AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

ENGAGING PATIENTS IN COMMUNICATION AT TRANSITIONS OF CARE

Final Report

Report prepared for the
Australian Commission on Safety and Quality in Health Care by:

A consortium from Deakin and Griffith Universities

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Acknowledgement
A consortium from Deakin and Griffith Universities was engaged by the Australian Commission on Safety and Quality in Health Care to undertake an integrative review about engaging patients in communication at transitions of care. This report is the product of that review. The investigators involved in this review were:

Deakin University Centre of Quality and Patient Safety (QPS) team was led by Professor Tracey Bucknall, and includes Professor Alison Hutchinson, Professor Mari Botti, Dr. Helen Rawson, Dr. Lauren McTier, Nicky Hewitt and Dr. Danielle Hitch.

Griffith University Centre of Research Excellence in Nursing (NCREN) team was led by Professor Wendy Chaboyer, and includes Professor Andrea Marshall, Associate Professor Brigid Gillespie, and Emeritus Professor Anne McMurray.

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EXECUTIVE SUMMARY

The Australian Commission on Safety and Quality in Health Care (the Commission) appointed researchers from Deakin and Griffith Universities to conduct an integrative review and report on tools and strategies that facilitate the engagement of patients in communication at transitions of acute care.

The purpose of the review was to:

1. Determine the current evidence and gaps in knowledge;
2. Identify enablers for, barriers to and myths about engaging patients in communication at transitions of care;
3. Identify examples of best practice in communication at transitions of care;
4. Identify strategies, tools and resources to enable patient engagement in communication at transitions of care and;
5. Integrate key stakeholders' knowledge and case studies with published evidence to inform the development of recommendations to promote communication at transitions of care.

An integrative review design enabled the inclusion of a diverse range of evidence relevant to the review aims, thus advancing our understanding of what factors may be successful in a given context. There were two Phases to this review. Phase 1 comprised of two concurrent stages: Stage 1, a review of research evidence and; Stage 2, consultations with key stakeholders to elicit information about innovations being used in current practice. Phase 2 synthesised Phase 1 findings, summarising effective strategies and tools that promoted patient engagement in communication at transitions of care. With this knowledge, the researchers compiled guiding principles and recommendations for the Commission to raise awareness of patient engagement, stimulate discussion and inform decision making at all levels of the health and education sectors.

The literature review in Stage 1 focussed specifically on the engagement of patients in communication with health professionals at transitions of care to, within and from acute care facilities. Twenty four studies that fulfilled the inclusion criteria were included in the review, three studies had multiple reports. The majority of studies focussed on handovers at different transition points, with bedside shift to shift handovers by nurses being examined in more than half the studies. Various methods were used, most being descriptive in nature. Only two studies measured effectiveness of interventions using randomised controlled trials (RCTs). Four main themes arose from the research literature. These were: roles for patients, families and health professionals; outcomes of communication at transitions; facilitating factors that enable communication at transitions and; barriers to engagement in communication at transitions of care.

Following consultation with staff of the Commission, five health services were identified across various states to develop case exemplars for Stage 2. Sixty two key stakeholder interviews occurred across seven hospitals. There were consistent findings across cases regarding the structures and processes that supported patient engagement in communication at transitions of care. These were at macro, meso and micro levels. Financial and professional relationships within private and public health services influenced at the macro level, while the organisational commitment to patient-centred care (PCC), as evidenced by clear statements in the hospital mission and values, influenced the culture, leadership and feedback systems at the meso level. Patient advocates and care co-ordinators, ward specific structures and processes to improve communication with patients and families, as well as consumer training in communication about care were found at the micro level.

Five themes that enabled patient engagement in communication at transitions of care emerged from the cross case analysis:

1. Organisational commitment to patient engagement;
2. Organisational culture and norms;
3. Individual health care provider's orientation and actions;
4. Understanding and negotiating patient preferences; and
5. Enacting information sharing and communication strategies.

Formal and/or informal endorsements of these characteristics within various contexts were either an enabler or barrier.

Phase 1, Stages 1 and 2 findings were synthesised into three overarching themes: enabling engagement, through organisation commitment and leadership across the organisation; adapting roles to context, revealed a context specific continuum that necessitates constant renegotiation during the trajectory of a patient hospitalisations; and achieving patient engagement, fostered a feeling of satisfaction amongst patients, families and health professionals in terms of the quality and safety of care received and care delivered.

The identification of tools, processes and strategies to promote patient and family engagement in communication about transitions of care were identified in both the literature and case studies. Whilst interventions in the international literature offered several tools and strategies, they may or may not have been evaluated prior to publication. The Australian cases selected for this project highlighted innovative quality improvement activities that have emerged, partly in response to the publication of the National Safety and Quality Health Service (NSQHS) Standards (2012). There was also consistent evidence arising from the research literature and case exemplars in regard to barriers to engagement across all levels and stakeholders.

In order to address the barriers and to enable engagement, guiding principles and essential elements are proposed to promote more effective patient-clinician communication. Importantly the health care sector needs to embed structures, processes and strategies across all levels and contexts; while educational providers need to prioritise early integration of patient engagement into curriculums and training of health professionals. Critically, patients and families must be respected for their insight throughout the continuum of care and provided with appropriate strategies to enable their participation in transitions to, within and from acute care hospital.

INTRODUCTION

In February 2014, the Australian Commission on Safety and Quality in Health Care appointed researchers from Deakin and Griffith Universities to review and report on tools and strategies that facilitate the engagement of patients in communication at transitions of care. The aim of the review was to inform the future development of resources to assist health professionals, patients and their families to engage in communication at transitions of care in acute health facilities. This report contains the findings of the integrative review and a key stakeholder interview, a summary of tools and strategies employed within health services and concludes with guiding principles and key elements for effective patient-clinician communication.

BACKGROUND

Emerging research demonstrates the positive influence that patient and family participation can have on patient outcomes [1-3], their satisfaction with care [4], their role in preventing adverse events during care [4] as well as reducing readmission to hospitals following discharge[5]. As a result, there is a growing interest, nationally and internationally, in redesigning health services to be not only more efficient with resources and implement effective practices, but also to be more patient-centred to further increase efficiency and effectiveness[6-8].

Patient-centred care (PCC) is recognised as a key dimension of safe, high quality health care. However, achieving this high standard of care depends on good communication between health professionals, patients and families. The Australian Commission of Safety and Quality of Care (the Commission) defines PCC as health care that is respectful of and responsive to, the preferences, needs and values of patients and consumers [7]. Participation in treatment decisions [9, 10], monitoring the effects of care and their progress towards health care goals, and providing suggestions for improving care [11, 12] are some of the ways patients and families can partner with health professionals to improve care outcomes. Knowing what to expect and being aware of choices affecting their care is more likely to result in the discovery of potential errors [13].

In particular, the quality and safety of patient care has been found to be seriously compromised during transitions of care, where patients are moved between health professionals and clinical settings [14]. Remarkably, 60% of adverse drug events are related to incomplete or incorrect transfer of medication information during transitions of care to, within and from acute care settings [15]. Similar preventable adverse events are reported at transitions of care amongst the elderly for missed diagnosis [16, 17], falls [18], nosocomial infections [17] and delirium [19].

In recognition of the potential for PCC to reduce adverse events in hospitals, major health policies have been released to support PCC [6-8, 20,]. Notably, the Australian Charter of Healthcare Rights , endorsed by the federal health ministers in 2008, identified that patients have a right to be included in decisions and choices about their care, and have the right to be respected [7]. More recently, the 2012 National Safety and Quality Health Service (NSQHS) Standards require all health services in Australia to ensure they actively partner with patients in their care by employing a system-wide, patient-centred care focus and approach [7]. Likewise, policy documents to promote PCC have been developed by the World Health Organisation [6], the UK Department of Health [21] and similar organisations in the USA [22].

Yet little is known about the roles patients currently play and the roles they could play in their care, the benefits of participation, and health professionals' willingness and ability to promote this participation in acute health contexts. There is also little known of the strategies and processes that can be implemented to promote patient engagement in their care, particularly during times of transition when clinical communication errors have been shown to be most prevalent [23, 24]. Without this evidence, patient safety approaches and programs to optimise patient engagement are at risk of being misdirected and achieving suboptimal quality improvement and patient safety outcomes.

AIM

The aim of this project was to review the literature and interview health professionals to inform future development of structures, practices, processes, tools and resources to enable health professionals, patients and their families to actively engage in communication at transitions of care to, within and from acute health facilities. The purpose of the review was to:

1. Determine the current evidence and gaps in knowledge;
2. Identify enablers for, barriers to, and myths about, engaging patients in communication at transitions of care;
3. Identify examples of best practice in communication at transitions of care;
4. Identify strategies, tools and resources to enable patient engagement in communication at transitions of care and;
5. Integrate key stakeholders' knowledge and case studies with published evidence to inform the development of recommendations to promote communication at transitions of care.

METHODOLOGY

A mixed method approach, including an integrative review and interviews of key stakeholders, was used to enable the inclusion of a diverse range of evidence relevant to the review aims. An integrative review is used when multiple sources of evidence are available for analysis and synthesis[25]. Such integrative reviews can accommodate all forms of scientific evidence (qualitative, quantitative and mixed), along with non-scientific evidence such theories, policies, literature reviews and practice reports. Integrative reviews have been described as synthesising evidence from a number of cases (with each case being a particular document, study or theory) to arrive at cross-case generalisations [26]. This systematic method also has the capacity to decrease bias and error yet represent the intrinsic complexity surrounding communication during transitions of care. Thus an integrative review advances the understanding by highlighting what factors work in a given context. To meet the aims of the review, only scientific evidence was included.

There were two Phases to this review. Phase 1 had two concurrent stages: Stage 1, a review of the research evidence on engaging patient participation in communication at transitions of care; and Stage2, consultations with key stakeholders to elicit information about current practice, what works for whom and in what circumstances. Phase 2 involved synthesis of the findings from Phase 1 to identify effective practices, processes and tools to promote patient engagement in communication at transitions of care and to inform the development of recommendations for the Commission about potential future undertakings.

The report is presented according to the Phases. For Phase 1, the two stages are reported separately to include the specific methods used, including the design, sampling, data collection and data analysis. For Phase 2, a meta-synthesis of Phase 1 findings is presented, followed by the tools and strategies to promote patient and family engagement in transitions of care, as well as the identified barriers to communication and engagement. To conclude, guiding principles have been outlined and recommendations for patients, families, health professionals, health services, professional and government policy makers are provided.

In Figure 1, the design of the project is illustrated.

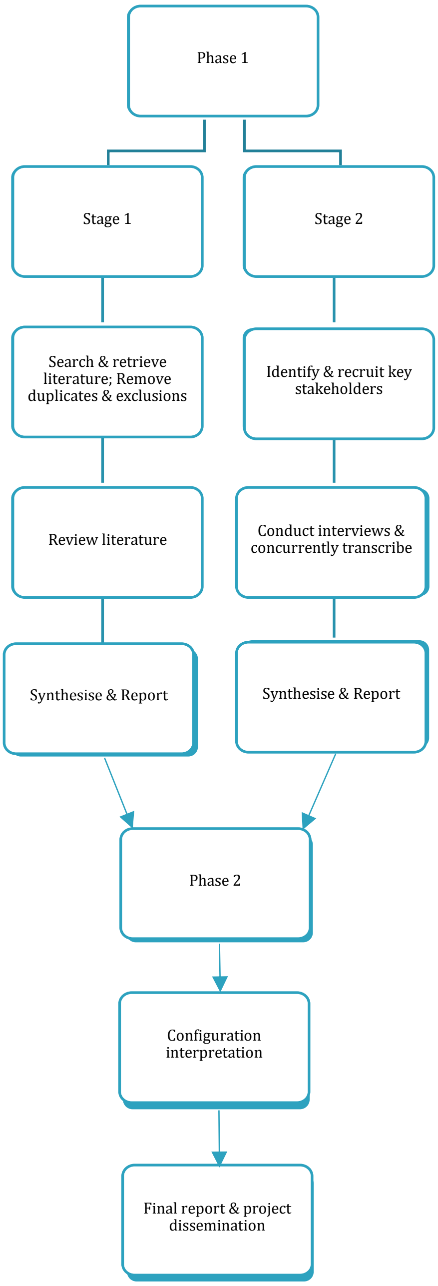

Figure 1: Flowchart of Project Design

PHASE 1

Stage 1: Integrative Review

Aim

The aim of the integrative review was to synthesise and analyse the peer-reviewed research evidence in relation to engagement of patients in communication at transitions of care within, to and from acute care facilities.

The following key terms were defined for the purpose of the review:

- *Engagement:* Any activities (verbal, written or behaviours) to enhance patients', families /carers' understanding of their condition, treatments and care plans, partnership and involvement in decision making and evaluation of care outcomes, and attempts to measure engagement behaviours.

- *Handover / Handoff:* The transfer of information, authority, responsibility and/or accountability for patient care from one health professional (or team of health professionals) to another, on a permanent or temporary basis, which concerns the patient's previous and present health and their planned future care [27-32].

- *Transition of care:* The movement of a patient from one setting of care to another [33]. Transitional care is defined as a "set of actions designed to ensure the coordination and continuity of care as patients transfer between different locations or different levels of care within the same location" [34]. Transitions also occur within a setting between various health professionals. A 'patient journey' framework was used to search the literature relating to transitions of care within acute care settings, and at the interface between acute and primary care.

- *Communication process*: Any form of communication strategy or process of communicating care needs, assessments and evaluations. However, the particular focus will be on verbal or written communication of care, i.e. the handover.

- *Acute care setting:* Hospital or other specialty facility that receives patients with an acute (new onset) illness, disease, condition, problem for cure or symptom management and/or support [35].

Method

Search Strategy

The SPICE framework was used to refine the objectives; inclusion criteria and search strategy for the integrative review (see Table 1). The framework was developed in the social sciences, and is an alternative to the PICO framework frequently used in health [36].

Table 1: Application of SPICE framework for objectives, inclusion criteria and search strategy

Setting: Transitions of care to, within and from acute care settings.

Perspective: Adults, children, patients, families, and health professionals who are engaged in communication at transitions of care.

Intervention/Phenomenon of interest: The participation of patients in the communication of transition processes from home/ residence/ clinic to hospital throughout hospitalisation and return to the community.

Comparison: Any communication process used to engage patients at transitions of care related to acute care settings. Not all studies will have a comparison but will remain included.

Evaluation: Synthesis of individual peer-reviewed studies, opinion and discussion papers, service evaluations, relevant policy documents and case reports by health services.

The search strategy arising from this framework was developed in consultation with a health sciences librarian experienced in conducting searches for literature and systematic reviews. Reports were selected if they described any form of communication process at the transition of care to, within and from acute care settings, and the report described patient, family or caregiver engagement/involvement in the transition of care communication (see Appendix A). All reports were examined for evidence of primary research. Studies were excluded if the patients were unable to communicate to family members, e.g. unconscious patients, neonates and infants. A language restriction was applied, with non-English reports excluded. This integrative review focused on studies that examined activities (verbal, written or behavioural) that engaged patient participation in communication at transitions of care.

The literature search was conducted in the following electronic bibliographic databases: The Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library), Web of Science™ Core Collection and Current Contents Connect (Thomson Reuters), Cumulative Index to Nursing and Allied Health Literature (CINAHL) Complete (Ebscohost), Medline (Ebscohost), PsycInfo (Ebscohost), EMBASE (with MEDLINE deselected under advanced search), and Sociological Abstracts (ProQuest). Search dates within each database for inclusion were limited to 2003 to 2013.

A comprehensive search strategy was developed for the CINAHL database to locate the setting, perspective, population, and phenomenon of interest as described within the SPICE framework (see Appendix B). Table 2 lists the major subject headings and text words used within the CINAHL search strategy. This search strategy was adapted to other databases with simple and advanced search functions.

Table 2: Search Terms: Major subject headings and text words with truncation (*) for Electronic Database Searches.

Setting: hospitalization, patient care, primary health care, primary care, patient centred care, patient care, person centred or person centred, family centred care, ‘specialties, nursing’, acute care, subacute care, nursing care, quality of nursing care, quality care, family practice, general practice, community health centers, community care, domiciliary care, health provider, residential facilities, nursing home patients, residential aged care, ambulatory care, rehabiliat*, caregivers

Perspective: patient discharge, ‘transfer, intrahospital’, transfer care, discharge plan*, discharge pathway*, hospital discharge, patient transfer, continuity of patient care, continuity care, patient care conferences, integrat* care, integrat* pathway*, care coordinat*, communication

Population: adult, child*, paediatric*or pediatric*, patient*, client*, consumer*

Activity (verbal, written, behavioral) /Intervention: hand off (patient safety), handoff or hand-off, handover or hand-over, shift reports, transition* care, ‘continuity information’

Phenomenon of interest: consumer participation, professional-client relations, professional-patient relations, professional-family relations, (‘patient, client or consumer’ as a prefix to ‘engagement, involve*, participat*, partnership, experienc*, willing*, or abilit*’), (‘patient, client, consumer, family or parent*’ as a prefix to attitude*),(‘patient, client or consumer’ as a prefix to communicat*), ‘decision making, patient’, (‘patient, client or consumer’ as a prefix to decision*)

Note: These search terms were used in the CINAHL search, with search terms adapted to the other databases.

The Cochrane Effective Practice and Organisation of Care Group’s Trials Register search coordinator advised that a separate search of the trials register was not required, as all records are located within the CENTRAL database. In addition to electronic databases searches, hand searching of reference lists was conducted for reports selected for eligibility assessment. The review was limited to research literature. Prior to data collection an *a priori* decision was made not to search grey literature for sources that were not original research. Higher degree theses were eligible as grey literature sources, and were searched for within the selected electronic databases.

Screening and Study Selection Process

The EndNote X7 reference management software (Thomas Reuters) was used to manage all searches, store full text publications, and facilitate the screening process. A unique identifier was assigned to every record retrieved, which enabled tracking of articles throughout the screening process. Duplicate records were removed from EndNote. A screening tool with the inclusion criteria was used to identify potentially relevant reports. At least two reviewers screened titles and abstracts independently for potential relevance. Full-text articles were retrieved for those records that did not have an abstract or had insufficient information to decide relevance. Independent secondary screening was conducted for records that had insufficient information within EndNote X7. Consensus agreement was reached on potentially relevant reports for eligibility assessment. Records that clearly did not meet the inclusion criteria were excluded following consensus. A Microsoft Excel spread-sheet was used to track the screening process.

Full-text reports were retrieved for all records included for eligibility assessment. Each report's eligibility for inclusion was assessed using specific inclusion and exclusion criteria contained within the screening/eligibility assessment tool (see Appendix A). Study eligibility was verified by a second reviewer. Disagreements were resolved through consensus, with a third-person arbiter used if agreement could not be reached.

Data Extraction and Quality Assessment

A data extraction form using Microsoft Excel spread-sheet was designed for the integrative review (see Appendix C). Data were collected on each study's purpose, theoretical framework, research methodology, design, setting, subjects, activities, procedures or interventions of interest, the results and evidence of methodological quality. One member of the research team extracted data from all included studies. A second member of the research team verified the extracted data for accuracy and completeness.

The approach used to assess methodological quality was determined by study design: quantitative, qualitative or mixed empirical methods. The use of these assessments increased the dependability of the information reviewed [37]. The Mixed Methods Appraisal Tool (MMAT) version 2011, (see Appendix D), developed at McGill University and designed to concurrently appraise qualitative (section 1), quantitative (section 2 or 3 or 4) and mixed methods studies (section 5) was used to assess methodological quality [38]. The MMAT is designed to appraise only methodological quality, not the reporting of the study. The overall quality score is presented using asterisks. The number of asterisks represent the quality appraisal for each type of study. Scores vary from 25 % (*) when one criterion is met, to 100 % (****) when all criteria are met. For mixed methods research studies an overall quality score was calculated based on the MMAT criteria. The lowest score of the study components is the overall quality score.

Data Analysis

The 'Framework' synthesis approach was used to extract and synthesise data [39]. This approach is suitable for both qualitative [40] and mixed method policy-oriented research [41].

The five analytical stages in the Framework approach are:

1. Familiarisation- becoming familiar with the content of data.
2. Identification of a thematic framework- identifying key issues, concepts and themes.
3. Indexing- systematically applying the thematic framework to the data.
4. Charting- rearranging the data according to the appropriate thematic reference.
5. Mapping and interpretation- identifying the key characteristics of the data.

Team members independently examined the data extraction tables and identified key themes from results and findings. Themes were combined and categorised to form an *a priori* analytical framework to inform data synthesis. One of the research team proceeded with indexing and charting the data, using the four identified themes as a framework. The evidence was reviewed in terms of what works for whom, and under what circumstances [42, 43]. This process also included mapping and interpreting the key characteristics of the data, and the resulting findings were reviewed by all members of the research team for accuracy and relevance.

Results

Screening and Selection

The search strategy elicited 2228 records for independent screening for potential relevance to the review. The flow diagram below (see Figure 2) shows the steps taken to screen and select relevant reports. Eligibility assessment was conducted using the inclusion and exclusion criteria on 147 potentially relevant reports, with the rationale for exclusion documented for 118 reports (see Figure 2). Twenty two studies were included once additional reports of the same study were taken into account.

