

The guidelines were reviewed for content, applicability to nursing scope of practice, accessibility and quality. The two guideline development methodologists appraised 6 international guidelines using the AGREE II tool (2). Guidelines with an overall score of six or seven (on a 7-point Likert scale) were considered high quality. Systematic reviews that answered research questions in high-quality guidelines were considered for GRADE-

ADOLOPMENT. GRADE-ADOLOPMENT provides a framework for adopting or adapting trustworthy recommendations from existing guidelines in this BPG (8).

The following guidelines were appraised as indicated:

- National Institute for Health and Care Excellence (NICE). Shared decision making [Internet]. Manchester (UK): NICE; 2021 Jun. Available from: <https://www.nice.org.uk/guidance/ng197>
  - Score: 6 out of 7.
  - This guideline was used as a supporting resource for good practice statement 2.0 on shared decision-making.
- National Institute for Health and Care Excellence (NICE). Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [Internet]. Manchester (UK): NICE; 2021 Jun. Available from: <https://www.nice.org.uk/guidance/cg138>
  - Score: 6 out of 7.
  - This guideline was used as a supporting resource for good practice statement 2.0 on shared decision-making.
- National Institute for Health and Care Excellence (NICE). Babies, children and young people's experience of healthcare [Internet]. Manchester (UK): NICE; 2021 Aug. Available from: <https://www.nice.org.uk/guidance/ng204>
  - Score: 7 out of 7
  - This guideline was used as a supporting resource for good practice statement 2.0 on shared decision-making.
- Cancer Care Ontario (CCO). Person-centred care guideline [Internet]. Toronto (ON): CCO; 2015 May. Available from: <https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/38631>
  - Score: 5 out of 7.
  - This guideline was not used as a supporting resource.
- Jardien-Baboo S, Rooyen D van, Ricks E, Jordan P, Ham-Baloyi W ten. Best practice guideline for patient-centred care in south african public hospitals. Africa Journal of Nursing and Midwifery [Internet]. 2019 Nov 13; 21(2):20 pages-20 pages. Available from: <https://unisapressjournals.co.za/index.php/AJNM/article/view/4590>
  - Score: 4 out of 7.
  - This guideline was not used as a supporting resource.
- National Institute for Health and Care Excellence (NICE). Decision-making and mental capacity [Internet]. Manchester (UK): NICE; 2018 Oct. Available from: <https://www.nice.org.uk/guidance/ng108>
  - Score: 6 out of 7
  - Even though it scored highly, this guideline was not used as a supporting resource because the guideline is to be used in conjunction with the United Kingdom's Mental Capacity Act.

3. **An environmental scan of standards.** Two guideline development methodologists also searched for standards published within Canada between Jan 2017 and March 2022 to gain an understanding of existing standards on people-centred care and to identify their scope. Exceptions were made for foundational standards published before January 2017. The standards were reviewed for content, applicability to nursing scope of practice and accessibility. The standards were not quality appraised.

The following standards were reviewed as indicated:

