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

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

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

Registered Nurses' Association of Ontario Guidelines:

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

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

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

Accreditation Canada:

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

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

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

Institute for Safe Medication Practices:

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

Safer Healthcare Now:

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

World Health Organization:

High 5s Project (2006).

Ministry of Health and Long Term Care:

The Excellent Care for All Act (2010).

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