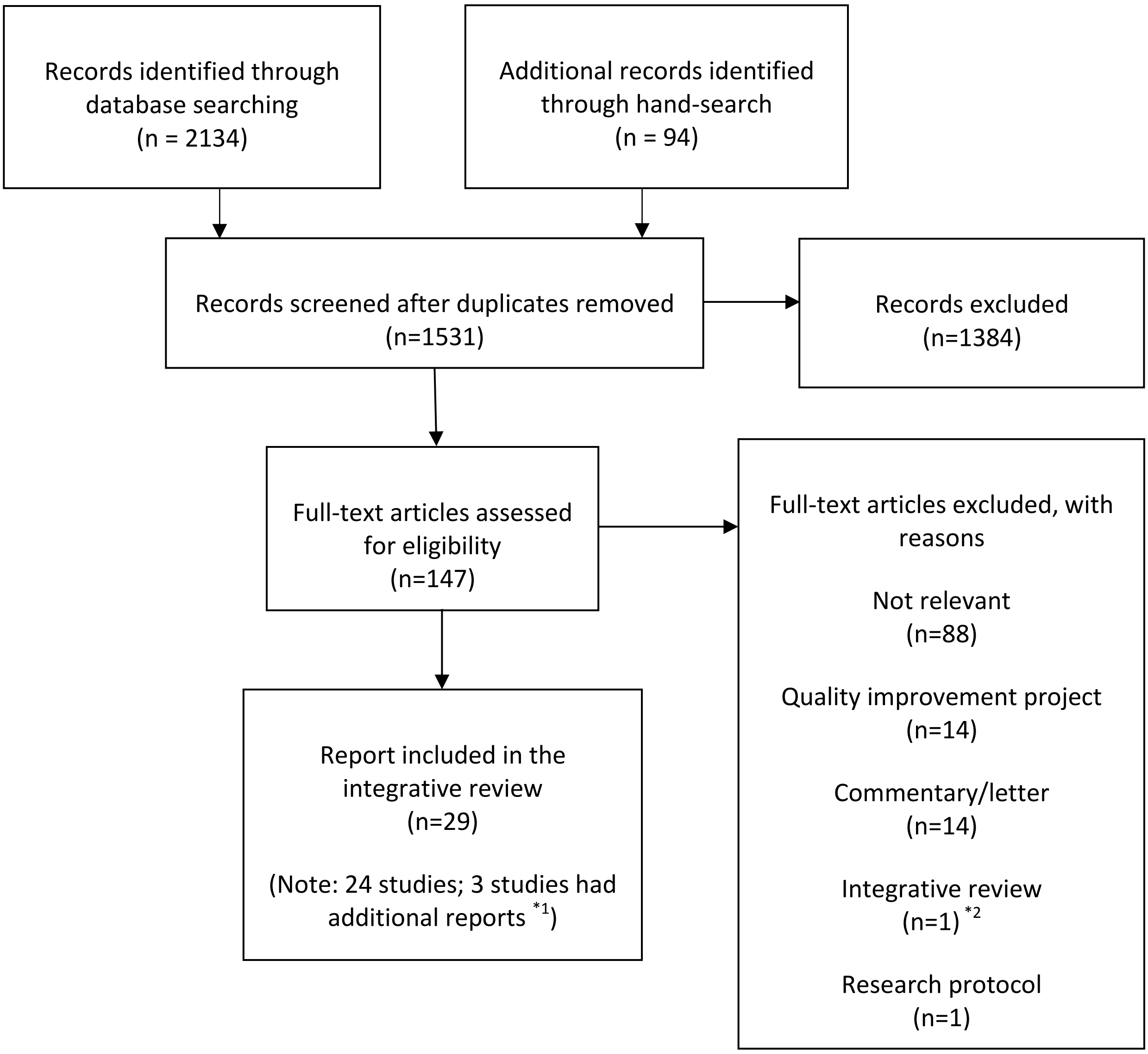

Figure 2: Flow Diagram of Records Searched, Screened and Selected for the Review

Footnote: *[1] To identify additional reports, see Chaboyer 2010, Coleman 2006, Henderson 2004, in the tables of characteristics of included studies (Appendix E). *[2] A hand search of references was conducted, no studies met the inclusion criteria.

Description of Study Characteristics

Characteristics of included studies were tabulated, with detailed descriptions of the study purpose, design, setting, sample, intervention and reported results within the appendices (see Appendix E). All studies, except for two [44, 45] were published in the past five years, with 21 studies published in the past three years. The majority of studies were from acute care settings in Australia (n=10) and North America (n=10), with four studies originating from Europe (see Table 3).

A range of research methods were used across the included studies (see Appendix E). Two studies had mixed method approaches [45, 46]. One of these studies had several reports [5, 45, 47, 48]. The primary reference included in this review was a randomized controlled trial (RCT) of older patients transitioning from hospital to home with a nurse transition coach and Personal Health Record as the intervention [45]. The associated reports provided results of the qualitative analyses of the intervention group [48], the study protocol [47] and the pilot study with historical controls [5].

Seven studies used quantitative research approaches to examine care transitions [32, 44, 49-53]. One RCT reported statistically significant differences between the intervention and control groups, however methodological quality was low [45]. In this study, group allocation concealment was unclear and it was unclear whether other aspects of care management were similar except for the intervention [45]. Only a third of the intervention group received the initial visit by the transition coach in hospital with hospital staff likely to be involved in patient readiness for discharge. There were also unexplained group differences at baseline and no power calculation for primary outcomes with sample discrepancies between reports [45]. The Henderson et al.[44] RCT which found no difference between groups for their primary outcome, also had unclear risk of selection and performance bias, with the minimisation randomisation technique requiring adjustment to improve the stratification of attributes between the two groups. Power to detect a difference may have been influenced by inconsistency in completing each of the various steps within the intervention and control groups [44].

Overall most quantitative studies used descriptive designs to measure staff, patient and/or family perceptions and attitudes towards care transitions, with the exception of one study with several reports [44, 54-56]. The Henderson et al. [44] report provided the method and results of a RCT, reporting the outcomes of the implementation of a joint crisis plan (JCP) within mental health compared to educational leaflets. The Henderson et al.[54] report provided an exploratory analysis of the intervention group through case series. Henderson et al. [44] was nominated as the primary reference for this review. Older reports presented the pilot study and intervention description [55, 56]. For the quantitative studies there were insufficient quantitative data available from similar studies to allow for further statistical analysis (i.e. meta-analysis).

Ten studies used qualitative approaches to explore perceptions of care transitions [28, 29, 31, 57-63]. Of these studies, three employed an ethnographic approach [57-59] and five involved interviews that were analysed using content analysis [28, 29, 31, 60, 61]. Both Chin et al. [28] and Flink et al. [29] coded data using a grounded theory approach. In addition, there were several manuscripts of the European Handover Project [29, 62, 63]. This was a large study conducted across several European countries (Italy, The Netherlands, Poland, Spain and Sweden). Flink et al. [29] reported the national analysis and cross-national secondary analyses. Two further manuscripts provided a report of the Swedish sub-study [62] and the Spanish sub-study [63]. There were several studies with a descriptive design that used a variety of data collection methods to provide an understanding of transitions in care from the perspective of the nursing staff and/or patients and their families [27, 30, 64-66]. One descriptive case study was published in two reports [27, 67].

Most studies were exploratory in nature. The majority of studies examined handover activities at the change of shift within an acute care setting. Thirteen studies specifically explored the perceptions of bedside handover [27, 28, 30-32, 46, 50-53, 60, 61, 65] with another two studies examining the content of conversations within bedside handover communication [59, 64]. One study examined unspecified care transitions, including transitions for hospitalised patients [49]. Other studies explored transitions of care from an acute care setting (secondary care) to primary care [45, 57, 58], from acute to sub-acute care [66], from primary to acute care [44], and all transitions to and from primary and secondary care [29, 62, 63].

Table 3 provides a summary of the included studies characteristics and a quality appraisal rating using the MMAT.

Table 3: Summary of Study Characteristics

First Author (Year)	Design	Setting	Sample	Intervention	Data Collection	Quality Appraisal*
Bradley (2013)	Mixed Methods	Rural hospital, Australia	N = 57 (9 Patients; 48 Nurses)	Bedside handover	Survey, interviews, observations and journaling	**
Chaboyer (2010)	Qualitative	Acute hospital, Australia	N = 34 Nurses (34 Nurses; 532 Handover observations)	Bedside handover	Interviews and observations	****
Chin (2011)	Qualitative	Maternity hospital, Australia	N = 30 (Women and their medical records)	Bedside handover	Interviews and medical record reviews	***
Coleman (2006)	Mixed Methods	Acute hospital, USA	N = 750 (Control group n=371 patients; Intervention group n=379 patients).	The Care Transitions Intervention	Interviews and administrative record reviews	** **
Flink, Hesselink (2012)	Qualitative	Acute hospitals, Europe	N = 90 patients (53 individual interviews; 37 participated in focus groups)	Handover between primary and inpatient care	Interviews	***
Flink, Ohlen (2012)	Qualitative	Acute and primary health, Sweden	N=23 patients	Handover between primary and inpatient care	Interviews	***

Friesen (2013)	Multiple Methods	Acute hospital, USA	Survey: n = 107 (93 adult patients; 14 parents) Interviews: n = 22 (16 patients; 6 parents)	Bedside handover	Survey and interviews	** **
Glenny (2013)	Qualitative	Health service, Canada	N = 32 (26 Health care providers; 6 Family caregivers)	Care transitions	Interviews	***
Groene (2012)	Qualitative	Acute and primary care, Spain	N=34 (12 Patients; 6 Hospital physicians; 5 Hospital nurses; 7 Primary care physician; 4 Primary care nurses)	Handovers at admission and discharge	Interviews	***
Henderson (2004)	Quantitative	Community mental health teams, UK	N=160	Joint Crisis Plans	Administrative record reviews	*** ***
Johnson, Cowin (2013)	Qualitative	Acute hospital, Australia	N=30	Bedside handover	Interviews	***
Johnson, Forbes (2013)	Qualitative	Acute hospital, Canada	N=43 (11 Patients; 8 Family; 24 Health care providers)	Handover from acute to primary care.	Interviews, observations, field notes, analytic memos, document analysis	****
Lepore (2013)	Quantitative	Acute hospitals, USA	N=520 patients	Communication for hospital discharge	Survey	***

Liu (2012)	Qualitative	Acute hospital, Australia	N=103 (76 Nurses; 27 Patients)	Medication communication	Observations and interviews	***
Maxson (2012)	Quantitative	Acute hospital, USA	N=75 (30 Patients (before) 30 Patients (after); 15 Nurses)	Bedside handover	Survey	*
McMurray (2011)	Qualitative	Acute hospital, Australia	N=10 patients	Bedside handover	Interviews	***
McTier (2013)	Multiple Methods	Acute hospital, Australia	N=98 patients (interviews) N=48 Observations: Focus groups interviews: n=2	Medication communication	Observations and interviews	*** **
Merrill (2012)	Multiple Methods	Acute hospital, USA	N=149 (119 Nurses surveyed, 11 focus groups, 30 Patient interviews)	Bedside handover	Survey and interviews	* **
Renehan (2013)	Multiple Methods	A Health Services in Victoria, Australia	Interviews: N=11 Clients, N=7 family/carers. Two focus groups, N=7 participants (included personal care attendants, diversional therapist, team leaders and managers)	Transition care program	Interviews, the Cohen Mansfield Agitation Inventory (CMAI) scale scores and File audits,	*** **

Sand-Jecklin (2013)	Quantitative	Acute hospital, USA	Pre-implementation: N=232 patients and N=70 family members on behalf of the patients; N=148 Nurses Post-implementation: N=178 patients and N=72 family members on behalf of the patients; N=98 nurses	Bedside handover	Survey and administrative record review	***
Street (2011)	Quantitative	Acute hospital, Australia	N=259 Nurses	Bedside handover	Survey and file audit	***
Tidwell (2011)	Quantitative	Acute hospital, USA	N not specified (Patient/Family: n not stated, Nurses: n=23)	Bedside handover	Survey	*
Tobiano (2013)	Qualitative	Rehabilitation ward, Australia	N=8 Family members	Bedside handover	Interviews, observations and field notes	***
Weingart (2013)	Quantitative	Health service, USA	Baseline (Pre-implementation): 85 respondents; Implementation (Phase 1): 87 respondents; Post-implementation (Phase 2): Not specified	Standardised handover	Survey	*

Footnote: MMAT (Mixed Methods Appraisal Tool), Quality assessment

Facilitating Patient Participation in Communication

Four main themes emerged from the data, including roles for patients, families and health professionals, outcomes of communication at transitions, facilitating factors that enable communication at transitions, and the barriers to engagement in communication at transitions of care.

Roles for Patients, Families and Health Professionals

Communication during transitions of care on admission, during, and through to discharge from acute health facilities occurred between the following stakeholders: patients, their families and health professionals. As Friesen et al. [30] noted, patient-centred handover is not limited to unilateral, or even bilateral communication. Effective transition communication involves interaction between multiple health professionals (from various disciplines), the patient and family member/s. Each of these stakeholders played a role in communication, but perceptions about these roles varied across the studies.

Patient Roles

In many of the studies included in this review, patients were recognised as partners with health professionals, as knowledgeable about their own needs, with the right to information regarding their health and care [61]. Parry, Kramer and Coleman [48] referred to the concept of the 'activated patient' from previous literature. Activated patients are those who believe they are an essential part of the health care team, and have the skills and knowledge to play an active role in their care (Hibbard, Stockard, Mahoney, & Tusler 2004 cited in Parry et al. 2006). Patients were acknowledged to have a role as participants in transition communication both within and between the service systems involved in their care [62]. By sharing information during transitional communication, the patient is 'kept in the loop' by the health professionals; without this inclusion their ability to actively participate in the process is compromised [30].

The expectations patients held about their role influenced their preferences for involvement and were informed by a range of factors. Some patients who believed health professionals expected them to take the initiative and be actively involved cited the service context as a factor in shaping their preference for involvement [29]. For example, patients from older persons' services in Poland were expected to take on an active role, whereas Dutch patients expected health care health professionals to take the lead in handover at transition [29]. The level of active participation by patients was observed to change in response to their perceptions of the health system, for example, patients assumed more active roles when health professionals were less proactive, and stepped back into passive roles when the health professionals were more overtly in control [29].

A continuum of participation for patients during handover was identified in a qualitative study of patient participation [29]. It provided a useful framework for considering the roles patients may play during communication at transitions. At one end of the continuum, patients are key actors in the handover process, assuming responsibility for initiating contact and communicating with health professionals. At the other end, health professionals are the key actors in the handover process, and lead all aspects of the interaction. In the middle of these two positions on the continuum, patients share equally the responsibility for handover with health professionals. Participation also varies depending on patients' health status, where those who are sicker tend to engage less in transition conversations. These positions were broadly supported by other studies in this review.

Patients in a Leadership Role

Patients who took the lead in the handover process considered this active role to be the only way to ensure effective communication and continuity of care [29]. Some arrived at this view based on past experiences of poor handover [29], which compelled them to take control of their own care. In both this leadership role and when sharing responsibility with health professionals, some patients saw ensuring the accuracy of information shared about them as part of their role [61]. A negative consequence of patients taking this leadership role was also identified when patients blamed themselves for not being effective in facilitating handover in situations where communication had broken down [29]. In these circumstances, the patients believed their care could have been better if they had exerted greater control or coordination over their communication with health professionals.

Patients Sharing Responsibility with Health Professionals

When sharing responsibility for handover, the information provided by the patient was seen to complement the handover communication between health professionals [29]. A frequently cited example of this shared role was patients contributing medication information during bedside handover, by describing the effect of their treatment or correcting wrong information [59]. While the outcomes of the studies reviewed indicated this was the most common role assumed by patients during handovers, there is little evidence of the specific roles assumed by each stakeholder in this situation.

Patients in a Passive Role

Patients who assumed a passive role in transition communication saw the health professionals as the leaders of handover, supposing that handovers were primarily conducted for the benefit of the health professionals and health service [29]. In this role, patient participation was limited to being a conduit for information or acting as a courier for referral or discharge documents to be passed on to their next service provider [63]. In other cases, patients listened passively to handover information, paying attention but not contributing to the conversation unless asked directly or prompted [61].

The importance of choice around participation was raised in regards to this more passive role. Not all patients want to assume an active role in transition communication, and this decision may be dependent on the context. For example, Chin et al. [28] found a substantial percentage of women (27%) did not want to participate in handover during labour, with some (20%) reporting feelings of vulnerability associated with requests to be present or participate. These researchers highlighted the importance of recognising how patients vary in their desire to take an active role in the ‘medical work’ of handovers, particularly as some patients experienced distress when they felt compelled to be involved bedside handovers. Feelings of frustration when urged to participate against a personal preference to take a passive role, or when the patient was feeling particularly unwell were also highlighted in a Swedish study of patients transferring from an emergency department back to primary care [62].

Family Roles

The role of families in transition communication was broadly recognised in many of the studies, and was perceived as both positive and helpful to effective care. Family participation was seen to be particularly valuable in situations involving elderly, critically ill, vulnerable or hearing impaired patients [57, 58, 60]. Family caregivers were an important source of information for health professionals; also playing a role in sharing information between health professionals by passing on feedback, contact details and instructions [57, 60]. In a study by Tobiano et al. [60], families reported feeling able to participate in bedside handovers by asking nurses for additional information. Notably, if families were unable to meet with allied health professionals during working hours, the responsibility for providing and retrieving information was shifted to the family as the family were seen as 'unavailable' [58]. Active participation by families in transition communication may depend therefore on their availability. In particular, their ability to fit in with the times of operation of specific health services.

Families recognised they provided both physical and emotional care to patients during care transitions, and described their role as being the 'glue' or 'leaders' in terms of their responsibilities [57, 60]. Indeed, their ability to participate in transition communication has been linked to their experiences of satisfaction with a service, and self-perception of their ability to fulfil their family role [28]. However, their role as participants was dependent on patients consenting to share information and, in some cases (as will be discussed in the section on barriers) this was not always provided.

Health Professional Roles

There was relatively little evidence directly related to the role of nurses in facilitating communication at transition with patients and families. Bradley and Mott [46] found that nurses supported patients taking an active role in their care. The nurses perceived their role to be more restricted to providing information to each other rather than to the patient. In another study, nurses were observed to initiate the vast majority (87.8%) of conversations related to changes in medication before discharge from hospital [64]. This emphasis on information exchange was also evident during bedside handovers, and the need for nurses to receive information about patients in addition to those they were assigned [27]. If information exchange was restricted only to assigned patients, nurses were concerned they could not fulfil their roles effectively if called to assist or communicate with other patients. However, due to time constraints experienced by many health professionals, a compromise has to be reached between receiving information only on patients which a nurse has been allocated, and the recommended practice of receiving handover for all patients on a ward [31].

The role of the health professional in transition communication was illustrated in a study of a Care Transition Intervention to enable older patients to play an active role in their care following hospital discharge [45, 48].The Care Transition Intervention was operationalized as; 1) Personal Health Record as a dynamic patient-centred record book "to facilitate communication and to ensure continuity of the care plan across providers and settings" and 2) structured visits and phone calls from a 'transition coach' [47, p.8]. The areas of focus of the transition coach's were medication self-management, the patient-centred record, primary care and specialist follow-up, and knowledge of "red flags", that is, warning symptoms or signs indicative of a worsening condition. The intervention was conducted over four stages within a 28-day period, and included a hospital visit prior to discharge, home visits, and follow up telephone calls. Coaching included role play and rehearsal of issues to discuss with health professionals, and review and encouragement to maintain a Personal Health Record and share it with the Primary Care Provider and/or specialist at follow-up visits. Specific sections within the Personal Health Record included critical medical information, a list of warning signs that correspond with the patient's chronic illness, a transfer checklist, and a section to write questions for healthcare providers. Patients/caregivers were charged with updating and maintaining this record. The transition coach was therefore a facilitator, rather than a direct care provider. Parry et al. [48] described patient's experiences with this one-on-one coaching for promoting self-management throughout the care transition in three overlapping teams: continuity throughout the care transition, self-management knowledge and skills, and coaching relationship.

Outcomes of Communication at Transitions

There are a range of outcomes associated with the communication that occurs between patient, families and health professionals during transitions of care. While the studies in this review focused on these outcomes, they also provide an understanding of the stakeholders' perceptions of this communication.

Patient Outcomes and Perceptions

Patients perceived that their participation in handover ensured the process proceeded more effectively [62]. Patients who participated in transition communication reported feeling empowered, and having a greater sense of control over their own care [28, 46, 62]. Some described feeling that their 'voices' had been heard, they were part of the process and their preferences were valued [27, 28, 46]. This approach enabled patients (and their families) to feel that their care was being personalised, and that they were considered a person first (and a patient second) [30, 60, 61].

Patients across several studies reported that identification as an individual was also related to the positive perception of being introduced to the incoming nurse [28, 30, 46]. These handovers allowed patients to get to know the person who would be caring for them, which was perceived as reassuring in some cases [30, 61]. The interpersonal aspect of transition communication was also described as pleasurable by some patients, who stated that participating in bedside handover provided a few moments of enjoyment which they appreciated [46]. Patients sometimes expressed a preference for working with health professionals or service providers they already knew, or with whom they had had previous positive experiences [29, 48, 49].

Patients felt the opportunity to check the accuracy of information being transferred was important, and being able to contribute and question incorrect information added to feeling safe [28, 50, 62]. As stated by one patient, *"I would feel a lot safer if it's presented in front of me. Talk to me about it. Educate me"* [30, p.213]. They also appreciated the chance to synthesise the information received about their care, ensuring that the information recorded drew together data from all the services and supports in their lives [30, 46]. This exchange of information enabled them to learn about their condition, and understand how their treatment might progress from the perspective of the health professionals [46, 61]. Patients' perceptions of being informed of their plan of care for the day increased significantly following the implementation of bedside handovers [50].

Patient satisfaction was reported in several studies as an outcome of introducing bedside handovers [28, 46, 49, 61, 65], with satisfaction rates increasing with the introduction of initiatives to increase communication between patients, families and health professionals. When patients perceived they had a good experience participating in this form of communication, it related to their overall idea of what was a 'good' handover, along with feelings of confidence and safety [28]. While some study authors made statements about the potential for including patients and families in transition communication to improve safety by reducing errors [50, 61], this is yet to be tested empirically.

Reduced rates of re-hospitalisation and associated costs were reported as an outcome of facilitated communication between patients, families and health professionals during transitions in care in one study [45]. Patients receiving assistance from a transition coach were around half as likely to be re-hospitalised as those who did not receive such assistance in this quasi-experimental study [45]. They also had significantly lower re-hospitalisation rates at 90 and 180 days for the condition that precipitated their index admission, which suggests a sustained beneficial effect [45]. At 180 days, the mean hospital costs for patients who received this assistance was also significantly lower than for those who did not receive such assistance. Coleman et al. [45] suggests this outcome may be due to the transition coach meeting a greater proportion of patient and family needs during the vulnerable time associated with change in care.