- 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](https://cno.org/Assets/CNO/Documents/Standard-and-Learning/Practice-Standards/41033_therapeutic.pdf)
    - The content of this standard was used as a supporting resource.
  - Health Quality Ontario (HQO). Palliative care [Internet]. Toronto (ON): HQO; 2018. Available from: <https://www.hqontario.ca/portals/0/documents/evidence/quality-standards/qs-palliative-care-clinical-guide-en.pdf>
    - This standard was not used in the BPG.
  - National Institute for Health and Care Excellence (NICE). Supporting adult carers [Internet]. Manchester (UK): NICE; 2021 Mar. Available from: <https://www.nice.org.uk/guidance/qs200>
    - This standard was not used in the BPG.
  - British Columbia College of Nurses and Midwives (BCCNM). Practice standard for BCCNM nurses: Boundaries in the nurse-client relationship [Internet]. Vancouver (BC): BCCNM; 2020 Nov. Available from: [https://www.bccnm.ca/RN/PracticeStandards/Lists/GeneralResources/RN\\_PS\\_Boundaries.pdf](https://www.bccnm.ca/RN/PracticeStandards/Lists/GeneralResources/RN_PS_Boundaries.pdf)
    - This standard was not used in this BPG.
  - General Pharmaceutical Council. Standards for pharmacy professionals [Internet]. Great Britain: General Pharmaceutical Council; 2017 May. Available from: [https://assets.pharmacyregulation.org/files/standards\\_for\\_pharmacy\\_professionals\\_may\\_2017\\_0.pdf?VersionId=C8dRrU1opDLdsuveSss5cKsPSwKObTi2](https://assets.pharmacyregulation.org/files/standards_for_pharmacy_professionals_may_2017_0.pdf?VersionId=C8dRrU1opDLdsuveSss5cKsPSwKObTi2)
    - This standard was not used in the BPG.
  - College of Physiotherapists of Alberta. Client-centered care [Internet]. College of Physiotherapists of Alberta; 2017 May. Available from: <https://www.cpta.ab.ca/for-physiotherapists/regulatory-expectations/standards-of-practice/client-centered-care/>
    - This standard was not used in the BPG.
4. **A review of the literature.** A literature review was undertaken to determine the available interventions related to people-centred care. Two guideline development methodologists searched for literature published between January 2017 and April 2022. Common findings

across studies were summarized and shared with the expert panel during the initial planning meetings.

5. **Key informant interviews.** 37 interviews were conducted virtually with experts in the field to understand the needs of direct care health and social service providers, researchers, patient advocates, and people with lived experience in relation to people-centred care.
6. **Discussion groups were convened.** Five virtual sessions were convened with a total of 29 people to understand the needs of direct care health and social service providers, researchers, patient advocates, and people with lived experience in relation to people-centred care.

### Assembly of the expert panel

RNAO aims for diversity in membership of an expert panel; this is in alignment with RNAO's Mission and Values (9). RNAO also aims for people impacted by BPG recommendations, especially people with lived experience and their families, to be included as expert panel members.

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

- searching the literature for researchers in the topic area;
- soliciting recommendations from key informant interviews;
- drawing from established professional networks, such as RNAO Interest Groups, the Best Practice Champions Network<sup>®</sup> and Best Practice Spotlight Organizations<sup>®</sup> (BPSO<sup>®</sup>); and
- contacting other nursing and health provider associations, topic-relevant technical associations or organizations, and advocacy bodies.

For this BPG, the RNAO best practice guideline development and research team assembled a panel of experts from nursing practice, research and education, policy, other members of the interprofessional team and people with lived experience, representing a range of sectors and practice areas (see the **RNAO best practice guideline expert panel**).

The expert panel engaged in the following activities:

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

In addition to the above, the expert panel co-chairs also participated in the following activities:

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

- moderated consensus processes (and voting if necessary)

### **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 first recommendation build meeting and prior to guideline publication. Any COI declared by an expert panel member was reviewed by the RNAO best practice guideline development and research team and expert panel co-chairs. No limiting conflicts were identified by members of the expert panel. See “Declarations of Conflicts of Interest Summary” under the “methodology documents” tab of the BPG webpage (<https://rnao.ca/bpg/guidelines/people-centred-care>).

### **Identifying priority recommendation questions and outcomes**

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

Between December 2022 and April 2023, the RNAO best practice guideline development and research team and the expert panel convened virtually four times to determine the priority topic areas for this BPG. The four meetings included an orientation meeting and three planning meetings. A comprehensive list of topic areas that the BPG could potentially address was developed at the meetings. This list was informed by:

- the environmental scan of guidelines
- the review of the literature
- key informant interviews and discussion groups
- expert panel discussion during the planning meetings

The list of potential topic areas was sent to the expert panel in a confidential online survey after they had an opportunity to discuss them during the orientation meeting. Expert panel members were asked to provide feedback and suggest additional topic areas. The results were presented to the expert panel during the first planning meeting, and a comprehensive list of recommendation areas was brainstormed and discussed. With assistance from a GRADE consultant, the guideline development methodologists categorized the topic areas into recommendations, good practice statements, scoping reviews or guiding principles. Initially, five recommendation areas, three good practice statements, two scoping reviews and five guiding principles were identified. However, after further consultation with the GRADE consultant, two of the five recommendation questions were felt to be better suited as good practice areas.

