Evaluating and Monitoring this Guideline

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

Table 4 is based on a framework outlined in the Registered Nurses' Association's *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* (RNAO, 2012b) and illustrates some specific indicators for monitoring and evaluating of this guideline.

TABLE 4. Structure, Process and Outcome Indicators for Monitoring and Evaluating this Guideline

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Objectives	**To evaluate the supports in the organization that allows nurses and the interprofessional team to integrate best practices associated with care transitions into their practice.**	**To evaluate changes in practice that lead to towards improved outcomes for clients undergoing care transitions.**	**To evaluate the impact of implementing the guideline recommendations.**
System	System structures in place to support organization settings and health-care providers promote safe and effective client transitions within, between or across settings such as legislation.	System wide processes are implemented to support transitions within, between and across settings and health providers.	% of adverse events related to care transitions % of costs associated with ineffective care transitions related to duplication of diagnostic test and treatments % of readmission rates due to ineffective transition processes

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Organization	Organization structures support client transitions within, between or across settings or health-care providers: ▯ Communication and information flow mechanisms in place ▯ Availability of personnel designated to assist with client transitions for continuity of care ▯ Education/ training availability for interprofessional team collaboration during care transitions	Facility has adopted and implemented policies and procedures to guide care transitions. Facility provides appropriate in-service training and education programs for health-care professionals at all levels on managing care transitions. Organization utilizes a standard form/approach to provide essential client information to receiving entities in care transitions. Organization has systems, structures and processes to ensure documentation of and access to essential client information (such as health conditions or problems, allergies, height, weight, vital signs, medication profile, advanced care directives) is routinely obtained and sent on transition (such as transfer to long term care). Organization has regulations for the transfer of client information that ensures privacy and confidentiality.	▯ % of avoidable multiple care transitions ▯ % of avoidable readmissions from post-discharge complications or adverse events ▯ % of costs associated with readmissions ▯ % of duplication of diagnostic tests and treatments ▯ % of adverse events on care transition related to poor medication reconciliation ▯ % of information and safety privacy breaches on care transition ▯ % staff receiving training on care transition ▯ % of critical incidents related to lack of information, communication or documentation of critical health conditions and problems, allergies, medication, advanced directives (such as do not resuscitate status) on care transition ▯ % met of Accreditation Canada's tests of compliance for communication, and medication reconciliation

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Nurse	Educational programs are in place related to the uptake and optimized use of nursing best practices for management of client transitions.	Nursing staff and staff designated as responsible for managing care transitions receive education and training.	% of nurses educated and trained on concepts, policy and procedures and documentation systems for managing care transitions % of nurses' satisfied with the planning experience and the quality of interaction and collaboration among interprofessional team members involved in care transition processes
Client	Education programs are available to assist clients and family and caregivers to manage care needs on transitions.	Clients receive verbal information and education and follow-up written information based on their needs on care transition in relation to: Medication Self-Management Follow-up with health-care providers Warning signs and symptoms of when to seek assistance from health-care providers Family and caregivers are assessed for ability to support client's care post discharge.	% clients with a pre-discharge needs assessment % clients whose discharge information is completed in a discharge summary (electronic, written or verbal form) for successful transition to other setting or health-care providers % of clients with documented transition plan incorporated into plan of care % of clients satisfied with transition processes % of clients who self-manage care related to: • medication list • follow-up appointments • warning signs and symptoms to be aware of and seek assistance for % of clients who seek help for warning signs and symptoms

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
			▯ % of clients, family and caregivers educated for each stage of the transition process ▯ % of total time spent on client/family and caregivers education during encounters with interprofessional team ▯ % of clients identified at risk on transition related to safety ▯ % clients who reported satisfaction with quality of life on transition ▯ % of clients who reported satisfaction with care transition ▯ % of medication incidents due to inadequate medication reconciliation on client transition ▯ % of clients readmitted within ≤30 days post transition (includes hospital and emergency room visits)
Financial costs	Mechanism in place to assess costs of managing client transitions (such as case coordinator, navigator, APN in role of transition coordinator, discharge planner).	Yearly budget costs for: ▯ Staffing for support of client transitions ▯ Client equipment ▯ Tools for enabling communication and practice (such as assessments, nursing order sets, care plans)	▯ % of alternate level of care, length of stay costs related to care transition delays ▯ % of readmission to hospital settings (includes emergency room visits) from long-term care within 30 days of transition ▯ % of costs related to adverse client-outcomes post care transition