Outcomes from communication between patients, families and health professionals during transition were not just limited to verbal conversations. Patients also reported observing health professionals making decisions about what should be documented in notes, and when able to contribute to these decisions, patients felt they contributed to consistency in their care [28]. For example, patients in a birth suite used their individually authored Birth Plans as a means to contribute to handover conversations, leading one patient to state, *"I orchestrated my own handover"* [28, p.61]. Patients in a mental health setting also contributed written documentation about transitions between care, in the form of a collaboratively authored joint care plan [44].

While the majority of reported outcomes for patients from transition communication with health professionals were positive, there were also some ambivalent or negative responses reported. In mental health services, 46–96% of consumers with joint care plans reported feeling positive at the time the plans were drawn up [44]. However, after 15 months their responses were mixed and the majority of consumers had made no use of the joint care plan. Those who had used their plan still experienced instances when their preferences were not followed, and therefore this form of transition communication may raise unrealistic expectations for patients. Interestingly, the other instance of patients providing a written document for transition communication (Birth Plans) also led to occasions where the patients perceived their preferences were being ignored or not considered important by health professionals [28].

Health professionals did not always facilitate patient and family participation in transition communication, asking few questions beyond the most immediate issues and inviting few contributions. This approach was described as 'procedural' and 'task oriented' by McTier et al. [64], who noted it reduced opportunities for patient education and the promotion of patient participation. When this occurred, patients perceived that they were not important or valued by health professionals and that they had to 'butt in' to play a role [29, 65]. Patients in two European studies stated they expected more personal attention from health professionals during their admission, and that information would flow more smoothly between health providers with their involvement in proactively initiating follow up [29, 63]. As found in one empirical study, patients who experienced poor transition communication can experience anxiety and frustration, which negatively impacts on their service experience as a whole [58].

Family Outcomes and Perceptions

There are relatively few studies that focus particularly on the experiences of family members in transition communication, although some study authors reported family views as incidental findings. Outcomes reported by family members in these studies tended to focus on their role in gathering information for and from health professionals [57]. In one study with elderly patients, family members perceived themselves to mostly be receivers of information from health professionals, as they felt the health professionals had more knowledge and understanding of the patient's condition [57]. This was despite their previously identified roles as 'leaders' or the 'glue' in the interrelationships between patients, families and health professionals.

The introduction of bedside reporting was positively perceived by families of paediatric patients, who viewed this initiative as demonstrating concern and respect for their child, increasing availability of staff and keeping both the child and family better informed [53]. Family members of elderly patients perceived that being allowed to participate in bedside handover was important to feeling included, and that receiving a clear picture of their family member's condition in these conversations improved their confidence and lessened their distress [60]. As a result of this inclusion, family members were better able to plan and prepare for the upcoming transitions, which was a factor in promoting successful transition, continuity of care and reducing re-hospitalisations [45, 58, 60]. Similar to patients, families who had poor experiences of transition communication experienced anxiety and frustration [58].

Health Professional Outcomes and Perceptions

Initiatives designed to increase communication with patients and families during transitions improved accountability and increased patient involvement [51] indicating that nurses had perceived a move away from these practices in more recent times. Similar to the patient outcomes, nurses in several studies reported increased satisfaction and confidence as a result of introducing strategies that facilitated patient, family and health professional communication during transition [46, 51, 53]. Numerous benefits associated with greater inclusion of patients and families in transition communication were identified by nurses, including more comprehensive and purposeful discussions, enhanced patient interactions, promotion of reflexivity, promotion of patient-centred practice and the opportunity for immediate feedback [46, 67]. Consequently, nurses reported preparing more thoroughly for these conversations, so as to appear prepared and efficient, and to give patients confidence in their caregiving [27].

The centrality of information exchange in transition communication was also a strong theme within the evidence from health professionals. Nurses who collaborated with patients and families in transition communication reported feeling that they had a better understanding of the needs of their patients, and that bedside handovers, in particular improved communication [50]. An observer of a bedside handover noted how the departing nurse was able to initiate conversation with the patient using the subjective interpersonal knowledge they had previously developed of them, which was warmly received by both the patient and incoming nurse [59]. In this case, the information being exchanged was not only clinical, but also interpersonal, and facilitated the next health professional developing rapport over the transition period. Like patients, nurses also appreciated the chance to formally introduce themselves to patients [67].

Nurses in some studies perceived the active engagement of the patient in the transfer of health information helped to ensure accurate and up to date information was received [27, 31]. This was supplemented by the nurses' ability to visually check the patient during these conversations, providing further objective information which confirmed information obtained by other means, and promoted recognition and recall [67]. In one study, nurses' perceptions of health professional accountability, medication reconciliation and confidence in communicating immediately with medical staff improved significantly following the introduction of bedside report [50].

As a result of introducing bedside handover, a significant reduction in nurse overtime was reported in one study [53]. The introduction of a transition coach intervention (delivered by nurses) was also found to be a relatively simple and low cost innovation to implement across a broad range of settings [45]. Changes to the ward environment as a result of implementing practices to facilitate transition communication with patients and families was also noted in two studies. In one case, a better flow of ward traffic was noted as health professionals no longer congregated in a central area [31]. In another study, the location of transition conversations was noted to be haphazard, occurring at the bedside, in corridors and at a central station. While patients were able to actively participate in the first instance, they were effectively excluded from conversations in other instances. The decision to speak away from them was often made jointly by the departing and oncoming nurses, based on clinical judgment around how ill their patients were and the sensitivity of the information to be communicated [59].

Many studies in this review focused on initiatives to implement beside handovers, on the assumption that conducting these transition conversations in the patient's presence would encourage participation. While there were some positive findings from patients' perspectives, the location of the handover does not appear to be in and of itself influential. One Australian study found that while almost one third of whole ward handovers and half of individual patient handovers took place at the bedside, patients were not usually involved in the communication process [52]. There is acknowledgement that engaging patients in transition communication can be challenging.

However, this process is perceived to support patient-centred care and the delivery of information at the point of care [31, 59]. Feelings of ambivalence and resistance from nurses towards adopting approaches to facilitate communication with patients and families were identified in several studies [51, 53, 64, 65]. Despite this, nurses still participated in initiatives to promote enhanced engagement of patients and families when such initiatives were introduced, resulting in outcomes such as significantly increased compliance with beside handover procedures (including incorporating patient involvement) [52]. Interestingly, Tidwell et al. [53] reported that nurses who were initially most resistant to the change to bedside handover eventually became the biggest champions of the new system.

Despite greater acceptance, nurses in some studies still did not perceive initiatives to facilitate transition communication with patients and families as effective after their implementation, indicating ongoing resistance to this change. In particular, nurses who retained a negative perception of including patients and families in transition communication often considered it to involve extra work. They also identified perceptions of patient preferences (i.e. not wanting to be woken up), which were not always supported by evidence directly collected from patients [65]. Changes to processes that included more active participation of patients and families in transition communication challenged the dominant discourse of unidirectional information delivery in health [59]. These perceptions may be a reflection of these more traditional attitudes.

Facilitating Factors Enabling Communication at Transitions

A range of factors which facilitate transition communication between patients, families and health professionals were identified across the studies reviewed. In addition, organisational facilitators (in the form of models of change, procedures and processes) were also identified, and had been used in some of these studies to overcome barriers or support the implementation of collaborative communication.

Patient Facilitators

Intrinsic patient characteristics were the most likely facilitators of transition communication. In a qualitative study, some patients were recognised to feel more empowered to participate due to their personality or previous positive experiences in transition communication [29]. These previous experiences included the formation of positive rapport with a particular health professional, leading them to prefer to seek and share information with that particular person [29]. The continuity in care which would enable this preference to be met is often an aim of health care service providers, but can be very difficult to achieve in practice (particularly in acute settings). Patients who do not have the characteristics or knowledge to participate optimally in transition communication may still be facilitated by targeted interventions from health professionals such as follow-up appointments, medication reconciliation, and health literacy strategies [63].

Transition communication occurs within the boundaries of a health service, and patients are not always aware of the norms which govern these interactions. These interactions can be particularly challenging when they occur on an ad hoc basis, and are not clearly defined and identified as opportunities to discuss transition issues [62]. In a study of transition experiences from emergency departments to other services, around one third of patients could not recall any formal transition conversations with health professionals prior to discharge, and none had attended a formal discharge planning conference [29]. To actively participate in transition communication, patients need to know how to communicate with health professionals in these circumstances and what is expected of them, and also have the health literacy, confidence and language skills to understand and contribute information effectively [29, 49, 63]. Efforts are also required to ensure patient understanding; checking their perception of the information they have been provided [64]. Patients are also more likely to participate in transition communication when they perceive they must take an active role to ensure their continuity and quality of care [29].

Patients' perceptions of the environment for communication with health professionals was also an important factor for facilitating transition communication. Patients who felt these conversations would be conducted in a positive, respectful, open and personally relevant manner were more likely to participate [61, 62]. The provision of these optimal conditions for patient participation in transition communication are likely to lead to long lasting effects, as better informed patients are more able to take part in future care and handovers [61, 64].

Family Facilitators

Only two family-related facilitators were identified in the studies reviewed. Tobiano et al. [60] found that families wanted a detailed account of their family member's condition, care and the interventions that were being provided. Shorter, focused handovers supported this, by providing a formalised space for families to get information without the need to interrupt health professionals during the rest of their shift. This information enabled them to feel they were doing all they could for their family member, and even if this was relatively little it was experienced as empowering. Johnson, Forbes, et al. [58] noted that information exchanges between physiotherapists and families were more effective when families were available to visit hospitals during regular working hours. Face to face meetings with health professionals were also considered more effective, but it was acknowledged that these were not always possible due to other commitments for family members.

Health Professional Facilitators

Health professional-related facilitators for encouraging patient and family participation in transition communication included individual intrinsic factors, but extrinsic influences were also identified in several studies. As mentioned previously, patients responded more positively to transition communication when health professionals exhibited positive attitudes towards transition communication. This was manifested as a response to patients' contributions to handover information, indicating an understanding of the individual patient's situation and adjusting communicated information according to patients' needs and abilities [29]. These attitudes were seen to contribute to a sense of continuity, providing the impression that the treating team were all 'on the same page' [48, 49]. Patients valued knowing how health professionals were communicating about their care, but nurses did not always understand the importance of this knowledge [30]. Avoiding the use of jargon or acronyms was also identified as a facilitating practice, which enabled patients to participate in the conversation on a more equal basis [27, 28, 61].

Other health professional practices that facilitated participation by patients and families in transition conversations included:

- introducing patients to other health professionals in a personal manner [61];
- speaking in a positive and relaxed manner [29];
- requesting permission before doing anything to or for the patient [49];
- demonstrating how information is being used to plan treatment [61];
- explaining the treatment that is happening to the patient [49];
- having some basic information about the patient before commencing transition conversations [59]; and
- thanking patients for their time at the conclusion of the conversation and asking if they have any further questions [27].

To facilitate the strategies referred to in previous sections, health professionals needed both tools and training to identify patients at risk of being excluded from transition communication (e.g. due to low health literacy, language barriers, complex interdisciplinary care or large number of medications) [63]. Nurses also identified that the mere presence of the patient at transition conversations prompted collection and discussion of key information with the patient, stating *"You can get a lot more observation and draw a lot more information when you actually look and see for yourself"* [27, p.31]. Initiatives such as bedside handovers allowed health professionals to get in closer physical and social proximity to patients, thereby enabling a more engaged dynamic experience during transition communication [59, 60].

In light of the previous comments on the need to help patients understand the norms and practices of the health care system, nurses also reported they needed to actively and explicitly encourage patient engagement by asking for input and providing clear instructions, particularly where there was the potential for misunderstanding [30, 61, 62]. In some cases, nurses were reported to be disconcerted and surprised by the idea they needed to do more than simply provide information [64], indicating that patient engagement may not come naturally. Thus, it cannot be assumed that nurses already possess all the skills and knowledge required to conduct a patient- and family-centred transition conversation. Education and training in this area can improve nurses' ability to facilitate patient and family participation, and the use of patients' real life comments and feedback in the content of this education is recommended [30].

General communication training is also recommended to facilitate nurses in conducting patient- and family-centred transition communication [31, 52]. Skilled communication is recognised as a crucial facilitator to the success of transition communication. As stated by one group of nurses, *"If we get a good communicator then we get a good handover"* and *"good communication includes being able to talk about problems"* [31, p.125].

Organisational Facilitators

Organisational facilitators took the form of models of change, models of care, and procedures and processes used to promote the inclusion of patients and families in transition communication.

Procedures and Processes

Several researcher teams developed their own procedures and processes to guide the inclusion of patients and families in transition communication. These procedures and processes need to be standardised to a certain extent, but should be adapted to local settings [52]. Glenny et al. [57] notes that these procedures and processes should focus on changing behaviours and practice rather than just supporting collaborative attitudes, and also advocates early intervention and involvement in discharge planning in preference to later actions. Ideally, the interventions promoted by these procedures and processes should also aim for long term impact which will enable involvement by patients and families long beyond their current episode of care [47].

A standard operating protocol for bedside handover was formulated for one Australian study [67], with five steps: preparation, introduction, information exchange, patient involvement and safety scan. The patient involvement step is designed to prompt health professionals to ask patients if they have questions or comments, and invite the patient to confirm or clarify information. The ISHAPED method is another example of a protocol for conducting bedside handovers, incorporating a standard process template [30]. ISHAPED (**I** = Introduce, **S** = Story, **H =** History, **A** = Assessment, **P**= Plan, **E** = Error Prevention, and **D** = Dialogue) guides health professionals to cover a standard series of areas in their transition communication with patients and families, with the 'dialogue' prompt specifically encouraging health professionals to ask patients questions and encourage their feedback.

Written handover sheets and e-whiteboards were introduced to handover in a study conducted in the acute setting. However, the intervention was not described in detail and the contents or structure of these aides were not provided [31]. The handover sheets were designed to provide information of all patients on the ward, but there was some debate as to whether this information should be standardised for all patients or unique to their circumstances. Whiteboards were also used in another study, and their potential role for informing patients was also acknowledged. Friesen et al. [30] reported these boards were used to display information the patient needed to know, thereby enabling them to be informed.

Scripts were also provided for transition communication in some studies, to provide nurses (and other health professionals) with structured support for including patients and family in transition communication. Such scripts were reported to be particularly helpful to nurses who were nervous about transition communication, as they provided a structured reference and a baseline for quality assessment [67]. In a study of paediatric patient transport, nurses were provided with additional training in how to lead an effective handover (via video modelling), using a script that included asking the patient's parent *Is that right?* and *"…did we miss anything?"* [32, p.43]. While this is a minimal form of inclusion, it does prompt health professionals to remember to ask these questions in what may be a very stressful situation.

ISBAR (Introduction, Situation, Background, Assessment, and Recommendations) was converted into a standardised script for nurses, which included describing treatment plans to the patient, asking the patient about their goals for the day, checking their understanding of the information discussed, providing clarification and answering any questions. SBAR (a version which does not specify the structure for introductions) was also used to formalize handover content in a single hospital study, with the authors suggesting it may engender trust between health professionals by ensuring the most salient information is routinely discussed and recorded [27].

In regards to written documentation, Chin et al. [28] provided some suggestions to promote the translation of patient and family preferences into practice. These recommendations included placing collaboratively authored documents (i.e. Birth Plans) in visible locations such as near the room door, and offering patients a standardised template for their instructions which integrates with existing medical records. An example of another discrete procedure was provided by Chaboyer et al. [27], explaining the steps taken to prepare patients and families for participation in handover. Before the conversation was due to occur, patients were informed when it would take place and asked if they wanted any assistance to prepare (i.e. help to visit the toilet) to ensure the conversation itself would not be interrupted.

Models of Care

Several studies highlighted the potential for the model of care adopted by a particular health service to either support or inhibit transition communication between patients, families and health professionals. Team nursing approaches (where nurses are not allocated to care for specific patients) were identified as providing support for the sort of communication which facilitated bedside handovers and the inclusion of patients and families [31]. However, task-based nursing or floating nurse models may not require nurses to receive handover on all patients, reducing the possibility of participating in patient- and family-centred transitions [31].

Models of Organisational Change

As the routine inclusion of patients and families in transition communication is yet to become regular practice in health care, its implementation often involves a process of change within health services. The most common model of change employed in the studies reviewed was the ‘unfreezing - moving - refreezing model’ proposed by Lewin [68]. In the first phase, current practices are examined and the status quo fully identified before change is introduced in the second (moving) phase. The final re-freezing phase focuses on consolidating and reinforcing the change undertaken to ensure its long term viability. This model of change was referenced in two of the included studies [46, 67].

Based on a qualitative study, McMurray et al. [67] established a specific model for successful change to bedside handover, which is broadly based on Lewin’s model. Their model has eight stages: 1) establish a sense of urgency, 2) create a powerful guiding coalition, 3) share the vision for outcomes of change, 4) communicate the vision to energise renewal, 5) remove obstacles to change, encourage risk taking and creativity, 6) plan for short term wins and reward, 7) ensure sustainability, reinvigorating with new challenges and 8) anchor changes within the work culture.

Regardless of the model of change used, there is recognition that health professionals need to be supported and empowered to participate in these processes [52]. Modelling of good practices by experienced nurses, accurate feedback, and group support are recommended for developing skills in nurses who struggle with the adaptation to a more collaborative approach to transition communication [67]. Highlighting the rationale behind the changes and having the full engagement of leadership was also facilitative; any institutional change must take individual, team and structural factors into account [67].

Barriers to Communication at Transitions of Care

Fewer barriers than facilitators to transition communication between patients, families and health professionals were identified. Organisational factors were identified as a barrier to transition communication, not all of which corresponded with facilitators identified in the previous section.

Patient Barriers

Patients' perceptions of patronising staff attitudes or that staff were too busy to see them were barriers to participating in transition communication, discouraging patients from asking questions and sometimes causing offence [28]. Although some patients indicated that privacy during transition communication may be an issue, the majority did not identify this as a major concern [61]. As stated by one patient, *"No, when you are sick, there is no privacy. Everyone needs to know what is going on"* [30, p.214].

Patient factors perceived as barriers to participation in transition communication were highlighted in previous sections (i.e. health literacy and language issues [62, 63]. Other barriers identified in the studies reviewed included the patient's immediate health status (e.g. presence of pain, post-operative recovery), poor cognitive function, hearing impairment, impaired consciousness, stage of labour or being in isolation due to infection control measures [27-30, 47, 64]. In regards to these barriers, Groene et al. [63, *p.i73*] highlighted that it is unreasonable to expect that all patients can become 'well informed' through facilitative measures, and all transition communication *"should be made equally safe for all patients, independent of their capacity for participation"*.

When patients were asked to act as couriers of information to new health services, they did not attach meaning to the information as they did not feel any ownership over it [58, 63]. As such, they did not always pay it sufficient attention, and at times delayed or omitted to transfer it to their new provider. Direct handover between primary and secondary health services rarely occurred, and when it did, it was often dependent on personal relationships between providers. This form of transition communication is therefore considered unsafe, due to the unreliable nature of the transfer and the potential for information to be misinterpreted or lost. Patients themselves reported that a lack of information was a key barrier to their participation, perceiving a gap between the information they received and that which they were required to play an active role in transition [62]. At times, nurses were observed to miss opportunities to fill these gaps for example when patients were seeking more information about their medications [64].

Interpersonal factors in the relationship between the patient and health professionals, or perceived expectations around behaviour were also identified as barriers. In some settings, patients were required to speak to large numbers of health professionals during transition conversations (i.e. medical ward rounds) and these were identified as somewhat intimidating situations [29]. Other patients felt reluctant to participate in transition communication, as they perceived this to be undermining the health professional's expertise and authority or they felt they were not 'adding value' to the health professional' understandings [28, 29]. Some patients also perceived that their presence at handovers may negatively impact on the discussion taking place, or that the health professionals already had all the required information about them on file [28, 29]. Poor therapeutic relationship with health professionals was also a barrier to participation in transition communication, as patients would not share information with health professionals they did not feel they could trust or be comfortable talking with [29]. Making decisions against the patient's explicitly stated wishes or without their knowledge was particularly damaging to this relationship, and the patient's and family's motivation to participate in future transition communication [29].

Family Barriers

Johnson, Forbes, et al. [58] identified several potential barriers to family involvement in transition communication. Firstly, health professionals have to take the family's ability to handle the situation' into account, and such a judgment is made at the health professional's discretion. Having a range of family members involved in transition communication is particularly challenging, as the family member present at the discussion is not always the person who will be following up the agreed arrangements. Alternative formats of communication to overcome availability concerns can also pose their own issues. Telephone contact with family may be experienced as confusing or uncertain by some families in the absence of non-verbal cues. Written information about aftercare (i.e. exercise programs) is not always provided in an accessible language and/or format. Whiteboards used for communication in a patient's room may be helpful to inform family, but become less effective when they are not kept up to date [57]. In regards to privacy issues, family members in one study indicated that any lack of privacy inherent in transition communication was outweighed by the potential benefits for better accuracy [60]. However, it should be noted that it is not their personal privacy which would be breached in this situation.

There are few structured approaches to involving family in transition communication available, and a family in one study reported feeling frustrated about being expected to take the initiative in approaching health professionals and maintaining communication with them [57]. Encounters with the health professionals were considered 'flukes' because no scheduled appointments were made for them to discuss their concerns. These families described the need to be proactive and persistent in making contact with health professionals, and were unsure what the 'right' questions were in order to elicit the information they needed. They also needed to deal with a series of health professionals over the course of their family member's stay in a health care service, and did not feel able to build continuity and rapport with any particular person. Just as patients need to be supported to participate in transition communication, families also needed to be made aware of norms and practices to get the most from these interactions.

Health Professional Barriers

In these studies, nurses identified several concerns about transition communication between patients, families and health professionals. Waking patients when performing night shift handovers or if patients were resting, was regarded as an unnecessary inconvenience by many nurses [65]. However, some nurses still observed the patient at this time, conducting the rest of the handover back at the central staff station [31].