In alignment with GRADE methods for assessing and presenting the evidence, outcomes were identified for each recommendation question. A comprehensive list of outcomes per recommendation question was developed, informed by a review of the literature, key informant

interviews, discussion groups and expert panel discussion. Outcomes were chosen based on what was considered important to people for decision-making. However, it was acknowledged that some outcomes may not have been captured through this process. To address this, the RNAO guideline development and research team identified core outcome constructs for each recommendation question. These constructs represent broader outcome categories associated with people-centred care. Individual outcomes for each recommendation question were then aligned with the relevant core constructs (see **Table 1**). During the systematic review, guideline development methodologists could add new outcomes that fit within these core constructs. The expert panel was provided with an update via email regarding the final list of outcomes for each recommendation question and was invited to provide feedback.

**Table 1:** Core constructs per recommendation question

Core Constructs	Outcomes	Outcomes	Outcomes
	Q1: Decision Aids	Q2: Sensory Environment	Q3: Champions
<b>Co-designed people-centred care</b> (person/family feeling respected, preferences heard, and at centre of care-partnership)	1. People’s participation in their care (i.e., involvement in decision making and treatment options)	1. People, family or caregiver satisfaction with or sensory-minimizing strategies	1. People, family or caregiver satisfaction with care (or with champion)
<b>Provider/people outcomes</b>	1. Provider satisfaction with care (or decision aid) 2. People’s knowledge (about benefits/harms) 3. People’s selection of a treatment/screening option that reflected what was most important to them 4. Provider care behaviors (establishing a therapeutic relationship, respectful of person’s preferences,	1. Provider satisfaction 2. Provider knowledge	1. Provider satisfaction 2. Provider care behaviors (e.g., establishing a therapeutic relationship, respectful of person’s preferences, cultural sensitivity, etc.)

	cultural sensitivity, etc.)		
<b>Clinical outcomes</b>	N/A	1. Physiologic measures	N/A
<b>Organizational or health system outcomes</b>	<ol style="list-style-type: none"> <li>1. Satisfaction with overall care (# of person/family complaints)</li> <li>2. Length of stay</li> <li>3. Re-admission rates</li> <li>4. Adoption and sustainability (of decision aid use)</li> </ol>	<ol style="list-style-type: none"> <li>1. Satisfaction with overall care (# of person/family complaints)</li> <li>2. Length of stay</li> <li>3. Re-admission rates</li> <li>4. Adoption and sustainability (of sensory-minimizing strategies)</li> </ol>	<ol style="list-style-type: none"> <li>1. Satisfaction (# of person/family complaints)</li> <li>2. Adoption and sustainability (of champions role, i.e., success of champions program)</li> </ol>
<b>Harms</b>	<ol style="list-style-type: none"> <li>1. People/caregiver burden</li> <li>2. Provider burden</li> </ol>	1. Provider burden	1. Provider burden

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

**Recommendation question #1:** Should decision aids used by health providers and people (to support shared decision-making [SDM] about treatment and care) be recommended or not?

**PICO research question #1**

**Population:** Health providers using decision aids (as part of SDM) and people making decisions about their health screening and health-care treatment options

**Intervention:** Decision aids

**Comparison:** No decision aids or usual decision-making process

**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 behaviors (establishing a therapeutic relationship respectful of person’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\*

\* For Recommendation question 1, the outcome “clinical outcomes” was not found in the literature.

**Recommendation question #2:** Should sensory-minimizing strategies that address noise and light (used to facilitate people-centred care) be recommended or not?

**PICO research question #2**

**Population:** Health providers at all levels of health and social service organizations or people receiving care

**Intervention:** sensory-minimizing strategies that address noise/lighting to facilitate people-centred care

**Comparison:** usual care or no sensory-minimizing strategy

**Outcomes:**

- people, family or caregiver 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\*

\* For Recommendation question 2, the outcomes “provider satisfaction,” “provider knowledge,” “re-admission rates,” “adoption and sustainability (of sensory-minimizing strategies),” and “provider burden” were not found in the literature.