Some nurses were also apprehensive about their knowledge being on show in a relatively public space, which was called 'stage fright' in one study [67]. As a result their participation in transition communication becomes more focused on personal accountability than actively engaging with the patient and their family. Nurses also expressed concern that some patients (particularly those for whom English is not a first language) may panic if they misinterpreted the information being discussed [28]. Health professionals also recognised the challenges posed by having to deal with multiple team members for both patients and families, particularly where there was no single contact person identified [57].

Privacy concerns were often raised by health professionals, particularly when transitions were held in public spaces such as at the bedside [31, 67]. Some nurses draw curtains in shared rooms to provide some privacy, but these do not prevent others in a room from hearing a transition conversation [59]. In some studies, nurses routinely asked visitors (including family) to wait in a lounge room until handover was complete and only allowed them to stay if the patient made a specific request [27]. While this second approach may seem more empowering, the first approach allows patients with difficult family relationships to passively accept them being asked to leave. Health professionals need to adhere to requirements around obtaining consent from patients to share their health information, but the processes around this can cause delay in information transfer during transition [57, 58]. Despite these concerns, many nurses believed that privacy issues are relatively minimal, can easily be overcome within existing practices and are outweighed by the benefits of greater accuracy and accountability [31, 67].

Language plays a crucial role in transition communication, both from a vernacular and professional perspective. In an increasingly diverse global community, both patients and health professionals need to be able to communicate across accents and verbal traditions, and this can at times be a barrier [31]. When these language issues are combined with the use of jargon or abbreviations, such barriers are compounded [28]. Concerns from patients about understanding the language used by health professionals was characterised as racism in one study [31], although expressing a preference for a health professional they can clearly understand may also be interpreted as a reasonable choice.

As noted in the previous section, health professionals do not always have existing knowledge and skills in enabling patient participation in handovers [29]. For example, they may have limited experience in managing transition communication for patients in difficult or unstable social situations [63]. Health professionals may also be unsure how to deal with several different or multiple stakeholders, such as when the patient is accompanied by a family member(s) [57]. In these situations, there can in effect be several different conversations occurring simultaneously in order to meet the needs of each stakeholder. However, Friesen et al. [30, p.215] states *"Nurses need to advocate for patients by removing barriers that restrict the patient voice from being heard"*, and may therefore require further training and development to take on this aspect of their role.

Organisational Barriers

Ward environments (both social and physical) can present unintentional barriers to transition communication. For example, professional boundaries based on hierarchical rank and professional autonomy can mitigate against the promotion of greater participation by patients and families in transition communication [67], with some members of the team having less motivation and opportunity to engage in this way. Some larger wards divide their nursing team into small sub-teams, and would therefore only handover those patients cared for by the smaller team. One study found that the main initiative used to promote collaborative communication (i.e. bedside handovers) was not perceived as beneficial by some nurses in these teams [31]. These nurses preferred to receive a handover for every patient on the ward. Furthermore, nurses who are employed part time may also be at a disadvantage when it comes to transition communication, as they are more at risk of being excluded from these conversations [52].

Some wards (particularly in older buildings) may not be as conducive to shared collaborative conversations; bedside settings may lack privacy and have high levels of background noise [31]. In these settings, nurses and other health professionals are in control of all spatial movement, and patients report being reluctant to seek help and information from nurses who are conducting transition conversations at a distance [31, 59]. Health professionals approach patients to initiate transition communication, and move away from them when they judge the patient's presence is either no longer required or desired. While health professionals are said to use common sense to determine what sensitive information should not be discussed in front of patients and families [27], this exerts a power imbalance and has been termed 'the tyranny of discretion' [59]. Conducting transition communication away from the patient can give rise to an air of secrecy, where the patient is the subject of conversation but not allowed to 'know' [30].

An example of the tension between patients' needs and those of the ward as an entity was provided by Liu et al. [59]. The patient had discussed his medication with his assigned nurse, and was 'promised' that his social identity as a private patient would be maintained in the public ward. As part of this, he expected to choose and control his own medication timing, and asked for his preferences to be adhered to. When a senior nursing health professional re-articulated this request, much of the team laughed. This disparity could be interpreted as an expression of the competing discourses of patient autonomy and disciplinary norms. In seeking to participate actively in transition communication, patients and families may be disrupting long standing practices and cultures. Resistance to this from health professionals could be a barrier to their participation.

Acute wards in particular are busy, fast paced environments, and during regular transitions (i.e. shift handovers) nurses reported being in a constant balancing act between time pressures and ensuring patient safety [59]. Sufficient time is required for tasks such as double-checking medication charts and to also facilitate patient and family engagement in discussion during handovers. However, psychological and social information tended to be overlooked when time was short [59, 61, 64]. Many patients and families were aware of and sympathetic to these time pressures, and expressed a reluctance to interrupt or 'interfere' by seeking to participate in shift handovers when health professionals appear pushed for time [29, 57, 61]. In some cases, this lead to patients disengaging from transition communication altogether, leaving the healthcare service in frustration before formal discharge was complete [29]. However, some took the opportunity for social talk during these conversations [46]. Some wards have adopted multiple transition communication methods in an effort to increase safety (i.e. written, verbal, handover notes), but this introduces the risk of ambiguous, incorrect and dangerously confusing information arising from these multiple sources [31, 63].

Summary Stage 1

The synthesis of peer-reviewed literature focussed specifically on the engagement of patients in communication at transitions of care within, to and from acute care facilities. Twenty four studies that fulfilled the inclusion criteria were included in the review. The majority (71%) of those studies focussed on various handovers, with bedside shift to shift handovers by nurses comprising 50%. A range of research methods were used within studies. Seven used quantitative methods, only two studies measured effectiveness of interventions using RCTs. Ten studies used qualitative approaches and eight studies used a mix of both qualitative and quantitative methods. Overall, most studies were exploratory in nature. Four main themes arose from the review of the literature. These were:

roles for patients, families and health professionals; outcomes of communication at transitions; facilitating factors that enable communication at transitions and; the barriers to engagement in communication at transitions of care.

Stage 2: Key Stakeholder Consultations

Introduction

In Phase 1, Stage 2, consultation with key stakeholders occurred concurrently with Stage 1 (integrative review) of the project. The objective of the second stage of this work was to describe strategies used by a range of key stakeholders to engage patients in communication associated with transitions in care. To meet this aim, the specific research questions were:

1. What are the structures, processes, tools and resources used by health care professionals to engage patients in communication associated with transitions in care?
2. What are the contextual variations within and between different services related to engaging patients in communication associated with transitions in care?
3. What support mechanisms and resources can be used to improve health professionals' ability to engage patients in their care transitions?

Methods

Conceptual Framework and Research Design

After discussions with the Commission, a series of case studies was undertaken, with cases being represented by a hospital and/or health service. In these discussions, it was determined that four to five cases would be studied. Collaboratively, the project team and staff of the Commission identified cases. Case studies are particularly useful when the focus of the study is on contemporary phenomena within a real life context and the investigator has little control over events [69]. Within each case, semi-structured interviews were used to gather the data. Donabedian's Structure, Process Outcome (SPO) model of quality care was used as the guiding framework for the interviews and their analyses [70]. This model provided focus and direction for data collection, analysis and structuring the findings. The SPO framework was used as prompts to elicit detail about resources, tools, strategies and processes used to promote patient engagement in communications about their transitions in care. Three hospitals' and Griffith University's Human Research Ethics Committees (HREC) approved this study.

Sample and Settings

A purposive sample of key stakeholders was recruited throughout Australia in collaboration with staff at the Commission. Purposive sampling ensured a broad representation of key stakeholders. These stakeholders included the following groups:

- Patients, families, patient advocates and volunteers;
- Hospital discharge planning team (or equivalent);
- Key health care professionals such as physicians, nurses, allied health professionals and administrators.

All stakeholders were either employed, interacted with, or were involved in acute health services across Australia.

Data Collection

Individual and group interviews were used to collect the data. Interviews were conducted by two registered nurses, very experienced in the conduct of qualitative interviews. After consenting, individuals or groups were interviewed using a semi-structured interview guide to elicit detailed explanations of patient engagement in transition planning and interactions. Interview questions were revised after meeting with the Commission staff, but prior to data collection. They were also tailored during the interviews to reflect the participants' background, with additional probes used as required. Examples of health professional questions include:

- "What are the major influences on your ability to engage patients in discussions about their care transitions?";
- "What do you do to help patients/families become involved?";
- "What policies, procedures, tools or other approaches do you use to engage patients/families in these communications?"; and
- "What helps/hinders you to engage patients/families in planning care transitions?"

Examples of patient, family and patient advocate questions include:

- "What has made it comfortable for you to speak up during interactions with health professionals (doctors, nurses etc.)?";
- "What things prevented you from speaking up or asking questions of health professionals?"; and
- "What advice or messages do you have for health professionals about how to involve patients in their care transitions?"

Interviews took place at a time of mutual convenience and were digitally recorded and transcribed. In the case of one hospital, participants were interviewed by phone as permission to interview on site was not granted, despite the hospital providing both HREC and Site Specific Assessment approval. Interviews lasted between 30 and 60 minutes. Data collection and analyses were conducted simultaneously; data collection continued until saturation of response themes was considered to have been achieved. In practical terms, saturation was considered to have been reached when no new response themes were identified during data collection and analysis.

Data Analysis

Interview data were transcribed and analysed using the complementary approaches of content analysis and thematic analysis. Content analysis was used for within case analysis and thematic analysis was used for cross case analysis. Content analysis techniques combine deductive and inductive techniques to identify both manifest and latent themes. The deductive analysis involves first a systematic categorisation of the interview data to ensure it is empirically meaningful in the context. This deductive analysis involved classifying the data into *a priori* categories of structures (including tools), processes and outcomes used to communicate with patients during transitions. Latent content analysis then involved inductive analysis to identify themes within the structures, processes, tools and strategies used (i.e. the deductively classified content was then analysed inductively). This analytic approach ensured contextual data were integrated into the findings to provide insights into relational factors such as health professional-consumer interactions, cultural influences, barriers to patient engagement, and organisational features as well as structures, processes, strategies and tools. Each case was analysed separately, with findings for each case articulated.

Thematic data analysis was subsequently used to analyse the data across the cases (i.e. cross case analysis) [71]. Thematic analysis of verbatim transcripts involved an iterative and inductive process of reading the transcripts to become familiar with the data, generating initial codes, searching for themes, reviewing the themes and finally defining the themes [71]. Regular meetings among the team were held to review and refine emerging findings.

A number of strategies were used to maximise data quality and increase the rigour of the qualitative research [72, 73]. In addition, concurrent transcription and analysis during the data collection period allowed for identification of themes that were then explored in subsequent interviews, increasing the validity and credibility of findings [74]. Regular meetings with the research team enhanced the trustworthiness and credibility of findings through discussing discrepancies and facilitating agreement on final themes.

Findings

Demographics of the Cases

Table 4 identifies the five cases that were studied, representing a variety of services and hospitals in four states. Hunter New England Health Services and Alfred Health included interviews with staff from two hospitals in the service (some of whom worked across both hospitals). In total, 62 people were interviewed. The types of interviews conducted included:

- Flinders Medical Centre: n = 8 individual interviews;
- Hunter New England Health and Hospital Service: n = 6 individual interview; n = 7 focus groups with 16 people total;
- St Vincent’s Private Hospital (Sydney): n = 8 individual interviews;
- St John of God Murdoch Hospital: n = 4 focus groups with 19 people total; and
  Alfred Health: n = 5 individual interviews.

Table 4: Summary of the Cases

Site	State	Hospital
1	SA	Flinders Medical Centre
2	NSW	St. Vincent’s Private (Sydney)
3	NSW	Hunter New England Health (John Hunter and Maitland Hospitals)
4	WA	St John of God Murdoch
5	Vic	Alfred Health (The Alfred and Caulfield Hospitals)

To ensure anonymity of participants (an HREC requirement), a summary of the individuals interviewed is presented in a separate table (see Table 5). The majority of participants were nurses, followed by allied health, patients and physicians.

Table 5: Description of the Sample

Sample Characteristics	**Frequency (%) n = 62**
Hospitals	7
Participants	62
Gender	
Female	52 (83.9)
Male	10 (16.1)
Group/Profession	
Nurse	36 (58.1)
Allied Health*	9 (14.5)
Doctor	7 (11.3)
Patient	7 (11.3)
Volunteer/Health Advocate	2 (3.2)
Family	1 (1.6)

Footnote: *Allied Health includes occupational therapist, dietician, physiotherapist, pharmacist, social worker and pastoral care.

Within-Case Content Analysis

Table 6 provides an overview of the structures and processes that emerged from an analysis and synthesis of the findings from each of the cases. One structure was at the macro level whereas others related to the meso level such as roles that spanned across the organisation including patient advocates/volunteers and car coordinators. Finally, some structures reflected unit level structures such as bedside handover and multidisciplinary team rounds. While some of these activities were described by several cases, others were evident in only one or two cases, but they still provide exemplars for practice.

Table 6: Structures and Processes across Cases

Level	**Structures**	**Processes**
Macro	Health service sector	The public and private sectors have different structures, financial constraints and working relationships, which influence how they ‘do business’. Some of these differences result in differing access to services including doctors, allied health etc. At the national/state level, funding structures, national standards and statewide guidelines influence service delivery (such as approaches to handover, discharge planning etc.).
Meso	Organisational commitment to patient-centred care	Various strategies (such as ensuring staff understand the principles and practices associated with PCC and the commitment to it, leader rounds to ‘walk the talk’) were used to share and embed PCC throughout the organisation. Strategic and organisational planning documents reflect the focus on consumer/patient engagement. Other formal documents may detail the action plans generated from consumer feedback.
Meso	Hospital culture, mission and values	Ways in which the organisation’s expectations for practice (how we do things around here) are communicated to and enacted by staff.
Meso	Leadership structure	Leaders, embedded throughout the organisation (i.e. at various levels), model and share the hospital’s expectations for working with patients and others.
Meso	Leader rounds	Leaders at various levels of the organisation walk around the wards asking patients/families and nursing staff about their day, their plans for care, preferences, needs and issues.
Meso	Patient/family feedback	Various processes are used to seek feedback including patient stories, formal surveys, follow-up phone calls after hospital discharge etc. Once this feedback is provided, it

		must be clear how the feedback is evaluated and acted on when required.
Meso	Organisation wide ward management principles	The aim of the principles is timely, active progression of patient care from time of arrival to hospital. Six Principles: 1. All patients are reviewed within two hours after being referred for admission. 2. Decision-making by senior members of the multidisciplinary team. 3. Multidisciplinary rounds for every patient every day. 4. Each team has a home ward and patient allocation on availability and equality of distribution. 5. Patients are actively managed to ensure they are only in hospital for as long as clinically necessary. 6. Appropriate transfer of care.
Micro	Patient advocate/volunteer	The roles the advocates/volunteers undertake should be clear to all involved. Activities they were involved in include communicating patient feedback through patient stories, contributing to process improvement (such as being part of collaborative practice teams), and providing practical advice to patients/families etc.
Micro	Care coordination role	Practices such as case management, admission processes and discharge planning were consistently described. Coordination of ‘complex’ patients was often a specialised role as compared to clinical nurses coordinating ‘non-complex’ patients. Eligibility for various services such as DVA* and HACC** influenced coordination. In some instances the ED*** to ward admission process involved use of medical assessment units and a focus on ensuring patients were admitted to the appropriate ward.
Micro	Multidisciplinary rounds	Ways in which ward rounds were conducted included strategies for nurses’, patients’/families’ participation in the rounds. One example was the SIBR**** model. In some instances, the multidisciplinary team come together before the round to identify any specific issues to be dealt with, determine who is the ‘round manager’ and any information about families who want to be included in the round and those who are not available to participate in the round. Specific formats are used to include patients/families in the round such as pausing and requesting their input and letting them know the team would follow up on more complex questions and concerns after the round.

Micro	Bedside handover	How the handover is enacted such as ways patients/families are notified of the process, how they are prepared, how they can participate must be clear to all involved.
Micro	Patient/family training	How patients/families are prepared for participating in various aspects of care is important. The extent to which they are 'legitimate' players in activities such as handover is key to success.

Abbreviations: *Department of Veteran Affairs (DVA), **Home and Community Care (HACC), ***Emergency Department (ED), ****Structured Interdisciplinary Bedside Rounds (SIBR).

Expected Outcomes

Participants described a number of expected outcomes, from the perspective of patients/families and staff/organisation. Patient/family outcomes reflected both better experiences for patients/families and better recovery in addition to a perception that involving patients in communication also promoted health professional accountability. Perceived outcomes for staff and the organisation revolved around developing authentic partnerships with patients/families, improved patient safety and compliance with national standards and a sense of job satisfaction. Specific perceived outcomes are noted next.

Patient/Family

- Comfort and emotional support
- Better recovery (physical comfort, emotional security, better able to cope)
- Comprehensive information appropriate to needs
- Questions answered
- Better informed decisions
- Preferences for care/services understood
- Family satisfaction
- Accountability of health professionals through appropriate communication

Staff/Organisation

- Including patients in care planning and decisions
- Allowing patients to negotiate transitions
- Individualising care
- Both continuity and consistency of care and information
- Staff and patients/families understand the plans for care
- Appropriate goals for care, rehabilitation etc.
- Integrating patient preferences into practice (part of what evidence-based practice is supposed to include)
- Safer care (medication administration, transfer and discharge, reduction in falls, pressure injuries etc.)
- Compliance with the national standards
- Job satisfaction (care consistent with philosophy)

Cross-Case Content Analysis

After the initial within case content analysis was completed, identifying the structures (including tools), processes and outcomes related to engaging patients in communication about transitions in care, cross-case thematic analysis was undertaken. Five themes emerged including: 1) Organisational commitment to patient engagement; 2) Organisational culture and norms; 3) Individual health care provider's orientation and actions; 4) Understanding and negotiating patient preferences; and 5) Enacting information sharing and communication strategies. Many of the themes illustrate how patient engagement was enabled; however, context and the extent of formal and informal endorsement could act as both barriers and enablers.

Organisational Commitment to Patient Engagement

Participants from all sites indicated there was a high level of commitment to patient engagement, from the chief executive officer, to managers to bedside staff. This commitment led to the endorsement and use of various strategies and tools to promote patient participation. Commonly, participants described how organisational mission, vision and values, which focused on patient-centred care, were embedded in daily work. This was reflected in formal structures as well as in everyday activities to promote patient-centred care. For example, participants described involving patients in bedside handover, in multidisciplinary rounds and in leadership rounds. The high level of commitment to patient engagement helped embed these activities into daily work practices. Box 1 contains verbatim quotes that reflect this theme.

Box 1: Organisational Commitment to Patient Engagement Participant Quotes

- “It probably comes from the Alfred’s values and missions and goals but I think it also comes from probably our nurse unit manager who we used to have on the floor who has just recently left, who put a lot of hard work into the floor to get us where we are.” RN
- “I know…the efforts the hospital will go to achieve, you know, try and make for a good experience”. RN
- “I think that’s one reason why people like to work here, is those sort of core values and the mission statement” [referring to patient centred care]. RN
- “‘Excellence’ here …. it looks at aligning our goals, aligning our behaviours and guiding our processes to get a consistent outcome. So in the aligning goals it really looks at the accountability of all managers, what are they responsible for…[We] hold our managers accountable and in the monthly accountability meetings they will look at the operations, complaints, compliments…..” Nurse Leader
- “…we have the willingness, less bureaucratic tape and more agility to get on with it [patient centred care]. Sometimes it’s not just about discretion, it’s about leadership too. If you really want to do it, you do it and ask permission. But it’s better to sometimes say sorry I won’t do it again than ask permission and never do anything.” Nurse Leader

Organisational Culture and Norms

Participants reflected on how organisational culture and norms influenced their practice in general and in particular the ways in which it influenced their attempts to engage patients in communication. They described how the traditional hierarchy, which segregated professional groups, with physicians holding the balance of power, could be a major barrier to teamwork and to patient-centred care. Participants noted this despite their organisation's commitment to patient engagement and patient-centred care. This theme seemed to reflect the interplay between the organisation and the individual, illustrating how expectations of professional groups, specialty areas and individual wards and settings influenced how groups worked together including how they involved patients. Box 2 contains verbatim quotes that reflect this theme.

Box 2: Organisational Culture and Norms Participant Quotes

- "….each ward has their own standards of behaviour so the staff have come together and looked at what behaviours they want to promote and what behaviours they don't want to have in their service, we call them standards of behaviour above and below the line and that is across the whole district in clinical and non-clinical areas and it's aligned to our core values which is "Collaboration, Openness, Respect and Empowerment" so staff have come and decided what respect looks like in that area." Nurse Leader
- "….focusing on what your culture is, whether you are fundamentally interested in service delivery, whether you work in a collaborative culture where you are engaged with colleagues from different disciplines and you model those behaviours between colleagues and between disciplines…" Physician
- "I think we've worked hard to develop communication tools with other facilities, we have a lot of our patients, either go back to nursing homes or are transitioning to a new facility from here because they can't go home anymore." RN
- "Private are better at that, they're better at networking. I do a lot of networking with outside agencies because it's to the benefit of the patient" RN

Individual Health Care Provider's Orientation and Actions

Participants' individual orientation and actions influenced how they translated the organisation's ethos into their practice including the extent to which they engaged patients and valued their input into care. They described that health care providers were autonomous, with the ability to act in a variety of ways. Most health care providers had a certain amount of individual discretion with regards to involving patients. Thus, individual health care providers' actions and behaviours may or may not be congruent with the organisation's focus on patient-centred care. Individuals also had control over the extent to which they viewed various patient care activities as 'their job' or 'our job' (i.e. the extent to which they worked in teams to ensure patient-centred care). This too influenced the extent to which they engaged patients in communication. Interviews with specialty services such as stomal care or wound therapy suggested commitment to a patient-centred approach was stronger or easier to enact in these services as compared to areas that had to deal with multiple competing goals, priorities, etc. Consequently, while there may have been an organisational commitment to patient-centred care, there appeared to be limited structures in place to ensure individual accountability for this. Box 3 contains verbatim quotes that reflect this theme.

Box 3: Individual Health Care Provider's Orientation and Actions Participant Quotes

- "I find them [nurses] quite open and willing to talk, but the doctors don't come all the time and when they do they've got their off-siders and their talking and writing and sometimes you think "did I hear that, what the doctor said?". They don't communicate back to you in a friendly sort of, they talk in medical terms, and you don't always understand [what] they're saying and you would like them to have a little bit better bed-side manner so that they can sit down and talk to you." Rehabilitation Patient
- "Well one of things that interferes is feeling that they haven't got time to speak to you. Some of them are so busy sometimes with the way the bed numbers are managed these days. So it seems like you might have days when they send people to other wards and there's very few nursing staff left. It seems to happen a fair bit." Surgical Patient
- "Sometimes a patient might come in for surgery, to go to a low level care when they go home and sometimes the doctors don't think it is necessary. Some give it consideration, but some don't like it at all. I would say that is a barrier [to transition]… I know we've got one doctor who just categorically doesn't want his patient's to go to any further transition". RN
- "Basically the thing that is limiting me to become more patient centric or to put more things in is just the resources of personnel, like my time and my team's time and I am very busy doing clinical work so design work to make things better just comes as a second or third thing down the… that's the only thing that is stopping me." Palliative Care Nurse 1

Understanding and Negotiating Patient Preferences

Participants described a number of ways patients participated in their care and were actively involved in communication about their care transitions, as is reflected in the structures and processes in Table 6 and tools described in Table 7 situated in the next section. Importantly, this theme also reflected the need to understand patient preferences and recognise that patients' physical conditions influenced their ability to participate. For example, many participants described patient cognition, culture, and language as barriers to be overcome to achieve patient engagement. They acknowledged the important role the family legitimately held during the patient's hospitalisation. Building trust with patients and families and investing time into establishing and maintaining relationships were both identified as important activities staff needed to do to benefit from patient and family input. Understanding patients' and families' goals for recovery and/or hospital discharge and recognising that health care providers' goals may differ to them was a benefit from investing in patient engagement activities. Related to this, managing patient expectations and negotiating appropriate input were described as important to promote both patient participation and patient safety. Patients and health advocates spoke about wanting their views to be taken into consideration when making decisions and determining longer term plans. Additionally, participants noted that some patients desired to actively negotiate options for their care transitions, such as their discharge destination and their access to support after discharge. But, other patients preferred a more passive approach, simply wanting to understand what was planned. Managing patient expectations and helping patients develop realistic expectations were activities mentioned by some participants. Others noted tensions between patient/family expectations and what could realistically be provided had to be managed. Box 4 contains verbatim quotes that reflect this theme.

Box 4: Understanding and Negotiating Patient Preferences Participant Quotes

- “If it's something that I'm concerned about I will find a way to talk to someone about it. I think that for someone who wasn't so assertive, sometimes if people are really, really busy you can feel as if you really shouldn't be taking up their time.” Surgical Patient
- “I am saying “remember the consumer”, so as an advocate I take the stories [and] I am representing them [patients] through taking the stories….” Patient Advocate
- “I think that was just listening, listening to her and working out a plan together”. RN
- “in rehab, the patient or their carer would have to agree to participate in the rehab program for them to actually become a rehab patient so they would be involved and setting their goals and their discharge destination.” Nursing Leader
- “I think a lot of it is to do with communication and them understanding exactly why they’re coming into hospital and the information that their doctor has given to them. Then, managing their expectations post op and their discharge plan…. Then what ideas they have in mind in managing their health needs once they’ve been discharged.” RN
- “I guess there’s the socially disenfranchised group who have been disempowered, so those from lower socioeconomic status and those from various cultural backgrounds perhaps feel less empowered to be involved with decision making in their care at the points of transition. Having said that, there’s some cultural groups that are very proactive and have strong views, both the patient themselves and their family around – that again is a cultural thing…a lot of rural people, believe it or not, particularly older rural people, don’t think that they have a voice. I still meet young people in some of my travels, who don’t seem to have a voice.” RN
- “So what happens here is that families are invited along [to a daily ward round] in a fairly structured way all members of the team will actually report to the patient and members of the family there, and they give them an overview of what’s happening and there’s the opportunity to ask questions.” RN
- “When someone’s discharged there needs to be a discharge summary for the GP. Patients can have – in our mind - , can have access to those and are free to look at them. But they do have a medical imperative. The other thing that we’re trying to create is a summary, a discharge summary that patients can actually use themselves as a summary of their stay.” RN
- “Pastoral care, they often pick up quite a bit of information from the patients that they may not share with the nurses because they think maybe the nurses don’t have time or whereas the pastoral care person maybe sat with them for an hour… they’ll [pastoral care] come to me and say, “oh, did you realise this was happening at home?” RN
- “…his wife…she had unrealistic expectations of being able to manage him at home. With getting the discharge team involved, the social worker talking to her, the doctors talking to her, she still wants to take him home and he keeps falling. So I’ve just had to have a very frank conversation with her, to talk to her about her expectations and how she would manage him, because it took four of us to ideally get him up. She feels from her point of view that if she – she doesn’t want to put him in care because she feels as though she’s abandoning him.” RN

Enacting Information Sharing and Communication Strategies

Participants discussed a variety of strategies (i.e. structures and processes) they used to engage patients, not surprising given that was the focus of the interviews. These strategies have been described already. Importantly though, they made several points to underline the usefulness and impact of these strategies. Participants noted health care professionals can simply give information or they can engage patients in a two way interaction about their care. The use of a patient care board is a good example of this, with some participants describing how patients write on the board, indicating their needs, preferences, priorities, etc. Nevertheless some patient participants displayed an indifference to this communication tool, others did not understand its purpose or their ability to write on it, and others explained they did not have a pen or other means of writing on it. However, it was clear that most communication processes were well established, predictable (by both patients/families and staff) and routine. Thus, they became the way things were done and were expected to be done (i.e. part of the culture). While participants used the strategies and tools available in their facilities to engage patients in communication and decision making, they also identified instances where patient privacy, literacy level, English as a second language, and cognitive decline were barriers to this process. Box 5 contains verbatim quotes that reflect this theme.

Box 5: Enacting Information Sharing and Communication Strategies Participant Quotes

- "'The Virtual Hospice' engages the transition between those areas to ensure a smooth patient experience from home to hospital and back out to aged care facility or back out to home. So we've worked on transition points in the virtual hospice specifically. That was the start and from there we've built up a series of tools and experiences that aim to make the transition and the flow much better." Physician
- "If it's something that you need to ask but then forget at the time that they come around, then the [care] board is useful for that." Surgical Patient
- "We've got Nursing Unit Managers and one of the things they do really well is leader rounding with patients. So, leader rounding with patients the leaders here go actively and ask how the care is, if they understand the care." Nursing Leader
- "This is the important part, the plan; you talk to the patient what's actually happening today and writing down, "this is the plan for today" in words they can understand. So you still have that conversation with the patient or the family, but you just jot it down [on the patient care board]." RN
- "…we leave out a "please leave your details if you would like to share your stories" form." Patient Advocate
- "…bedside handover…and rounding. I suppose those are two strategies to keep patients engaged with decisions." RN
- "Usually we do have whiteboards…we feel we could be using them a bit better." RN
- "That's the point of it [communication]. It's the 'go-to person' backward and forward. It used to be that person would feed back at the weekly team meetings, but our systems and processes have changed such that there's a daily discussion, what's called a journey board discussion, where the key liaison person has the opportunity to update all team members. In that time you can actually then feedback as well, so the loop is a daily loop rather than a weekly loop." RN

Summary Stage 2

Following consultation with staff of the Commission, five health services were identified across various states to develop case exemplars. Sixty two key stakeholder interviews occurred across seven hospitals. Structures and processes that consistently emerged from the cases were at macro, meso and micro levels. Macro level structures and processes were influenced by the financial and professional relationships within private and public health services. Meso level structures and processes were influenced by organisational commitment to PCC, hospital mission, values and culture, leadership structures, leader rounds, and organisational patient and family feedback systems. Micro level structures and processes consisted of: various hospital roles such as patient advocates and care co-ordinators; processes to improve communication with patients and families such as multidisciplinary rounds and bedside handovers by nurses that included families; and training of patients and families to be involved in communication of care. However, the extent of formal and/or informal endorsement within various contexts could act as either an enabler or barrier.

Phase 2:

Meta-Synthesis

Approach

We used Sandelowski and Barroso's methodology to guide this phase. A qualitative meta-synthesis was used to extract and synthesise our findings and related research literature [26]. Extracted findings were grouped, and the groups labelled according to themes. The configuration method of synthesis was used, whereby findings were viewed as complementary, as opposed to confirming each other. A strength of configuration is that it allows findings to be linked together in a manner that would not be possible as single reports [26]. Findings from each case helped illuminate other perspectives rather than attempt to test the findings. The guiding principles and recommendations bring together key elements, strategies, tools and resources identified to be effective in promotion of patient participation in transitions of care to improve patient safety and provide guidance for system-wide health service improvements, education and research.

Data Synthesis

Phase 2 integrated and interpreted the findings from Phase 1, Stages 1 and 2. The synthesis linked findings and highlighted the various perspectives necessary to promote patient participation in transitions of care.

Three overarching themes emerged from the meta-synthesis of findings from the integrative review and stakeholder interviews; enabling engagement, adapting roles to context, and achieving patient engagement.

The first theme, ***enabling engagement***, captured the interplay between leaders who drive and support a patient-centred approach, overtly demonstrating organisational commitment, and the care teams/services that enacted patient engagement. The organisation's mission, values and goals for a patient-centred approach provides the foundation for an organisational culture that promotes patient-centred models of care.

The second theme, ***adapting roles to the context***, reflected the need for health professionals', patients' and families' perspectives' to be incorporated into engagement strategies. The extent of engagement, from passive to active, is on a continuum that is context specific. The context reflects the patient's situation, the physical setting, the people involved and the transition context. Adapting roles in a dynamic situation requires continuous renegotiation between patients, families and staff, depending on the context.

The final theme, ***achieving patient engagement***, identified the perceived benefits of having patients/families actively participate in various discussions with health professionals. When patients/families actively participate, they feel better informed and perceive that care is personalised. This leads to a sense of emotional security and satisfaction. For health professionals, this active patient/family participation allowed them to better understand patients' circumstances, conduct more accurate patient assessment and promote individualised care. Patient/family participation left health professionals with a sense of job satisfaction. Ultimately, this engagement promotes patient safety, with health professionals also noting it demonstrates compliance with the NSQHS Standards [75].

Tools, Processes and Strategies

A purpose of the review was to identify strategies, tools and resources that have been evaluated in the literature or are currently being used within health services that enable patient engagement in communication at transitions of care. Some of these strategies and tools were discovered during the key stakeholder interviews and as such are yet to be evaluated.

In Table 7, tools, processes and strategies found in the research literature and arising from key stakeholder's interviews are listed. A description of the tool, process or strategy as well as references to the source is provided.

Table 7: Useful Tools, Processes and Strategies

Items	
The Care Transition Measure (Research Tool)	Description: A measure of quality of care from the patients perspective, which was administered during telephone follow up. Assesses across four key domains: (1) information transfer; (2) patient and caregiver preparation; (3) self-management support; and (4) empowerment to assert preferences.
	Source: Coleman EA, Smith JD, Frank JC, Min SJ, Parry C and Kramer AM. Preparing patients and caregivers to participate in care delivered across settings: the care transitions intervention. *Journal of the American Geriatrics Society*. 2004; 52: 1817-25.
Personal Health Record (PHR)	Description: A person-centred document, which includes the core details needed to facilitate transition across care settings. Details recorded include - active problem list, medications, allergies, whether advance directives have been completed, a list of red flags or warning symptoms and signs that correspond to patient's chronic illness. PHRs also include space for the patient to "record questions and concerns in preparation for his or her next encounter" (p. 1823)
	Source: Coleman EA, Parry C, Chalmers S and Min S-J. The care transitions intervention: results of a randomized controlled trial. *Archives of Internal Medicine*. 2006; 166: 1822-8.

Joint Crisis Plans Proforma	Description: Documents which are held by mental health consumers, which specify treatment preferences for times when the consumer is unable to assert them. Information included addresses both experiences of previous treatment, and directions for future treatment.
	Source: Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K and Szmukler G. Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. *BMJ*. 2004; 329: 136.
Standardised Handoff Tool	Description: Script used to guide handoff between paediatric services. The script includes prompts to particular content, and also when to invite contributions from parents and other stakeholders.
	Source: Weingart C, Herstich T, Baker P, et al. Making good better: Implementing a standardized handoff in pediatric transport. *Air Medical Journal*. 2013; 32: 40-6.
SBAR	Description: Standardised script used by nurses to facilitate transition communication. Similar to the ISBAR script described above, but does not specify the content of the introductory phase of the conversation.
	Source: Chaboyer W, McMurray A and Wallis M. Bedside nursing handover: A case study. *International Journal of Nursing Practice*. 2010; 16: 27-34.
ISHAPED	Description: Standard bedside template designed to provide a structure for guiding communication between staff at handover. Elements convey critical information, information to minimise the risk of omissions, and steps to engage the patient in handover communication at the change of shift.
	Source: Friesen MA, Herbst A, Turner JW, Speroni KG and Robinson J. Developing a patient-centered ISHAPED handoff with patient/family and parent advisory councils. *Journal of Nursing Care Quality*. 2013; 28: 208-16.

HowsYourHealth.org	Description: Internet-based health assessment and feedback system to improve patent engagement and transition from hospital. The "assessment system automatically provides a) a summary report for the patient and the care team, b) information tailored to each patient's needs, c) a personal portable health plan" (p. 339).
	Source: Lepore M, Wild D, Gil H, et al. Two useful tools: to improve patient engagement and transition from the hospital. *The Journal of Ambulatory Care Management*. 2013; 36: 338-44.
Bedside handover	Description: Communication tool between staff and patients/families. Used by staff to share information about which patients are being discharged/transferred, expected admissions and patients who are expected to stay in the unit. Information such as care team names, goals for the day, expected date of discharge and discharge plans, patient requests are handed over. Helps everyone know the plan; it is reviewed daily. Mnemonics such as ISBAR may be used to facilitate information sharing.
	Source: Interviews
Multidisciplinary rounds	Description: Rounds that include a formal process to invite patients and/or families and bedside nurse to contribute. Terms such as SIBR rounds (Structured Interdisciplinary Bedside Rounds) are being used. May include a 'pause' in conversation whereby the healthcare team stops conversation, and specifically invites comments from patients/families.
	Source: Interviews
Hourly rounding	Description: Nursing staff 'round' on patients every hour, checking if patients require anything.
	Source: Interviews

Patient care boards	Description: Whiteboards, located around the patient bedside, record key information about the plan of care such as an upcoming test. Patients/families may be able to write comments on the board for staff.
	Source: Interviews
Leader rounds	Description: Executives, directors or managers visit patients, asking them about their experiences, their goals, preferences and plans and any issues they have.
	Source: Interviews
Patient led discharges	Description: Patients in the maternity area negotiate a date/time of discharge with hospital staff.
	Source: Interviews
Patient stories	Description: Patient experiences are documented and shared with staff. Formal communique used to share patient stories with staff. The patient advocate takes responsibility for this activity.
	Source: Interviews
Protocols and checklists	Description: Help to plan care. Often involve some prompts to involve patients/families.
	Source: Interviews
Patient/family information brochures, information packs, envelopes, business cards, videos	Description: A variety of written (or electronic) information is provided to patients/families such as sharing practical information (visiting hours, banks, buses etc.), bereavement services, transfer processes, electronic and written versions of discharge plan etc. These resources can simply be distributed to patients or can become a tool to engage discussions.

	Source: Interviews
‘Let me know’ initiative	Description: Staff wear a ‘Let me know button’ to prompt patients/families for feedback. Rental TV messages and screensavers also contain this message. ‘Let me know’ encourages patients/families to call the discharging ward for advice on patient care.
	Source: Interviews
Case conferences/ Family meetings	Description: Consultant and patients/families gather to discuss the plan for the patient (sometimes in person, sometimes over the phone). Often multidisciplinary.
	Source: Interviews
Patient passports	Description: Developed as part of the tools for the Virtual Hospice. The personal section includes information about who the person is ‘as a person’ and may include photos. A section focuses on the illness history and experiences. Another section, termed ‘spectrum’, allows patients to track their symptoms.
	Source: Interviews
Virtual Hospice **(www. virtualhospice.com.au)**	Description: End-of-life care experience web resources. Designed to provide a welcoming, safe therapeutic space for people with advanced illnesses; their caregivers; and the health professionals who support them. Various sections of and tools for patients, families and health professionals.
	Source: Interviews

Post-discharge follow-up phone calls	Description: Try to complete these within 24 hours of discharge. May be completed by any member of the team (nurse, doctor, allied health). Set questions regarding things like medications, access to care (ex. pain control), individualised questions as well.
	Source: Interviews
Patient experience surveys	Description: A variety of methods are used to gain patients' perspective of their hospital experience. Surveys (example Press Ganey), pre-discharge feedback using electronic tablets, follow up phone calls after hospital discharge etc. are used to gain this information.
	Source: Interviews
Postcards to bereaved families	Description: Postcard lets the family know the staff members have been thinking about them. Postcards invite families to visit the staff or attend a memorial service at the hospital if they would like.
	Source: Interviews
Collaborative practice teams	Description: Formal group in the unit that includes doctors, nurses and allied health professionals as well as a health/consumer advocate. Review processes, identifying areas for improvement.
	Source: Interviews
Various staff roles responsible for coordinating patient discharge	Description: Job titles include Innovation Facilitator, Patient Care Coordinator, Case Management Coordinators etc. These staff are responsible for tracking patient movements from preadmission to discharge, through daily rounding with the nurse unit managers. Discharge planning (proactive) is a focus of the role.

	Source: Interviews
Team training	Description: Team training is used to improve performance of staff. Staff are taught to 'speak up' about safety concerns and other things they are curious about. Application of the principles learned facilitate engagement with patients and families.
	Source: Interviews

Barriers to Patient and Family Engagement

There was consistency in the barriers to engaging patients in communication about their care transitions across Stage 1 (Integrative Review) and Stage 2 (Stakeholder Interviews). These barriers were described in detail in the integrative review findings and are reinforced in this meta-summary, grouped into the domains of patient/family, staff, interpersonal and organisational barriers.

Patient/Family Barriers: A number of barriers related to patients and their families emerged from both the integrative review and interviews. Some of these reflected the physical condition of the patient, such as acuity of illness, cognitive functioning and fatigue levels whereas others reflected both patients' and families' social and cultural backgrounds like language issues, health literacy (knowledge of their condition, the health system etc.) and stigma associated with age and diagnosis. Another barrier revolves around identifying the family members who should be involved in communication, especially where there are large, disparate families with conflicting or differing views. Some patients and families lack an understanding of the extent to which they can participate. Unrealistic expectations emerged as a barrier to engagement, with the need to discuss and 'negotiate' these expectations in a frank manner identified by interview participants. Finally, the interviews showed family requests for services were not always congruent with patients' wishes. Associated with this, inappropriate patient and or family preferences such as an unrealistic desire to return home when assistance was required, emerged as another barrier from the interviews.

Health Professional Barriers: Several individual health professional barriers were evident in the findings from both the integrative review and the interviews. Some health professionals displayed less well developed skills or invested less time in getting to know patients/families, a prerequisite for active engagement. Technical medical terminology used by health professionals is a barrier for patients to engage in communication, which is also loosely linked to health literacy of patients/families. Interestingly, health professionals, specifically nurses, identified the need to ensure patient privacy and confidentiality as a barrier. At times the sheer number of health professionals involved in a patient's care can be a barrier, with patients and families unsure of who to talk to about what. This barrier is related to work process barriers, because it arises partially as a result of how patient treatment and care is provided in hospitals. Interview participants noted that in the private sector, the perceived power medical consultants had over nursing staff and organisational processes was also a barrier because it restricts the conversations nurses might have with patients. This was congruent with the integrative review finding that professional boundaries based on hierarchical rank and professional autonomy can mitigate against patient participation.

Interpersonal Barriers: The relationship among patients, families and health professionals can also create a barrier to patient engagement. Interview participants described how building rapport and a trusting relationship helped patients and their families feel confident to speak up. Without these positive relationships, patient and families are reluctant to actively contribute to discussions. A lack of continuity of staff related to shift work contributed to this barrier. Additionally, when larger groups of health professionals are present, some patients/families feel intimidated, as illustrated in the integrative review. Finally, family dynamics such as conflicts and tensions within families can result in less engagement in communication. For example, some patients did not want staff to disclose information to families, although privacy and confidentiality were generally not of concern to patients and their families.

Organisational Barriers: A number of characteristics of the ward and work processes within the organisation act as barriers to engaging patients in communication about their care transitions. For example, older hospitals with several beds in one room were perceived as a barrier to open communication. Both the integrative review and interview participants identified workload and lack of time as barriers to engage patients. Interview participants described multiple transfers within the hospital, exposing patients/families to numerous services local ward routines as another barrier. An additional barrier is associated with the perception that providing tools and processes, such as patient whiteboards and bedside handover, ‘automatically’ results in patient participation. Both the review and the interviews showed that patients/families needed to gain an understanding of the purpose of tools and processes and what is expected in terms of engagement by patients/families needs to be understood. Interview participants described a lack of a standard process to ensure general practitioners received a summary of the patient’s admission on discharge from hospital. Other organisational barriers include the variation in access to services between the private and public sector and variation in access to services during the weekends.

In summary, there was a consistency in the barriers identified in the integrative review and stakeholder interviews. These barriers were categorised into the domains of patient/family, staff, interpersonal and organisational barriers. Understanding these barriers provides the foundation for a number of recommendations.

GUIDING PRINCIPLES

In conducting this review a number of principles to guide patient engagement in communication at transitions of care became evident.