**Recommendation question #3\*:** Should the use of champions (to support health providers delivering people-centred care) be recommended or not?

**PICO research question #3**

**Population:** Health providers at all levels of the health and social service organization or people receiving care

**Intervention:** Stand alone or multicomponent intervention that uses a champion to deliver people-centred care

**Comparison:** No health provider champions

**Outcomes:**

- people, family or caregiver satisfaction with champion\*\*
- provider satisfaction
- provider care behaviors
- satisfaction with overall care
- adoption and sustainability (of champions role, i.e., success of champions program)\*\*
- provider burden\*\*

\* See Updates to the recommendation questions and outcomes section below.

\*\* For Recommendation question 3, the outcomes of “person, family or caregiver satisfaction with champion,” “adoption and sustainability (of champions role),” and “provider burden” was not found in the literature.

**Updates to the recommendation questions and outcomes****Indirect evidence searches**

For **Recommendation question 3**, after conducting an initial systematic review search for direct evidence, it was decided to look for indirect evidence to answer the question. Although

direct evidence allows for more confidence in the results, in the absence of direct evidence GRADE suggests that indirect evidence can be used and downgraded accordingly (1). Directness is judged by assessing how closely the target population, intervention, and outcomes of interest in the research evidence align with those in the recommendation question (1). An indirect evidence search was conducted, with the help of a health sciences librarian, by broadening the intervention of the recommendation question (i.e., a standalone or multicomponent intervention that uses a champion model to promote or role model behaviour towards any particular innovation). After conducting an indirect evidence search for **Recommendation question 3**, it was determined that the current evidence was insufficient to assess the certainty of effects of champions compared to no champions in promoting or role modeling behaviour related to any particular innovation. As such, no recommendation was made. However, champions are a large component of implementation science where they assume formal and informal leadership roles to support the introduction, implementation and/or sustainability of best practice guidelines in workplace settings. With expert panel input, a decision was made to include implementation tips in the guideline related to the role of champions in supporting the implementation of good practice statements and recommendations.

### Developing good practice statements

The RNAO best practice guideline development and research team developed five good practice statements to capture the need for health providers to conduct shared-decision making, establish a therapeutic relationship, create and maintain a plan of care, conduct advance care planning, and offer virtual care as a alternative to in-person care, when appropriate, for all people accessing health-care services. Good practice statements are actionable statements that should be done in practice and the benefits of the action clearly outweigh the harms (10). Consensus was reached through discussion with the panel on each of the following five questions:

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

Through discussion, the expert panel determined that each of the five criteria had been met; therefore these areas become good practice statements.

### Systematic retrieval of the evidence

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

For this BPG, a search strategy was developed by RNAO's best practice guideline development and research team and a health sciences librarian for each of the aforementioned PICO research questions.

For **Recommendation question 1**, a search for relevant research studies published in English between March 2022 and February 2024 was applied to the following databases: Cumulative Index

to Nursing and Allied Health (CINAHL), Medline, Cochrane Central, Cochrane Database of Systematic Reviews, Embase and Emcare. A large Cochrane Review that was published in 2024 on this topic area was found. The authors of the Cochrane Review included RCTs published before March 2022; therefore for this research question, a search for relevant research studies was conducted between 2022 and 2024.

For **Recommendation question 2**, a search for relevant research studies published in English between January 2018 and July 2023 was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Medline, Cochrane Central, Cochrane Database of Systematic Reviews, Embase, Emcare, and PsycInfo. Initially, the search included studies that looked at sensory-minimizing strategies broadly (e.g., high intensity lights, noise, etc.); however, after consultation with the expert panel this was narrowed down to strategies that address noise and light only.

For **Recommendation question 3**, a search for relevant research studies published in English between January 2018 and August 2023 was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Medline, Cochrane Central, Cochrane Database of Systematic Reviews, Embase, Emcare, and PsycInfo.

The systematic reviews were registered in PROSPERO (CRD42023475962).

Expert panel members were asked to review their personal libraries for key studies not found through the above search strategies (see PRISMA diagrams under the “methodology documents” tab of the BPG webpage). Detailed information on the search strategy for the systematic reviews, including the inclusion and exclusion criteria and search terms, can be found in supplementary materials under the “methodology documents” tab of the BPG webpage.

Systematic review search dates were limited to the last five years to capture the most up-to-date evidence. For **Recommendation question 1**, only systematic reviews and randomized control trials were included as the topic area of decision aids is well researched. For **Recommendation questions 2 and 3**, all study designs were included in the searches.

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

All included studies were independently assessed for risk of bias by study design using validated and reliable tools. Randomized controlled trials were assessed using the Risk of Bias 2.0 tool (11), cluster randomized controlled trials were assessed using the Revised Cochrane risk-of-bias tool for cluster-randomized trials (12); non-randomized controlled trials were assessed using the ROBINS-I tool (13), and systematic reviews were assessed using the ROBIS tool (14). The two guideline development methodologists reached consensus on all scores through discussion.

For data extraction, the included studies were divided equally between the guideline development methodologists who each extracted information from their assigned studies; each reviewed the other’s work for accuracy.

The health science librarian conducted an indirect search for studies that answered **Recommendation question 3**, including studies published in English from January 2018 to March 2024. The search was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Medline, Cochrane Central, Cochrane Database of Systematic Reviews, Embase, Emcare, and PsycInfo.

In March 2025, the health science librarian conducted an update search for relevant studies published in English between July 2023 and March 2025 that answered **Recommendation question 2**. The search was applied to the following databases: Medline, Embase, Emcare Nursing, APA PsychInfo, EBM Reviews: Cochrane Central, EBM Reviews: CDSR, and CINAHL. Results from four studies were incorporated into the discussions of evidence for **Recommendations 2**. See PRISMA diagrams online for studies included in the update search.

## Determining certainty and confidence of evidence

### Certainty of evidence

The certainty of quantitative evidence (i.e., the extent to which one can be confident that an estimate of an effect is true) is determined using GRADE methods (1). First, the certainty of the evidence is rated for each prioritized outcome across studies (i.e., for a body of evidence) per recommendation (1). This process begins with the study design and then requires an examination of five domains—risks of bias, inconsistency, imprecision, indirectness and publication bias—to potentially downgrade the certainty of evidence for each outcome. For example, a body of quantitative evidence for one priority outcome may begin with high certainty, but due to serious limitations in one or more of the five GRADE criteria, it will be rated down by one or two levels (1). See **Table 2** for a definition of each of these certainty criteria.

**Table 2. GRADE certainty criteria**

Certainty criteria	Definition
<b>Risk of bias</b>	Limitations in the study design and execution that may bias study results. Valid and reliable quality appraisal tools are used to assess the risk of bias. First, risk of bias is examined for each individual study and then examined across all studies per defined outcome.
<b>Inconsistency</b>	Unexplained differences (heterogeneity) of results across studies. Inconsistency is assessed by exploring the magnitude of difference, and possible explanations in the direction and size of effects reported across studies for a defined outcome.
<b>Indirectness</b>	Variability between the research and review question and context within which the recommendations would be applied (applicability). Four sources of indirectness are assessed: <ul style="list-style-type: none"> <li>• differences in population</li> <li>• differences in interventions</li> <li>• differences in outcomes measured</li> <li>• differences in comparators.</li> </ul>

<b>Imprecision</b>	The degree of uncertainty around the estimate of effect. This is usually related to sample size and number of events. Studies are examined for sample size, number of events and confidence intervals.
<b>Publication bias</b>	Selective publication of studies based on study results. If publication bias is strongly suspected, downgrading is considered.

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. Available from: <https://gdt.grade.pro.org/app/handbook/handbook.html#h.svwngs6pm0f2>.

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

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

GRADE categorizes the overall certainty of evidence as high, moderate, low or very low. See **Table 3** for the definitions of these categories.