First, a strong and shared commitment to the philosophy of patient-centred care and patient participation in care must be embedded at all levels of the health service and across all disciplines. Leadership in nursing, allied health and medicine across all levels of the organisation is necessary to ensure a culture that supports patient engagement. The NSQHS Standards have been, and will continue to be, important drivers for cementing patient-centred care within organisations. Nevertheless, the provision of resources is necessary to promote the establishment of structures and processes that facilitate patient engagement in communication, and to support the systematic implementation of these approaches across organisations.

Second, the benefits of patient and family engagement in care are poorly understood and as such patients, families and health professionals require preparation and training for participation in transition discussions. Patients, their families and health professionals need to understand the various tools and strategies available to them to improve communication.

To enable participation (or not) depends on knowing patient preferences and respecting patient choices. For patients and families to participate there needs to be clarity about who their care team is and their plan of care. Patient engagement must begin early, to identify patient values, goals, expectations and preferences. With the assistance of health professionals, these preferences may be tempered by discussion about what is realistic and possible. Health professionals also need to recognise and reflect on the timing, location, privacy and appropriateness of information sharing and the difference between dispatching information and engaging in two-way communication. Communication should occur with careful consideration to health literacy, language barriers and culture.

Finally, the tools or strategies designed to promote patient engagement must be appropriate and useful for specific clinical settings but also require a level of standardisation to ensure consistent implementation. They must also allow some flexibility in order to take into consideration individual patients' conditions and preferences.

In summary, the three guiding principles reflect the knowledge (i.e. benefits of patient input), skills (in using tools) and attitude (in a commitment to patient-centred care) that will promote patient engagement in communication about their care transitions.

ESSENTIAL ELEMENTS FOR EFFECTIVE PATIENT-CLINICIAN COMMUNICATION

Patients and Families
• Express preferences, expectations and goals to staff. • Provide feedback throughout the care experience using a variety of formal and informal strategies.

Health Professionals

- Document patient preferences, expectations and goals of care.
- Encourage patients and their families to provide feedback to staff about their care experience.
- Ensure a formalised time (preferably face to face) for family member/s to receive a detailed account of the patient's care and the interventions being provided, and the opportunity to ask questions.

Units/Wards

- Develop a standard process for assessing patients' condition, their abilities, goals and preferences for care, to assist health care providers to engage with patients and their families in care planning and decision making.
- Allocate specific times for patient and family communication whenever possible rather than leaving patient/family queries to random encounters with staff.
- Develop a formal process to engage patients and families when appropriate in transition discussions.
- Redesign ward processes to ensure a multidisciplinary approach to determine treatment and discharge pathways such as SIBR rounding and case conferencing.
- Adopt models of care that facilitate patient and/or family in transition discussions, for example, team as opposed to task-based nursing.
- Adopt a standardised procedure for transition discussions (i.e. steps in the process, including patient involvement). Examples may include ISBAR (Introduction, Situation, Background, Assessment, and Recommendations) and ISHAPED (**I** = Introduce, **S** = Story, **H** = History, **A** = Assessment, **P** = Plan, **E** = Error Prevention, and **D** = Dialogue).
- Train and assist staff, patients and families to use tools and processes such as patient care boards, bedside handover and multidisciplinary rounds effectively, to actively participate in communication.
- Provide patients/families with discharge information.
- Develop a display of care team members and their roles, such as a photo board.

Health Services

- Adopting a patient-centred philosophy, while necessary to promote patient engagement, is not enough. Members of the organisation from senior leaders to clinical and auxiliary staff need to both understand and enact the philosophy.
- Develop processes and strategies to ensure consumer involvement in developing and implementing policies and procedures on patient engagement.
- Use a structured change management approach to implement the policy for inclusion of patients/family members in transition discussions.
- Formalise the patient/consumer advocate role such as developing a position description, recruiting and training advocates, in order to support hospitals' strategies to promote patient-centred care and patient engagement.
- Develop and support the role of the volunteer to introduce patients and families to services, elicit feedback for quality planning, inform patients of their charter of rights and to collect patient 'stories' to assist staff to understand patient journeys.
- Develop and endorse a policy statement on the inclusion of the patient and/or family in transition discussions.
- Provide a process for evaluating and acting on patient and family feedback.
- Collect and disseminate patient stories to develop a better understanding of the patient experience, which can be used to highlight effective care and health service gaps.
- Provide guidelines and scripts for staff on how to include the patient and their family in transition discussion (considering roles, behaviour, coaching).
- Provide training and support for staff in how to undertake transition communication.
- Consider introduction of a care coordination role to facilitate communication during care transitions.
- Assess patient information needs and preferences for type of information they require prior to the development of materials (video, printed brochures etc).

Education

- Embed NSQHS Standards in the undergraduate curricula for health professionals.
- Provide educational experiences that allow students to practice engaging other health care professionals and patients in communication such as simulated multidisciplinary rounds, case conferencing and handover.
- Expose undergraduate students to a variety of tools to engage patients in communication.
- Provide health professionals with training to be more inclusive of patients/families in transitioning across health care settings.

Policy

- Accrediting bodies should be approached to incorporate the NSQHS Standards in assessing undergraduate curricula.
- Communicate and disseminate successful tools and strategies for engaging patients/families in communication at transitions of care.
- Develop resources to support patient engagement.

Research

- Research the effectiveness of tools, interventions and strategies to engage patients in a variety of contexts and patient situations.

CONCLUSION

This report was prepared on behalf of the Commission to advance understanding of current practices, research evidence and gaps in knowledge in relation to communication with patients at transitions in care, and to identify examples of innovations emerging from Australian health services. The report aims to inform future development of resources to assist patients, families and health professionals to engage in communication at transitions of care to, within and from acute health facilities. The findings highlight organisational strategies for enabling engagement, the adapting roles played by patients, families and health professionals, that may change over time and depend on the patient situation or context; and finally, as perceived by patients families and health professionals, the benefits and outcomes of achieving patient engagement. With this knowledge, the researchers have compiled guiding principles for the Commission to raise awareness of patient engagement, stimulate discussion and inform decision making at all levels of the health and education sectors.

REFERENCES

1. Arnetz JE, Almin I, Bergström K, Franzén Y and Nilsson H. Active patient involvement in the establishment of physical therapy goals: effects on treatment outcome and quality of care. *Advances in Physiotherapy*. 2004; 6: 50-69.

2. Arnetz JE, Winblad U, Höglund AT, et al. Is patient involvement during hospitalization for acute myocardial infarction associated with post-discharge treatment outcome? An exploratory study. *Health Expectations*. 2010; 13: 298-311.

3. Rachmani R, Levi Z, Slavachevski I, Avin M and Ravid M. Teaching patients to monitor their risk factors retards the progression of vascular complications in high-risk patients with Type 2 diabetes mellitus—a randomized prospective study. *Diabetic Medicine*. 2002; 19: 385-92.

4. Weingart SN, Zhu J, Chiappetta L, et al. Hospitalized patients' participation and its impact on quality of care and patient safety. *International Journal For Quality In Health Care*. 2011; 23: 269-77.

5. Coleman EA, Smith JD, Frank JC, Min SJ, Parry C and Kramer AM. Preparing patients and caregivers to participate in care delivered across settings: the care transitions intervention. *Journal of the American Geriatrics Society*. 2004; 52: 1817-25.

6. World Health Organisation. Patients for Patient Safety. Geneva: World Health Organization, 2007.

7. Australian Commission on Safety and Quality in Health Care. Patient-centred care: Improving quality and safety through partnerships with patients and consumers. Sydney: Australian Commission on Safety and Quality in Health Care, 2011.

8. Joint Commission of Accreditation in Healthcare Organizations (JCAHO). Patients as partners: maximizing the effectiveness of your safety program with patient participation. *Joint Commission Perspectives on Patient Safety*. 2003; 3: 1.

9. Longtin Y, Sax, H., Leape, L. L., Sheridan, S. E., Donaldson, L., & Pittet, D. Patient participation: current knowledge and applicability to patient safety. *Mayo Clinic Proceedings*. 2010; 85: 53-62.

10. Wellard S, Lillibridge J, Beanland C and Lewis M. Consumer participation in acute care settings: an Australian experience. *International Journal of Nursing Practice*. 2003; 9: 255-60.

11. Iedema R, Allen S, Britton K and Gallagher TH. What do patients and relatives know about problems and failures in care? *BMJ Quality & Safety*: 1-8 (2011).

12. Rathert C, Huddleston N and Pak Y. Acute care patients discuss the patient role in patient safety. *Health Care Management Review*. 2011; 36: 134-44.

13. Joint Commission International Center for Patient Safety. Joint Commission Resources: Patient inclusive Care: Encouraging patients to be active participants in their care. *Perspectives on Patient Safety* 5: 8 (2005).

14. Parrish MM, O'Malley K, Adams RI, Adams SR and Coleman EA. Implementation of the care transitions intervention: sustainability and lessons learned. *Professional Case Management*. 2009; 14: 282-93.

15. Pronovost P, Weast B, Schwarz M, et al. Medication reconciliation: a practical tool to reduce the risk of medication errors. *Journal of Critical Care*. 2003; 18: 201-5.

16. Barber N. Designing information technology to support prescribing decision making. *Quality and Safety in Health Care*. 2004; 13: 450-4.

17. Forster AJ, Murff HJ, Peterson JF, Gandhi TK and Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Annals of Internal Medicine*. 2003; 138: 161-7.

18. Paniagua MA, Malphurs JE and Phelan EA. Older patients presenting to a county hospital ED after a fall: missed opportunities for prevention. *The American Journal of Emergency Medicine*. 2006; 24: 413-7.

19. Nazareth I, Burton A, Shulman S, Smith P, Haines A and Timberall H. A pharmacy discharge plan for hospitalized elderly patients—a randomized controlled trial. *Age and Ageing*. 2001; 30: 33-40.

20. National Health and Hospitals Reform Commission. A Healthier Future for all Australians: Final Report. Canberra: Australian Government, 2009.

21. Joint Commission on Accreditation of Healthcare Organisations. Speak Up: help prevent errors in your care. 2005.

22. Institute of Medicine (US). Committee on Quality of Health Care in America. *Crossing the quality chasm: A new health system for the 21st century*. Washington, D.C.: National Academies Press, 2001.

23. Botti M, Bucknall T, Cameron P, et al. Inter-professional communication and team climate in complex clinical handover situations: Issues for patient safety in the private sector. Final Report to the Australian Commission of Safety and Quality in Health Care. 2009

24. Thomas MJ, Schultz TJ, Hannaford N and Runciman WB. Failures in transition: learning from incidents relating to clinical handover in acute care. *Journal for Healthcare Quality*. 2013; 35: 49-56.

25. Whittemorre R and Knafl K. The integrative review: updated methodology. *Journal of Advanced Nursing*. 2005; 52: 546-53.

26. Sandelowski M and Barroso J. *Handbook for Sythesizing Qualitative Research*. New York: Springer, 2007.

27. Chaboyer W, McMurray A and Wallis M. Bedside nursing handover: A case study. *International Journal of Nursing Practice*. 2010; 16: 27-34.

28. Chin GSM, Warren N, Kornman L and Cameron P. Patients' perceptions of safety and quality of maternity clinical handover. *BMC Pregnancy and Childbirth*. 2011; 11: 58.

29. Flink M, Hesselink G, Pijnenborg L, et al. The key actor: A qualitative study of patient participation in the handover process in Europe. *BMJ Quality and Safety*. 2012; 21: i89-i96.

30. Friesen MA, Herbst A, Turner JW, Speroni KG and Robinson J. Developing a patient-centered ISHAPED handoff with patient/family and parent advisory councils. *Journal of Nursing Care Quality*. 2013; 28: 208-16.

31. Johnson M and Cowin LS. Nurses discuss bedside handover and using written handover sheets. *Journal of Nursing Management*. 2013; 21: 121-9.

32. Weingart C, Herstich T, Baker P, et al. Making good better: Implementing a standardized handoff in pediatric transport. *Air Medical Journal*. 2013; 32: 40-6.

33. Ma E, Coleman E, Fish R, Lin M and Kramer A. Quantifying posthospital care transitions in older patients. *Journal of American Medical Directors Association*. 2004; 5: 71-4.

34. Coleman E, Mahoney E and Parry C. Assessing the quality of preparation for posthospital care from the patient's perspective: the care transitions measure. *Medical Care*. 2005; 43: 246-55.

35. Hirshon JM, Risko N, Calvello E, et al. Health systems and services: the role of acute care. *Bulletin of the World Health Organization* 2013; 91: 386-8.

36. Booth A. Formulating answerable questions. In: Booth A and Brice A, (eds.). *Evidence-Based Practice for Information Professionals: a handbook* London: Facet, 2004, p. 61-70.

37. Lincoln YS and Guba EG. *Naturalistic Inquiry*. Beverly Hills, CA: Sage, 1985.

38. Pluye P, Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., Griffiths, F., Boardman, F., Gagnon, M.P., & Rousseau, M.C. Proposal: A mixed methods appraisal tool for systematic mixed studies reviews: (2011, accessed on 1 May 2014 from http://mixedmethodsappraisaltoolpublic.pbworks.com).

39. Ritchie J and Spencer L. Qualitative data analysis for applied policy research. In: Bryman A and Burges R, (eds.). *Analysing Qualitative Data*. London: Routledge, 1994, p. 173-94.

40. Noyes J and Popay J. Directly observed therapy and tuberculosis: how can a systematic review of qualitative research contribute to improving services? A qualitative meta-synthesis. *Journal of Advanced Nursing*. 2007; 57: 227-43.

41. Rashidian A, Eccles MP and Russell I. Falling on stony ground? A qualitative study of implementation of clinical guidelines' prescribing recommendations in primary care. *Health Policy*. 2008; 85: 148-61.

42. Rycroft-Malone J, McCormack B, Hutchinson AM, et al. Undertaking realist synthesis: illustrating the method. *Implementation Science*. 2012; 7: 33.

43. McCormack B, Rycroft-Malone J, DeKorby K, et al. A realist review of interventions and strategies to promote evidence-informed health care: a focus on change agency. *Implementation Science*. 2013; 8: 107.

44. Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K and Szmukler G. Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. *BMJ*. 2004; 329: 136.

45. Coleman EA, Parry C, Chalmers S and Min S-J. The care transitions intervention: results of a randomized controlled trial. *Archives of Internal Medicine*. 2006; 166: 1822-8.

46. Bradley S and Mott S. Adopting a patient-centred approach: an investigation into the introduction of bedside handover to three rural hospitals. *Journal of Clinical Nursing*. 2013; 23: 1927-36.

47. Parry C, Coleman EA, Smith JD, Frank J and Kramer AM. The care transitions intervention: a patient-centered approach to ensuring effective transfers between sites of geriatric care. *Home Health Care Services Quarterly*. 2003; 22: 1-17.

48. Parry C, Kramer HM and Coleman EA. A qualitative exploration of a patient-centered coaching intervention to improve care transitions in chronically ill older adults. *Home Health Care Services Quarterly*. 2006; 25: 39-53.

49. Lepore M, Wild D, Gil H, et al. Two useful tools: to improve patient engagement and transition from the hospital. *The Journal of Ambulatory Care Management*. 2013; 36: 338-44.

50. Maxson PM, Derby KM, Wrobleski DM and Foss DM. Bedside nurse-to-nurse handoff promotes patient safety. *Medsurg Nursing: Official Journal of The Academy Of Medical-Surgical Nurses*. 2012; 21: 140-4.

51. Sand-Jecklin K and Sherman J. Incorporating bedside report into nursing handoff: evaluation of change in practice. *Journal Of Nursing Care Quality*. 2013; 28: 186-94.

52. Street M, Eustace P, Livingston PM, Craike MJ, Kent B and Patterson D. Communication at the bedside to enhance patient care: A survey of nurses' experience and perspective of handover. *International Journal of Nursing Practice*. 2011; 17: 133-40.

53. Tidwell T, Edwards J, Snider E, et al. A nursing pilot study on bedside reporting to promote best practice and patient/family-centered care. *Journal of Neuroscience Nursing*. 2011; 43: E1-5.

54. Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K and Szmukler G. Views of service users and providers on joint crisis plans. *Social Psychiatry and Psychiatric Epidemiology*. 2009; 44: 369-76.

55. Sutherby K, Szrnukler GL, Halpern A, et al. A study of ‘crisis cards' in a community psychiatric service. *Acta Psychiatrica Scandinavica*. 1999; 100: 56-61.

56. Sutherby K and Szmukler G. Crisis cards and self-help crisis initiatives. *Psychiatric Bulletin*. 1998; 22: 4-7.

57. Glenny C, Stolee P, Sheiban L and Jaglal S. Communicating during care transitions for older hip fracture patients: family caregiver and health care provider's perspectives. *International Journal of Integrated Care* 13: e044 (2013, accessed March 2014).

58. Johnson H, Forbes D, Egan MY, Elliott J, Stolee P and Chesworth BM. Hip-fracture care in rural southwestern ontario: An ethnographic study of patient transitions and physiotherapy handoffs. *Physiotherapy Canada*. 2013; 65: 266-75.

59. Liu W, Manias E and Gerdtz M. Medication communication between nurses and patients during nursing handovers on medical wards: A critical ethnographic study. *International Journal of Nursing Studies*. 2012; 49: 941-52.

60. Tobiano G, Chaboyer W and McMurray A. Family members' perceptions of the nursing bedside handover. *Journal of Clinical Nursing*. 2013; 22: 192-200.

61. McMurray A, Chaboyer W, Wallis M, Johnson J and Gehrke T. Patients' perspectives of bedside nursing handover. *Collegian*. 2011; 18: 19-26.

62. Flink M, Ohlen G, Hansagi H, Barach P and Olsson M. Beliefs and experiences can influence patient participation in handover between primary and secondary care - A qualitative study of patient perspectives. *BMJ Quality and Safety*. 2012; 21: i76-i83.

63. Groene RO, Orrego C, Sunol R, Barach P and Groene O. "It's like two worlds apart": An analysis of vulnerable patient handover practices at discharge from hospital. *BMJ Quality and Safety*. 2012; 21: i67-i75.

64. McTier L, Botti M and Duke M. Patient participation in medication safety during an acute care admission. *Health Expectations*. 17: Epub ahead of print Dec 17 2013 DOI: 10.1111/hex.12167.

65. Merrill KC and Brown K. Nursing handoff at the bedside: does it improve outcomes? *Communicating Nursing Research*. 2012; 45: 311-.

66. Renehan E, Haralambous B, Galvin P, Kotis M and Dow B. Evaluation of a transition care cognitive assessment and management pilot. *Contemporary Nurse*. 2013; 43: 134-45.

67. McMurray A, Chaboyer W, Wallis M and Fetherston C. Implementing bedside handover: strategies for change management. *Journal of Clinical Nursing*. 2010; 19: 2580-9.

68. Lewin K. *Field Theory in Social Science*. New York: Harper and Row, 1951.

69. Yin RK. *Case Study Research: Design and Methods*. Thousand Oaks, CA: Sage, 2009.

70. Donabedian A. *Explorations in quality assessment and monitoring: Vol.1. The criteria and standards of quality*. Ann Arbour, MI: Health Administration Press, 1980.

71. Braun V and Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006; 3: 77-101.

72. Hsieh HF and Shannon SE. Three approaches to qualitative content analysis. *Qualitative Health Research*. 2005; 15: 1277-88.

73. Miles M and Huberman A. *Qualitative Data Analysis*. 2nd ed. London: Sage, 2004

74. Strauss A and Corbin J. *Basics of Qualitative Research: techniques and procedures for developing grounded theory.* 3rd ed. California: Sage, 2007.

75. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney: Australian Commission on Safety and Quality in Health Care, 2012.

Appendix A: Screening and eligibility assessment tool

SCREENING PROCESS with ELIGIBILITY ASSESSMENT: EVALUATION OF THE POTENTIAL RELEVANCY OF REPORTS FOR INCLUSION IN THE INTEGRATIVE REVIEW.

1. Review each title/abstract from the database search. If the title relevancy is unclear, review the abstract. If abstract relevancy is unclear, review the full text report to decide on potential relevancy. Exclude all titles/abstracts that are clearly irrelevant.

2. Screen the search strategy with the following inclusion criteria in mind. When a report has potential relevancy for the topic, apply the following Inclusion Criteria to each potentially relevant report.