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

**Table 3: Certainty of evidence**

Overall certainty of evidence	Definition
<b>High</b>	We are very confident that the true effect lies close to that of the estimate of the effect.
<b>Moderate</b>	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.
<b>Low</b>	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
<b>Very low</b>	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, 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 2018 Aug 31]. Table 5.1, Quality of evidence grades. Available from: <https://gdt.grade.pro.org/app/handbook/handbook.html#h.9rdbelsnu4iy>

## Formulating recommendations

### Summarizing the evidence

The guideline development methodologists analyzed all studies pertaining to each research question and drafted recommendations that answer the research questions accordingly. For each draft recommendation, the two guideline development methodologists constructed GRADE evidence profiles. GRADE evidence profiles are used to present decisions on determining the certainty of evidence and to present general information about the body of research evidence, including key statistical or narrative results (1).

The evidence profiles for the body of quantitative studies included two tables. The first table presented the study design, the decisions made by the two guideline development methodologists on the five key GRADE certainty criteria for rating the evidence, the number of participants in the intervention and/or control group, the key results and the transparent judgments about the certainty underlying the evidence for each outcome (1). In the second table, further details about each of the individual studies was provided, including: the study design, the country/countries where the study was conducted, details about the intervention and/or control groups, reported findings, and the risk of bias as assessed by the two guideline development methodologists. For this BPG, meta-analyses were not performed.

For more detail, please see the GRADE evidence profiles for each recommendation, organized per outcome under the “methodology documents” tab of the BPG webpage (<https://rnao.ca/bpg/guidelines/people-centred-care>).

### Evidence-to-Decision frameworks

Evidence-to-Decision (EtD) frameworks outline proposed recommendations and summarize all necessary factors and considerations based on available evidence and expert panel judgements for formulating the recommendation statements. EtD frameworks are used to help ensure that all important factors (i.e., certainty of the evidence, benefits/harms, values and preferences, and health equity) required to formulate recommendation statements are considered by the expert panel (1). Both quantitative and qualitative evidence are incorporated into the frameworks. The guideline development methodologists draft the EtD frameworks with available evidence from the systematic reviews.

For this BPG, the EtD frameworks included the following areas of consideration for each drafted recommendation statement (see **Table 4**):

- background information on the magnitude of the problem
  - includes the PICO question and general context related to the research question
- the balance of benefits and harms of an intervention

- certainty and/or confidence of the evidence
- values and preferences
- health equity

### Decision making: Determining the direction and strength of recommendations

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

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

The decision on the direction and strength of each recommendation statement was determined by discussion of the judgments made for each of the factors in the EtD frameworks and a consensus-building process facilitated by the co-chairs and the RNAO guideline development and research team (15). Since the recommendations are explicitly linked to the body of evidence, agreement was reached (15). In determining the strength of a recommendation statement, the following was considered: (see **Table 4**):

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

If the expert panel deemed there was insufficient evidence to develop a recommendation (i.e., limited number of studies, and/or very low certainty evidence), they also had the option not to proceed with a recommendation.

**Table 4: Key considerations for determining the strength of recommendations**

Factor	Definition	Sources
<b>Benefits and harms</b>	<p>Potential desirable and undesirable outcomes reported in the literature when the recommended practice or intervention is used.</p> <p>“The larger the difference between the desirable and undesirable effects, the higher the likelihood that a strong recommendation is warranted. The narrower the gradient, the higher the likelihood that a conditional recommendation is warranted” (16).</p>	Includes research exclusively from the systematic review.
<b>Certainty and confidence of evidence</b>	<p>The extent of confidence that the estimates of an effect are adequate to support a recommendation.</p> <p>The extent of confidence that a review finding is a</p>	Includes research exclusively from the systematic review.