DATABASE:	**REPORT ID:** **First AUTHOR and YEAR of publication**	**Database Record NO.**
SPICE Framework	Inclusion Criteria Questions:	YES/NO
A. Intervention and Setting Communication at transitions of care in, within, and from acute care setting?	Does the article/report describe any form of communication process at the transition of care to, within and from acute care settings? **Guide:** **Communication process** = any form of communication strategy or process of care needs, assessments and evaluations. However, the particular focus will be on verbal or written communication of care i.e. the handover **Transition of care** = The movement of a patient from one setting of care to another. Transitional care is defined as a “set of actions designed to ensure the coordination and continuity of care as patients transfer between different locations or different levels of care within the same location”. The transition between acute and primary care, acute and subacute care including rehabilitation, acute and residential care are to be included. **Acute care setting** = hospital or other specialty facility which receive patients with an acute (new onset) illness, disease, condition, problem for cure or symptom management and/or support.	
B. Perspective	Does the article/report describe patient, family or caregiver engagement/involvement in the transition of	

Patients (adults and child), caregivers or parent/guardian engagement	care communication? **Guide:** **Engagement** = encompasses any activities (verbal, written or behaviours) to enhance patients', families/carers' understanding of their condition, treatments and care plans, partnership and involvement in decision making and evaluation of care outcomes, and attempts to measure engagement behaviours.	
If the answer is YES to A. Intervention and Setting, and B. Perspective (both questions), the article/report is potentially relevant.		
C. Exclusion	Exclusion Question:	YES/NO
Studies will only be included if they report on patient engagement in communication at transitions of care.	Does the article/report describe family or caregiver engagement/involvement in the transition of care for patients who are unable to communicate, e.g. unconscious patients, neonates and infants?	
If the answer is YES to C. Exclusion Question, the article/report is not eligible for inclusion, as it is not relevant.		
DECISION: tick the box ELIGIBLE FOR INCLUSION, AS RELEVANT ☐ NOT ELIGIBLE, AS NOT RELEVANT ☐ UNCLEAR, FULL-TEXT REQUIRED ☐		
RATIONALE FOR EXCLUSION:		

Appendix B: Database Search Strategies

Cumulative Index to Nursing and Allied Health Literature (CINAHL)

Complete (Ebscohost) Search Strategy

#	**Search Lines**
S1	(MH "Hospitalization+") OR (MH "Patient Care+") OR (MH "Primary Health Care") OR ("primary care") OR (MH "Patient Centred Care") OR (patient N3 care) OR ("person centred" or "person centred") OR (MH "Family Centred Care+") OR (MH "Specialties, Nursing+") OR ("acute care") OR (MH "Subacute Care") OR ("subacute care") OR (MH "Nursing Care+") OR (MH "Quality of Nursing Care") OR (quality N3 care) OR (MH "Family Practice") OR ("general practice") OR (MH "Community Health Centers") OR ("community care") OR ("domiciliary care") OR ("health provider") OR (MH "Residential Facilities+") OR (MH "Nursing Home Patients") OR ("residential aged care") OR ("ambulatory care") OR (rehabiliat*) OR (MM "Caregivers")
S2	(MH "Patient Discharge+") OR (MH "Transfer, Intrahospital") OR (MH "Transfer Care (Saba CCC)") OR (MH "Discharge Planning (Iowa NIC)") OR (discharge plan*) OR (discharge N3 pathway*) OR (hospital N3 discharge) OR (patient N3 transfer) OR (patient N3 discharge) OR (MH "Continuity of Patient Care+") OR (continuity N3 care) OR (MH "Patient Care Conferences+") OR (integrat* N3 care) OR (integrat* N3 pathway*) OR (care N3 coordinat*) OR (MH "communication+")
S3	S1 OR S2
S4	(MH "Adult+") OR (adult) OR (MH "Child+") OR (child*) OR (paediatric*) OR (pediatric*) OR (MH "Patients+") OR (patient*) OR (client*) OR (consumer*)
S5	S3 AND S4
S6	(MH "Hand Off (Patient Safety)+") OR (handoff OR hand-off) OR (handover OR hand-over) OR (MH "Shift Reports") OR (transition* N3 care) OR (continuity N3 information)
S7	S5 AND S6
S8	(MH "Consumer Participation") OR (MH "Professional-Client Relations") OR (MH "Professional-Patient Relations+") OR (MH "Professional-Family Relations") OR (patient N3 engagement) OR (client N3 engagement) OR (consumer N3 engagement) OR (patient N3 involve*) OR (client N3 involve*) OR (consumer N3 involve*) OR (patient N3 participat*) OR (client N3 participat*) OR (consumer N3 participat*) OR (patient N3 partnership) OR (client N3 partnership) OR (consumer N3 partnership) OR (patient N3 experienc*) OR (client N3 experienc*) OR (consumer N3 experienc*) OR (patient N3 willing*) OR (client N3 willing*) OR (consumer N3 willing*) OR (patient N3 abilit*) OR (client N3 abilit*) OR (consumer N3 abilit*) OR (MH "Patient Attitudes") OR (MH "Consumer Attitudes") OR (MH "Family Attitudes+") OR (patient N3 attitude*) OR (client N3 attitude*) OR (consumer N3 attitude*) OR (parent* N3 attitude*) OR (S4 N3 communicat*) OR (MH "Decision Making, Patient+") OR (patient N3 decision*) OR (client N3 decision*) OR (consumer N3 decision*)
S9	S7 AND S8 (Limiters - Published Date: 20030101-20131231)

MEDLINE Complete (EbscoHost) Search Strategy

#	**Search Lines**
S1	(MH "Hospitalization+") OR (MH "Patient Care+") OR (MH "Primary Health Care") OR ("primary care") OR (MH "Patient Centred Care") OR (patient N3 care) OR ("person centred" or "person centred") OR (famil* N3 care) OR (MH "Specialties, Nursing+") OR ("acute care") OR (MH "Subacute Care") OR ("subacute care") OR (MH "Nursing Care+") OR (MH "Quality of Health Care") OR (quality N3 care) OR (MH "Family Practice") OR (MH "General Practice+") OR ("general practice") OR (MH "Community Health Centers+") OR ("community care") OR (MH "Home Care Services+") OR ("domiciliary care") OR ("health provider") OR (MH "Residential Facilities+") OR (MH "Home Health Nursing") OR ("nursing home") OR ("residential aged care") OR (MH "Ambulatory Care+") OR (MH "Ambulatory Care Facilities+") OR ("ambulatory care") OR (MH "Rehabilitation+") OR (MH "Rehabilitation Nursing") OR (MH "Rehabilitation Centers+") OR (rehabilitat*) OR (MM "Caregivers")
S2	(MH "Patient Discharge") OR (MH "Patient Transfer") OR (discharge plan*) OR (discharge N3 pathway*) OR (hospital N3 discharge) OR (patient N3 transfer) OR (patient N3 discharge) OR (MH "Continuity of Patient Care+") OR (continuity N3 care) OR (integrat* N3 care) OR (integrat* N3 pathway*) OR (care N3 coordinat*) OR (MH "Communication+")
S3	S1 OR S2
S4	(MH "Adult+") OR (adult) OR (MH "Child+") OR (child*) OR (paediatric*) OR (pediatric*) OR (MH "Patients+") OR (patient*) OR (client*) OR (consumer*)
S5	S3 AND S4
S6	(MH "Patient Handoff") OR (handoff OR hand-off) OR (handover OR hand-over) OR ("shift report") OR (transition* N3 care) OR (continuity N3 information)
S7	S5 AND S6
S8	(MH "Consumer Participation+") OR (MH "Patient Participation") OR (MH "Professional-Patient Relations+") OR (MH "Professional-Family Relations+") OR (MH "Nurse-Patient Relations") OR (patient N3 engagement) OR (client N3 engagement) OR (consumer N3 engagement) OR (patient N3 involve*) OR (client N3 involve*) OR (consumer N3 involve*) OR (patient N3 participat*) OR (client N3 participat*) OR (consumer N3 participat*) OR (patient N3 partnership) OR (client N3 partnership) OR (consumer N3 partnership) OR (patient N3 experienc*) OR (client N3 experienc*) OR (consumer N3 experienc*) OR (patient N3 willing*) OR (client N3 willing*) OR (consumer N3 willing*) OR (patient N3 abilit*) OR (client N3 abilit*) OR (consumer N3 abilit*) OR (patient N3 attitude*) OR (famil* N3 attitude*) OR (client N3 attitude*) OR (consumer N3 attitude*) OR (parent* N3 attitude*) OR (S4 N3 communicat*) OR (MH "Decision Making+") OR (patient N3 decision*) OR (client N3 decision*) OR (consumer N3 decision*)
S9	S7 AND S8
S10	S7 AND S8 (Limiters - Date of Publication: 20030101-20131231 Search modes - Boolean/Phrase)

The Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library) Search Strategy

#	**Search Lines**
#1	MeSH descriptor: [Hospitalization] explode all trees
#2	MeSH descriptor: [Patient Care] explode all trees
#3	MeSH descriptor: [Primary Health Care] explode all trees
#4	"primary care"
#5	MeSH descriptor: [Patient-Centred Care] explode all trees
#6	patient next/3 care
#7	"person centred" or "person centred"
#8	MeSH descriptor: [Family Nursing] explode all trees
#9	MeSH descriptor: [Specialties, Nursing] explode all trees
#10	"acute care"
#11	MeSH descriptor: [Subacute Care] explode all trees
#12	"subacute care"
#13	MeSH descriptor: [Nursing Care] explode all trees
#14	MeSH descriptor: [Quality of Health Care] explode all trees
#15	quality next/3 care
#16	MeSH descriptor: [General Practice] explode all trees
#17	"general practice"
#18	MeSH descriptor: [Community Health Centers] explode all trees
#19	"community care"
#20	MeSH descriptor: [Home Care Services] explode all trees
#21	"domiciliary care"
#22	"health provider"
#23	MeSH descriptor: [Residential Facilities] explode all trees
#24	"residential aged care"
#25	MeSH descriptor: [Ambulatory Care] explode all trees
#26	"ambulatory care"
#27	MeSH descriptor: [Rehabilitation] explode all trees
#28	rehabilitat*
#29	MeSH descriptor: [Caregivers] explode all trees
#30	caregiver
#31	$^{25\text{-}\#30}$ from 2003 to 2013, in Trials
#32	MeSH descriptor: [Patient Discharge] explode all trees
#33	MeSH descriptor: [Patient Transfer] explode all trees
#34	discharge plan*
#35	discharge next/3 pathway*
#36	hospital next/3 discharge
#37	patient next/3 transfer
#38	patient next/3 discharge
#39	MeSH descriptor: [Continuity of Patient Care] explode all trees
#40	continuity next/3 care
#41	integrat* next/3 care
#42	integrat* next/3 pathway
#43	care next/3 coordinat*
#44	MeSH descriptor: [Communication] explode all trees
#45	{or #32-#44} from 2003 to 2013, in Trials

#46	#31 or #45
#47	MeSH descriptor: [Adult] explode all trees
#48	adult
#49	MeSH descriptor: [Adolescent] explode all trees
#50	MeSH descriptor: [Child] explode all trees
#51	child*
#52	paediatric*
#53	pediatric*
#54	MeSH descriptor: [Patients] explode all trees
#55	patient*
#56	client*
#57	consumer*
#58	{or #48-#57} from 2003 to 2013, in Trials
#59	#46 and #58
#60	MeSH descriptor: [Patient Handoff] this term only
#61	handoff or handover
#62	"hand-off" or "hand-over"
#63	"hand over"
#64	shift report
#65	MeSH descriptor: [Referral and Consultation] explode all trees
#66	transition* next/3 care
#67	continuity next/3 information
#68	{or #60-#67} from 2003 to 2013, in Trials
#69	#59 and #68
#70	MeSH descriptor: [Consumer Participation] explode all trees
#71	MeSH descriptor: [Professional-Patient Relations] explode all trees
#72	MeSH descriptor: [Professional-Family Relations] explode all trees
#73	(patient next/3 engagement) or (client next/3 engagement) or (consumer next/3 engagement)
#74	(patient next/3 involve*) or (client next/3 involve*) or (consumer next/3 involve*)
#75	(patient next/3 participat*) or (client next/3 participat*) or (consumer next/3 participat*)
#76	(patient next/3 partnership) or (client next/3 partnership) or (consumer next/3 partnership)
#77	(patient next/3 experienc*) or (client next/3 experienc*) or (consumer next/3 experienc*)
#78	(patient next/3 willing*) or (client next/3 willing*) or (consumer next/3 willing*)
#79	(patient next/3 abilit*) or (client next/3 abilit*) or (consumer next/3 abilit*)
#80	MeSH descriptor: [Nurse-Patient Relations] explode all trees
#81	(patient next/3 attitude*) or (client next/3 attitude*) or (consumer next/3 attitude*) or (parent* next/3 attitude*)
#82	#58 next/3 communicat*
#83	MeSH descriptor: [Decision Making] explode all trees
#84	(patient next/3 decision*) or (client next/3 decision*) or (consumer next/3 decision*)
#85	{or #70-#84} from 2003 to 2013, in Trials
#86	#69 and #84

Web of Science^{TM} Core Collection and Current Contents Connect (Thomson Reuters) Search Strategy

#	**Search Lines**
# 1	TITLE: ((Hospitalization OR "Primary Health Care" OR "primary care" OR (patient NEAR/3 care) OR ("person centred" OR "person centred") OR ("family centred care" OR "family centred care") OR (Nursing Specialties) OR "acute care" OR "subacute care" OR "Nursing Care" OR (quality NEAR/3 care) OR "Family Practice" OR "general practice" OR "Community Health Centers" OR "community care" OR "domiciliary care" OR "health provider" OR "Residential Facilities" OR "Nursing Home" OR "residential aged care" OR "ambulatory care" OR rehabilitat* OR "Caregiver")) Timespan=All years Search language=English
# 2	TOPIC: ((Hospitalization OR "Primary Health Care" OR "primary care" OR (patient NEAR/3 care) OR ("person centred" OR "person centred") OR ("family centred care" OR "family centred care") OR (Nursing Specialties) OR "acute care" OR "subacute care" OR "Nursing Care" OR (quality NEAR/3 care) OR "Family Practice" OR "general practice" OR "Community Health Centers" OR "community care" OR "domiciliary care" OR "health provider" OR "Residential Facilities" OR "Nursing Home" OR "residential aged care" OR "ambulatory care" OR rehabilitat* OR "Caregiver")) Timespan=All years Search language=English
# 3	#1 OR #2
# 4	TITLE: ((patient NEAR/3 discharge) OR (Intrahospital Transfer) OR "Transfer Care" OR "discharge plan*" OR (discharge NEAR/3 pathway*) OR (hospital NEAR/3 discharge) OR (patient NEAR/3 transfer) OR "Continuity of Patient Care" OR (continuity NEAR/3 care) OR "Patient Care Conference*" OR (integrat* NEAR/3 care) OR (integrat* NEAR/3 pathway*) OR (care NEAR/3 coordinat*) OR communication) Timespan=All years Search language=English
# 5	TOPIC: ((patient NEAR/3 discharge) OR (Intrahospital Transfer) OR "Transfer Care" OR "discharge plan*" OR (discharge NEAR/3 pathway*) OR (hospital NEAR/3 discharge) OR (patient NEAR/3 transfer) OR "Continuity of Patient Care" OR (continuity NEAR/3 care) OR "Patient Care Conference*" OR (integrat* NEAR/3 care) OR (integrat* NEAR/3 pathway*) OR (care NEAR/3 coordinat*) OR communication) Timespan=All years Search language=English
# 6	#4 OR #5
# 7	#3 OR #6
# 8	TITLE: ((adult OR child* OR paediatric* OR pediatric* OR patient* OR client* OR consumer*)) Timespan=All years Search language=English
# 9	TOPIC: ((adult OR child* OR paediatric* OR pediatric* OR patient* OR client* OR consumer*)) Timespan=All years Search language=English
# 10	#8 OR #9
# 11	#7 AND #10
# 12	TITLE: ((handoff OR hand-off) OR (handover OR hand-over) OR "Shift Reports" OR (transition* NEAR/3 care) OR (continuity NEAR/3 information))

	Timespan=All years Search language=English
# 13	TOPIC: ((handoff OR hand-off) OR (handover OR hand-over) OR "Shift Reports" OR (transition* NEAR/3 care) OR (continuity NEAR/3 information)) Timespan=All years Search language=English
# 14	#12 OR #13
# 15	#11 AND #14
# 16	TITLE: ("Professional-Client Relations" OR "Professional-Patient Relations" OR "Professional-Family Relations" OR (patient NEAR/3 engagement) OR (client NEAR/3 engagement) OR (consumer NEAR/3 engagement) OR (patient NEAR/3 involve*) OR (client NEAR/3 involve*) OR (consumer NEAR/3 involve*) OR (patient NEAR/3 participat*) OR (client NEAR/3 participat*) OR (consumer NEAR/3 participat*) OR (patient NEAR/3 partnership) OR (client NEAR/3 partnership) OR (consumer NEAR/3 partnership) OR (patient NEAR/3 experienc*) OR (client NEAR/3 experienc*) OR (consumer NEAR/3 experienc*) OR (patient NEAR/3 willing*) OR (client NEAR/3 willing*) OR (consumer NEAR/3 willing*) OR (patient NEAR/3 abilit*) OR (client NEAR/3 abilit*) OR (consumer NEAR/3 abilit*) OR "Patient Attitudes" OR "Consumer Attitudes" OR "Family Attitudes" OR (patient NEAR/3 attitude*) OR (client NEAR/3 attitude*) OR (consumer NEAR/3 attitude*) OR (parent* NEAR/3 attitude*) OR ((adult OR child* OR paediatric* OR pediatric* OR patient* OR client* OR consumer*) NEAR/3 communicat*) OR (patient NEAR/3 decision*) OR (client NEAR/3 decision*) OR (consumer NEAR/3 decision*)) Timespan=All years Search language=English
# 17	TOPIC: ("Professional-Client Relations" OR "Professional-Patient Relations" OR "Professional-Family Relations" OR (patient NEAR/3 engagement) OR (client NEAR/3 engagement) OR (consumer NEAR/3 engagement) OR (patient NEAR/3 involve*) OR (client NEAR/3 involve*) OR (consumer NEAR/3 involve*) OR (patient NEAR/3 participat*) OR (client NEAR/3 participat*) OR (consumer NEAR/3 participat*) OR (patient NEAR/3 partnership) OR (client NEAR/3 partnership) OR (consumer NEAR/3 partnership) OR (patient NEAR/3 experienc*) OR (client NEAR/3 experienc*) OR (consumer NEAR/3 experienc*) OR (patient NEAR/3 willing*) OR (client NEAR/3 willing*) OR (consumer NEAR/3 willing*) OR (patient NEAR/3 abilit*) OR (client NEAR/3 abilit*) OR (consumer NEAR/3 abilit*) OR "Patient Attitudes" OR "Consumer Attitudes" OR "Family Attitudes" OR (patient NEAR/3 attitude*) OR (client NEAR/3 attitude*) OR (consumer NEAR/3 attitude*) OR (parent* NEAR/3 attitude*) OR ((adult OR child* OR paediatric* OR pediatric* OR patient* OR client* OR consumer*) NEAR/3 communicat*) OR (patient NEAR/3 decision*) OR (client NEAR/3 decision*) OR (consumer NEAR/3 decision*)) Timespan=All years Search language=English
# 18	#16 OR #17
# 19	#15 AND #18
# 20	#15 AND #18 Refined by: Databases=(WOS OR CCC) AND PUBLICATION YEARS=(2012 OR 2007 OR 2013 OR 2006 OR 2011 OR 2005 OR 2003 OR 2010 OR 2004 OR 2009 OR 2008)

PsycInfo (Ebscohost) Search Strategy

#	Search Lines
S1	(DE "Hospitalization") OR (DE "Hospitalized Patients") OR (DE "Mental Health Services") OR

	(DE "Primary Health Care") OR ("primary care") OR (patient N3 care) OR ("person centred" or "person centred") OR (famil* N3 care) OR (DE "Nursing") OR ("acute care") OR ("subacute care") OR (DE "Quality of Care") OR (quality N3 care) OR ("general practice") OR ("family practice") OR (DE "Community Mental Health Centers") OR (DE "Community Mental Health") OR (DE "Community Psychiatry") OR (DE "Community Mental Health Services") OR ("community care") OR (MM "Community Services") OR ("domiciliary care") OR ("health provider") OR (DE "Nursing Homes") OR (DE "Residential Care Institutions") OR ("nursing home") OR ("residential aged care") OR (DE "Respite Care") OR ("ambulatory care") OR (DE "Rehabilitation" OR DE "Rehabilitation Centers") OR (rehabilitat*) OR (DE "Caregivers")
S2	DE "Psychiatric Hospital Discharge") OR (DE "Hospital Discharge") OR (DE "Facility Discharge") OR (DE "Client Transfer") OR (DE "Discharge Planning") OR (discharge plan*) OR (discharge N3 pathway*) OR (hospital N3 discharge) OR (patient N3 transfer) OR (patient N3 discharge) OR (DE "Continuum of Care") OR (continuity N3 care) OR (integrat* N3 care) OR (integrat* N3 pathway*) OR (care N3 coordinat*) OR (DE "Verbal Communication" OR DE "Communication")
S3	S1 OR S2
S4	adult OR child* OR paediatric* OR pediatric* OR (DE "Patients" OR DE "Geriatric Patients" OR DE "Medical Patients" OR DE "Psychiatric Patients" OR DE "Surgical Patients" OR DE "Terminally Ill Patients") OR patient* OR client* OR consumer*
S5	S3 AND S4
S6	(handoff OR hand-off) OR (handover OR hand-over) OR ("shift report") OR (transition* N3 care) OR (continuity N3 information)
S7	S5 AND S6
S8	DE "Client Participation" OR DE "Participation") OR ("professional-client relations") OR ("professional-patient relations") OR ("nurse patient interaction") OR ("professional-family relations") OR (patient N3 engagement) OR (client N3 engagement) OR (consumer N3 engagement) OR (patient N3 involve*) OR (client N3 involve*) OR (consumer N3 involve*) OR (patient N3 participat*) OR (client N3 participat*) OR (consumer N3 participat*) OR (patient N3 partnership) OR (client N3 partnership) OR (consumer N3 partnership) OR (patient N3 experienc*) OR (client N3 experienc*) OR (consumer N3 experienc*) OR (patient N3 willing*) OR (client N3 willing*) OR (consumer N3 willing*) OR (patient N3 abilit*) OR (client N3 abilit*) OR (consumer N3 abilit*) OR (DE "Client Attitudes") OR (DE "Parental Attitudes") OR (patient N3 attitude*) OR (client N3 attitude*) OR (consumer N3 attitude*) OR (parent* N3 attitude*) OR (S4 N3 communicat*) OR (DE "Decision Making") OR (patient N3 decision*) OR (client N3 decision*) OR (consumer N3 decision*)
S9	S7 AND S8
S10	S7 AND S8 Limiters - Publication Year: 2003-2013

EMBASE Search Strategy

(MEDLINE deselected under advanced search)