	reasonable representation of the phenomenon of interest (17).	
	Recommendations are made with different levels of certainty or confidence; the higher the certainty or confidence, the higher the likelihood that a strong recommendation is warranted (16).	
<b>Values and preferences</b>	<p>The relative importance or worth of the health outcomes of following a particular clinical action from a person-centred perspective.</p> <p>“The more values and preferences vary or the greater the uncertainty in values and preferences, the higher the likelihood that a conditional recommendation is warranted” (16).</p>	<p>Includes evidence from the systematic review (when available) and other sources, such as insights from the expert panel.</p> <p>During the systematic review screening process, if studies did not directly answer the research question (i.e., they did not discuss the outcomes of interest) but were relevant to preferences for the intervention from a person-centred perspective, those studies were also included in this section.</p>
<b>Health equity</b>	<p>Represents the potential impact of the recommended practice or intervention on health outcomes or health quality across different populations.</p> <p>The greater the potential for increasing health inequity, the higher the likelihood that a conditional recommendation is warranted (18).</p>	<p>Includes evidence from the systematic review (when available) and other sources, such as insights from the expert panel.</p>

Source: Adapted by the RNAO expert panel 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. Available from: <https://gdt.gradeapro.org/app/handbook/handbook.html#h.svwngs6pm0f2>

### Scoping reviews to support the guideline

For this BPG, one scoping review was conducted according to the Arksey and O’Malley framework (19) to identify and map the evidence describing collaborative communication strategies that can assist people (and care partners). RNAO’s best practice guideline development and research team and a health sciences librarian developed the search strategy. A search for relevant articles

published in English between 2018 and 2023 was applied to the following databases: Medline, Embase, Cochrane Database of Systematic Reviews, and CINAHL. The search was limited to the last five years to capture the most up-to-date evidence. The following study designs were included: systematic reviews, meta-analyses, literature reviews, quantitative studies, guiding frameworks, evidence-based/consensus guidelines, and qualitative studies.

For the scoping review, articles related to any collaborative communication strategies to support health providers become more adept with people-centred care (e.g., motivational interviewing, cognitive behavioural therapy, appreciative inquiry, teach-back, acceptance and commitment therapy, active listening) were included. Detailed information on the search strategy for the scoping review, including the inclusion and exclusion criteria and search terms, is available online under the “methodology documents” tab of the BPG webpage (<https://rnao.ca/bpg/guidelines/people-centred-care>).

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

For data extraction, one guideline development methodologist extracted information from 70% of the included studies, while the second guideline development methodologist extracted information from 30% of the included studies. Each guideline development methodologist reviewed the other methodologist’s extracted information for accuracy. One guideline development methodologist then analyzed and grouped studies according to themes.

### **Supporting resources and appendices**

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

1. **Relevance:** Supporting resources and appendices should be related to the subject of the BPG or recommendation. In other words, the resource or appendix should be suitable and appropriate in relation to the purpose and scope of the BPG or the specific recommendation(s).
2. **Timeliness:** Resources should be timely and current. Resources should be published within the last 10 years or in line with current evidence.
3. **Credibility:** When assessing credibility, the trustworthiness and expertise of the source material’s author or authoring organization is considered. Potential biases are also assessed, such as the presence of advertising or the affiliation of the authors with a private company selling health-care products.
4. **Quality:** This criterion assesses the accuracy of the information and the degree to which the source is evidence-informed. The assessment of quality is in relation to the subject of the resource. For example, if a tool is being suggested, is that tool reliable and/or valid?
5. **Accessibility:** This criterion considers whether the resource is freely available and accessible online.

6. **Engagement of persons with lived experience:** This criterion considers whether the resource was created or co-created in collaboration with or by persons with lived experience.

### **Drafting the guideline**

Three guideline development methodologists wrote the draft of this BPG. The expert panel reviewed the draft and provided written feedback. The BPG then proceeded to obtain both internal and external reviews.

### **Quality assurance**

RNAO staff carry out quality assurance of the guideline, including reviews of the evidence profiles, evidence-to-decision frameworks and drafts of the BPG. The associate director of guideline development and research is responsible for ensuring that the guideline is produced in accordance with the RNAO BPG development handbook, methods outlined in the BPG, GRADE methods, and international guideline standards such as AGREE II and the RIGHT reporting standards (1–3). One senior manager and the associate director review the evidence profiles, evidence-to-decision frameworks and BPG drafts to ensure adherence to the established methodology. An external review of an early draft of the BPG, along with the evidence profiles, is conducted to ensure adherence to GRADE methodology.

### **External review**

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

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

External reviewers are individuals with subject matter expertise in the guideline topic or those who may be affected by its implementation. Reviewers may be nurses, other members of the interprofessional team, nurse executives, administrators, research experts, educators, nursing students, or people with lived experience and their family members. See supplementary materials under the “methodology documents” tab on the BPG webpage (<https://rnao.ca/bpg/guidelines/people-centred-care>).

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

The external reviewers are asked the following questions about each good practice statement:

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

The external reviewers are asked the following questions about each recommendation:

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

In addition, the external reviewers are asked:

- Are the appendices appropriate? Are there any gaps in the content provided?
- Do you think the title, *People-Centred Care*, is appropriate and clear?
- Do you have any additional comments/suggestions about the background section and guiding principles of the guideline?
- Do you have any additional comments/suggestions about the glossary of terms?

Survey submissions are compiled, and feedback is summarized by the RNAO best practice guideline development and research team. The RNAO best practice guideline research and development team reviews the feedback received, consults the expert panel where necessary, and modifies the BPG content.

For this BPG, the external review process was completed between April 2025 and May 2025. External reviewers with diverse perspectives provided feedback (see **External reviewers** in the full BPG online, linked here: <https://rnao.ca/bpg/guidelines/people-centred-care>).

### Limitations

- Due to feasibility, only three systematic reviews were conducted.
- The systematic review searches were conducted from 2018 to 2023 with update searches conducted until March 2025, only in the English language. The scoping review search was conducted from 2018 to 2023, only in the English language.

### Procedure for updating the guideline

The RNAO commits to updating all BPGs, as follows:

1. Each BPG will be reviewed by the RNAO every five years following publication of the previous edition.
2. Whether it is a new BPG topic or an update an existing BPG, careful consideration needs to be made regarding selection of the BPG for development. For new editions, an assessment of the uptake of the existing BPG is conducted, such as asking:
  - Is this a mandatory guideline that BPSOs need to implement?
  - How many BPSOs are actively implementing this BPG?
  - How many times has the BPG been downloaded?
3. Further, an assessment of existing, recent and/or in-production high quality guidelines of the same topic by other organizations is completed. If the uptake of a BPG is high and there are no existing high quality BPGs on the same topic, this may indicate a higher

- priority for the next edition to be completed. However, if the uptake is low and/or there is another high-quality guideline on the same topic, the BPG may be retired.
4. New BPG topics are determined by a set of criteria to guide the systematic assessment of a selected list of suggested topics and feedback from a range of external reviewers, partners or others impacted by the topic area. Any group or individual may propose a BPG topic to RNAO through a variety of methods such as the following:
    - “[Suggest a guideline topic](#)” on the RNAO website;
    - writing to RNAO’s CEO or director/associate directors of the International Affairs and Best Practice Guidelines (IABPG) Centre;
    - a rapid review or environmental scan (i.e., scoping search for trends, hot topics, practice concerns);
    - a survey requesting that individuals rank identified topics on a five-point Likert scale; and
    - report sources (e.g., coroner’s inquest, government or related agency).
  5. RNAO selects topics for BPG development annually. All topics submitted are identified, and priority topics are chosen based on the following systematic assessment criteria:
    - key priority areas identified by the Government of Ontario, request from major public health agency, Coroner’s inquest;
    - within the scope of nursing practice (RN, NP, RPN/LPN), and applicable in a range of practice settings;
    - based on a multidisciplinary approach;
    - builds on previously developed BPGs or general topic areas;
    - potential for partnerships in BPG development with other agencies;
    - perceived need for the guideline, as identified by those submitting a topic for consideration;
    - evidence to support the guideline recommendations is available; and
    - no other high-quality guideline exists on the topic area.
  6. Upon reviewing all submissions based on the above criteria, the results are shared with the BPG guideline development and research team, the Director of the IABPG Centre, and the CEO of RNAO, who reports the selected topics to Government of Ontario.

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