#	Search Lines
#1	'child hospitalization'/exp OR hospitalis* OR 'patient care'/exp OR 'primary health care'/exp OR 'primary care' OR patient NEAR/3 care OR ('person centred' OR 'person centred') OR 'family centred care'/exp OR 'nursing discipline'/exp OR 'acute care' OR 'subacute care' OR 'nursing care'/exp OR quality NEAR/3 care OR 'general practice'/exp OR ('family practice' OR 'general practice') OR 'health center'/exp OR 'community care'/exp OR ('community care' OR 'domiciliary care') OR 'health provider' OR 'residential home'/exp OR 'nursing home patient'/exp OR 'residential aged care' OR 'ambulatory care' OR 'rehabilitation'/exp OR rehabilitat* OR 'caregiver'/exp
#2	'hospital discharge'/exp OR 'intrahospital transfer' OR 'discharge planning' OR 'discharge plan' OR discharge NEAR/3 pathway OR 'patient discharge' OR hospital NEAR/3 discharge OR patient NEAR/3 transfer OR continuity NEAR/3 care OR 'patient care conferences' OR integrat* NEAR/3 care OR integrat* NEAR/3 pathway OR care NEAR/3 coordinat* OR 'interpersonal communication'/exp OR communicat*
#3	#1 or #2*
#4	'adult'/exp OR adult OR 'juvenile'/exp OR child* OR paediatric* OR pediatric* OR 'patient'/exp OR patient* OR client* OR consumer*
#5	S3 AND S4
#6	'clinical handover'/exp OR handoff OR 'hand off' OR handover OR 'hand over' OR 'shift report' OR transition NEAR/3 care OR continuity NEAR/3 information
#7	S5 AND S6
#8	'nurse patient relationship'/exp OR 'professional-client relations' OR 'professional-patient relations'/exp OR 'professional-family relations'/exp OR patient NEAR/3 engagement OR client NEAR/3 engagement OR consumer NEAR/3 engagement OR patient NEAR/3 involvement OR client NEAR/3 involvement OR consumer NEAR/3 involvement OR patient NEAR/3 participation OR client NEAR/3 participation OR consumer NEAR/3 participation OR patient NEAR/3 experience OR client NEAR/3 experience OR consumer NEAR/3 experience OR patient NEAR/3 willingness OR client NEAR/3 willingness OR consumer NEAR/3 willingness OR patient NEAR/3 ability OR client NEAR/3 ability OR consumer NEAR/3 ability OR 'patient attitude'/exp OR 'consumer attitude'/exp OR 'family attitude'/exp OR patient NEAR/3 communication OR 'patient decision making'/exp OR patient NEAR/3 decision OR client NEAR/3 decision OR consumer NEAR/3 decision AND [embase]/lim AND [2003-2013]/py
#9	#7 AND #8 AND [embase]/lim AND [2003-2013]/py

Sociological Abstracts (ProQuest) Search Strategy

#	**Search Lines**
S1	SU.EXACT.EXPLODE("Hospitalization") OR SU.EXACT.EXPLODE("Care") OR SU.EXACT.EXPLODE("Primary Health Care") OR SU.EXACT.EXPLODE("Quality of Health Care") OR SU.EXACT.EXPLODE("Community Mental Health Centers") OR SU.EXACT.EXPLODE("Health Professions") OR SU.EXACT.EXPLODE("Nursing Homes") OR SU.EXACT.EXPLODE("Caregivers") OR ("primary care") OR (patient N/3 care) OR ("person centred" or "person centred") OR ("family centred care")OR (Nursing Specialties) OR ("nursing care") OR ("acute care") OR ("subacute care") OR (quality N/3 care) OR ("Family Practice") OR ("general practice") OR ("community care") OR ("domiciliary care") OR ("health provider") OR ("residential aged care") OR ("ambulatory care") OR (rehabilitation)
S2	SU.EXACT.EXPLODE("Discharge") OR ("intrahospital transfer*") OR (discharge N/3 plan*) OR (discharge N/3 pathway*) OR (hospital N/3 discharge) OR (patient N/3 transfer*) OR (patient N/3 discharge*) OR (continuity N/3 care) OR (integrat* N/3 care) OR (integrat* N/3 pathway) OR (care N/3 coordinat*) OR SU.EXACT.EXPLODE("Discussion" OR "Interpersonal Communication") OR SU.EXACT.EXPLODE("Conversation" OR "Letters (Correspondence)" OR "Verbal Communication")
S3	S1 OR S2
S4	SU.EXACT.EXPLODE("Children" OR "Preschool Children") OR SU.EXACT.EXPLODE("Adolescents") OR SU.EXACT.EXPLODE("Adults" OR "Elderly" OR "Middle Aged Adults" OR "Young Adults") OR SU.EXACT.EXPLODE("Mental Patients" OR "Outpatients" OR "Patients") OR SU.EXACT.EXPLODE("Clients") OR SU.EXACT.EXPLODE("Consumers") OR (adult*) OR (child*) OR (paediatric*) OR (pediatric*) OR (patient*) OR (client*) OR (consumer*)
S5	S3 AND S4
S6	(handoff OR hand-off) OR (handover OR hand-over) OR ("Shift Reports") OR (transition* N/3 care) OR (continuity N/3 information)
S7	S5 AND S6
S8	SU.EXACT.EXPLODE("Client Relations" OR "Practitioner Patient Relationship") OR SU.EXACT.EXPLODE("Parental Attitudes") OR SU.EXACT.EXPLODE("Attitudes" OR "Client Satisfaction") OR SU.EXACT.EXPLODE("Participative Decision Making") OR SU.EXACT.EXPLODE("Decision Making") OR SU.EXACT.EXPLODE("Group Decision Making") OR (patient N/3 engagement) OR (client N/3 engagement) OR (consumer N/3 engagement) OR (patient N/3 involve*) OR (client N/3 involve*) OR (consumer N/3 involve*) OR (patient N/3 participat*) OR (client N/3 participat*) OR (consumer N/3 participat*) OR (patient N/3 partnership) OR (client N/3 partnership) OR (consumer N/3 partnership) OR (patient N/3 experienc*) OR (client N/3 experienc*) OR (consumer N/3 experienc*) OR (patient N/3 willing*) OR (client N/3 willing*) OR (consumer N/3 willing*) OR (patient N/3 abilit*) OR (client N/3 abilit*) OR (consumer N/3 abilit*) OR (patient N/3 attitude*) OR (client N/3 attitude*) OR (consumer N/3 attitude*) OR (parent* N/3 attitude*) OR (patient N/3 decision*) OR (client N/3 decision*) OR (consumer N/3 decision*) OR (S4 AND communicat*)
S9	S7 AND S8
S10	S7 AND S8 Limits applied Narrowed by: Entered date: 01/ 01/ 2003 - 31/ 12/ 2013

Appendix C: Data Collection Tool

The Data Collection Tool

Category	Additional instructions
Record in Endnote	
First author	
Year	
Title	
Type of publication	1- Original Research, 2-Systematic or Integrative Review, 3-Quality Improvement or Innovation Project, 4-Commentary or Letter, 5-Other (state)
Research question or study purpose	
Theoretical/conceptual framework	
Definitions of concepts	
Research methodology	1. Quantitative (1a. = randomised study, 1b. = non-randomised study), 2. Qualitative or 3. Mixed Method
Study design	
Context/setting	
Subjects/participants	Inclusion criteria of participants or method of recruiting participants, with participant characteristics described.
Sample size	
Interventions (types, elements)/ Procedures	If the study has an intervention, describe the intervention and comparison (if relevant) and any specific procedures for each group.
Instruments	Description of the instrument and its features, indicate whether the instrument was the 'intervention' or if the instrument was used for data collection purposes only.
Data collection methods	Describe the method of data collection and the length of follow-up.

Results / Outcomes	Report the results pertinent to the research question or purpose of the research. Use quotation marks if text is verbatim.
Was the study reliable?	State the reasons for your judgment. Guide: what steps were taken to ensure assessment tools or instruments were reliable/trustworthy, what steps were taken to ensure the methods were dependability (see table 1 guide).
Was the study valid?	State the reasons for judgment. Guide: For intervention studies, evaluate for evidence of low risk of selection, performance, attrition (withdrawal) and detection bias, and generalisability. For qualitative/descriptive studies, evaluate for evidence of credibility, confirmability, and transferability (see table 1 guide).
Other comments	Indicate if ethical approval was not sought, if there were perceived conflicts of interest, or if other outcomes/results were presented that were not directly linked to the research question or purpose. Use this column for any other comments.

Appendix D: Mixed Methods Appraisal Tool (MMAT) – Version 2011

For dissemination, application, and feedback: Please contact pierre.pluye@mcgill.ca, Department of Family Medicine, McGill University, Canada.

The MMAT is comprised of two parts (see below): criteria (Part I) and tutorial (Part II). While the content validity and the reliability of the pilot version of the MMAT have been examined, this critical appraisal tool is still in development. Thus, the MMAT must be used with caution, and users' feedback is appreciated. Cite the present version as follows.

Pluye, P., Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., Griffiths, F., Boardman, F., Gagnon, M.P., & Rousseau, M.C. (2011). *Proposal: A mixed methods appraisal tool for systematic mixed studies reviews.* Retrieved on [date] from http://mixedmethodsappraisaltoolpublic.pbworks.com. Archived by WebCite® at http://www.webcitation.org/5tTRTc9yJ

Purpose: The MMAT has been designed for the appraisal stage of complex systematic literature reviews that include qualitative, quantitative and mixed methods studies (mixed studies reviews). The MMAT permits to concomitantly appraise and describe the methodological quality for three methodological domains: mixed, qualitative and quantitative (subdivided into three sub-domains: randomized controlled, non- randomized, and descriptive). Therefore, using the MMAT requires experience or training in these domains. E.g., MMAT users may be helped by a colleague with specific expertise when needed. The MMAT allows the appraisal of most common types of study methodology and design. For appraising a qualitative study, use section 1 of the MMAT. For a quantitative study, use section 2 or 3 or 4, for randomized controlled, non-randomized, and descriptive studies, respectively. For a mixed methods study, use section 1 for appraising the qualitative component, the appropriate section for the quantitative component (2 or 3 or 4), and section 5 for the mixed methods component. For each relevant study selected for a systematic mixed studies review, the methodological quality can then be described using the corresponding criteria. This may lead to exclude studies with lowest quality from the synthesis, or to consider the quality of studies for contrasting their results (e.g., low quality vs. high).

Scoring metrics: For each retained study, an overall quality score may be not informative (in comparison to a descriptive summary using MMAT criteria), but might be calculated using the MMAT. Since there are only a few criteria for each domain, the score can be presented using descriptors such as *, **, ***, and ****. For qualitative and quantitative studies, this score can be the number of criteria met divided by four (scores varying from 25% (*) -one criterion met- to 100% (****) -all criteria met-). For mixed methods research studies, the premise is that the overall quality of a combination cannot exceed the quality of its weakest component. Thus, the overall quality score is the lowest score of the study components. The score is 25% (*) when *QUAL=1 or QUAN=1 or MM=0*; it is 50% (**) when *QUAL=2 or QUAN=2 or MM=1*; it is 75% (***) when *QUAL=3 or QUAN=3 or MM=2*; and it is 100% (****) when *QUAL=4 and QUAN=4 and MM=3* (QUAL being the score of the qualitative component; QUAN the score of the quantitative component; and MM the score of the mixed methods component).

Rationale: There are general criteria for planning, designing and reporting mixed methods research (Creswell and Plano Clark, 2010), but there is no consensus on key specific criteria for appraising the methodological quality of mixed methods studies (O'Cathain, Murphy and Nicholl, 2008). Based on a critical examination of 17 health-related systematic mixed studies reviews, an initial 15-criteria version of MMAT was proposed (Pluye, Gagnon, Griffiths and Johnson-Lafleur, 2009). This was pilot tested in 2009. Two raters assessed 29 studies using the pilot MMAT criteria and tutorial (Pace, Pluye, Bartlett, Macaulay et al., 2010). Based on this pilot exercise, it is anticipated that applying MMAT may take on average 15 minutes per study (hence efficient), and that the Intra-Class Correlation might be around 0.8 (hence reliable). The present 2011 revision is based on feedback from four workshops, and a comprehensive framework for assessing the quality of mixed methods research (O'Cathain, 2010).

Conclusion: The MMAT has been designed to appraise the *methodological quality* of the studies retained for a systematic mixed studies review, not the quality of their *reporting* (writing). This distinction is important, as good research may not be 'well' reported. If reviewers want to genuinely assess the former, companion papers and research reports should be collected when some criteria are not met, and authors of the corresponding publications should be contacted for additional information. Collecting additional data is usually necessary to appraise *qualitative research and mixed methods studies*, as there are no uniform standards for reporting study characteristics in these domains (www.equator-network.org), in contrast, e.g., to the CONSORT statement for reporting randomized controlled trials (www.consort-statement.org).

Authors and contributors: Pierre Pluye[1], Marie-Pierre Gagnon[2], Frances Griffiths[3] and Janique Johnson-Lafleur[1] proposed an initial version of MMAT criteria (Pluye et al., 2009). Romina Pace[1] and Pierre Pluye[1] led the pilot test. Gillian Bartlett[1], Belinda Nicolau[4], Robbyn Seller[1], Justin Jagosh[1], Jon Salsberg[1] and Ann Macaulay[1] contributed to the pilot work (Pace et al., 2010). Pierre Pluye[1], Émilie Robert[5], Margaret Cargo[6], Alicia O'Cathain[7], Frances Griffiths[3], Felicity Boardman[3], Marie-Pierre Gagnon[2], Gillian Bartlett[1], and Marie-Claude Rousseau[8] contributed to the present 2011 version.

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Types of mixed methods study components or primary studies	**Methodological quality criteria (see tutorial for definitions and examples)**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	- Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?				
	- Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).				
	Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?				
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?				
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?				
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?				
2. Quantitative randomized controlled (trials)	2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?				
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?				
	2.3. Are there complete outcome data (80% or above)?				
	2.4. Is there low withdrawal/drop-out (below 20%)?				
3. Quantitative non-randomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?				
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?				
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?				
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?				
	4.2. Is the sample representative of the population understudy?				
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?				
	4.4. Is there an acceptable response rate (60% or above)?				
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?				
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?				
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?				
	Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.				

PART I. MMAT criteria & one-page template (to be included in appraisal forms)

*These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated.

Appendix E: Table of characteristics of included studies

Table of characteristics of included studies

Study ID	Bradley 2013
Reference	Bradley S and Mott S. Adopting a patient-centred approach: an investigation into the introduction of bedside handover to three rural hospitals. *Journal of Clinical Nursing*. 2013; 23: 1927-36.
Purpose	To study empirically the process and outcomes of the implementation of nurse-to-nurse bedside handover in three rural South Australian hospitals.
Design	Mixed methods
Setting	Three small rural hospitals, Australia
Subjects	Patients Nurses
Sample size	N = 57 (Patients n=9, Nurses n=48)
Intervention	Nurse to nurse bedside handover
Data Collection	Pre and post implementation survey of staff. Ethnographic interviewing of staff (pre and post implementation) and patients (post implementation) with observation and journaling.
Results	Patients preferred the bedside handover method over the traditional closed-door office handover approach. Patients perceived that the bedside handover process; • Includes social aspects for the patient • Provides an opportunity to know who is looking after them and • Allows patients to be included in discussion related to their care. Nurses believed the level of patient involvement in their own care increased with bedside handover.
MMAT	5. Mixed methods: **

Study ID	**Chaboyer 2010**
Reference	Chaboyer W, McMurray A and Wallis M. Bedside nursing handover: A case study. *International Journal of Nursing Practice*. 2010; 16: 27-34. * McMurray A, Chaboyer W, Wallis M and Fetherston C. Implementing bedside handover: strategies for change management. *Journal of Clinical Nursing*. 2010; 19: 2580-9.
Purpose	To describe the structures, processes and perceived outcomes of bedside nursing handover.
Design	Qualitative
Setting	Two hospitals, Australia
Subjects	Nurses
Sample size	N = 34 (Interviews n=34, Handover observations n=532)
Intervention	Bedside handover
Data Collection	In-depth interviews and semi-structured observations of handover.
Results	Perceived outcomes included improving accuracy and service delivery, and promoting patient-centred care. SBAR was used at one hospital for between 45% - 65% of the handovers. Patients actively involved in between one-third to slightly over half of handovers. Patients and family invited to comment or ask questions near the end of the handover. Medical jargon kept to a minimum. Nurses thought the accuracy of the handover was improved, and bedside handover promoted patient-centred care and improvements to nursing services.
MMAT	1.Qualitative: ****

Footnote:* Additional report provide supplementary information about the study.

Study ID	**Chin 2011**
Reference	Chin GSM, Warren N, Kornman L and Cameron P. Patients' perceptions of safety and quality of maternity clinical handover. *BMC Pregnancy and Childbirth*. 2011; 11: 58.
Purpose	To investigate postnatal patients' perceptions of maternity handover and factors that affect the quality and safety of this process, to inform future handover improvements from a patient's perspective.
Design	Qualitative
Setting	Australian tertiary maternity hospital
Subjects	Women giving birth in the Family Birth Unit
Sample size	N = 30 (women and their medical records)
Intervention	Handover procedures
Data Collection	Semi structured interviews analysed by thematic coding using constant comparison Medical record review with descriptive statistical analysis of entries.
Results	Around half the women were aware of handover. Health professional awareness of patient information was perceived by patients as evidence of handover, positive teamwork, care and communication. Patients perceived collaborative cross-checking and patient / support people inclusion as protective mechanisms that promoted quality and safety. Team situational awareness (TSA) was also promoted in this way.
MMAT	1.Qualitative: ***

Study ID	**Coleman 2006**
References	Coleman EA, Parry C, Chalmers S and Min S-J. The care transitions intervention: results of a randomized controlled trial. *Archives of Internal Medicine*. 2006; 166: 1822-8. **(Primary reference)** *[1] Parry C, Coleman EA, Smith JD, Frank J and Kramer AM. The care transitions intervention: a patient-centered approach to ensuring effective transfers between sites of geriatric care. *Home Health Care Services Quarterly*. 2003; 22: 1-17. *[2] Coleman EA, Smith JD, Frank JC, Min SJ, Parry C and Kramer AM. Preparing patients and caregivers to participate in care delivered across settings: the care transitions intervention. *Journal of the American Geriatrics Society*. 2004; 52: 1817-25. *[3] Parry C, Kramer HM and Coleman EA. A qualitative exploration of a patient-centered coaching intervention to improve care transitions in chronically ill older adults. *Home Health Care Services Quarterly*. 2006; 25: 39-5353.
Purpose	RCT: To test whether an intervention designed to encourage older patients and their caregivers to assert a more active role in their care transitions can reduce rates of rehospitalisation. Qualitative descriptive study: To explore patient's experiences of a one-on-one coaching to enhance patient self-management throughout care transitions.
Design	Mixed Methods
Setting	Not-for-profit capitated delivery system (1 hospital, 8 skilled nursing facilities, 1 home health care agency) that cares for more than 60 000 patients 65 years or older, United Stated of America.
Subjects	65 years or older, admitted to the participating delivery system's contract hospital during the study period for a nonpsychiatric condition, community dwelling (ie, not from a longterm care facility), residing within a predefined geographic radius of the hospital (thereby making a home visit feasible), with a working telephone, English speaking, no documentation of dementia in the medical record, no plans to enter hospice, not participating in another research protocol, documented diagnosis of stroke, congestive heart failure, coronary artery disease, cardiac arrhythmias, chronic obstructive pulmonary disease, diabetes mellitus, spinal stenosis, hip fracture, peripheral vascular disease, deep venous thrombosis, and/or pulmonary embolism. Participants who answered fewer than 3 questions correctly on 4-item cognitive screening test could participant in study if they had an able and willing proxy.
Sample size	RCT: N = 750 (Control Group n=371, Intervention Group n=379). Discrepancy: N=976 (total sample for quantitative data reported in qualitative study). Qualitative descriptive study: N=32 (completion of intervention in the last 30-45 days).
Intervention	Intervention group: The Care Transitions Intervention operationalized into 1) Personal Health Record and 2) structured visits and phone calls with a transition coach (advanced practice nurses) during a 28-day post-hospital discharge period. . Four pillars of care transition intervention – medication self-

	management, patient-centred record, follow up, red flags. Control group: Usual care
Data Collection	Randomised controlled trial: Outcomes of interest were abstracted from administrative records, and included rate of non-elective rehospitalisation at 30, 90, and 180 days after discharge (primary outcome), and rate of rehospitalisation for the same condition that prompted index hospitalisation (secondary outcome). Qualitative descriptive study (intervention group only): Individual or focus group interviews audiotaped and augmented with field notes.
Results	RCT: Primary outcome - Intervention group had lower rehospitalisation rates at 30 days (8.3 vs. 11.9, P=.048 adjusted) and at 90 days (16.7 vs. 22.5, P=.04 adjusted) than the control group. No statistical significant difference at 180 days (P= 0.28 adjusted). Secondary outcome - Intervention group had lower rehospitalization rates for the same diagnosis that precipitated the index hospitalization at 90 days (5.3 vs. 9.8, P=.04 adjusted) and at 180 days (8.6 vs. 13.9, P=.046 adjusted) than the control group. There was no statistical significant difference at 30 days (P= 0.18 adjusted). Logistic regression analysis was used to adjust for possible imbalances in the randomization in the evaluation of primary and secondary outcomes. Post hoc analysis - Mean hospital costs were lower for intervention patients ($2058) vs. controls ($2546) at 180 days (transformed log, P=.049). Qualitative descriptive study: Three overlapping categories: 1) continuity throughout the care transition, 2) self-management knowledge and skills, and 3) the coaching relationship. Over half the respondents mentioned the importance of meeting the coach in person, and many explicitly mentioned how the face to face contact made in the hospital and home visits served to build rapport and increase patient confidence to ask questions and express concerns.
MMAT	1.Qualitative: ** 2. Quantitative randomized controlled (trials): **

Footnote: * Additional reports provide supplementary information about the study. *1 Protocol, *2 Pilot Study (Non-randomised comparative study with historical controls), *3 Qualitative Study (intervention group of RCT only).

Study ID	**Flink, Hesselink 2012**
Reference	Flink M, Hesselink G, Pijnenborg L, et al. The key actor: A qualitative study of patient participation in the handover process in Europe. *BMJ Quality and Safety*. 2012; 21: i89-i96.
Purpose	To explore the patients' experiences and perspectives related to the handovers between their primary care providers and the inpatient hospital
Design	Qualitative
Setting	Five European countries (The Netherlands, Spain, Poland, Italy and Sweden)
Subjects	>18 years, Diagnosed with either diabetes mellitus, chronic obstructive pulmonary disease (COPD), heart failure, asthma or/and poly-pharmacy (>6 drugs) Discharged to home or nursing home (under responsibility of primary/community care)
Sample size	N = 90 (53 individual interviews and 37 participated in focus groups)
Intervention	Handovers between primary care providers and inpatient hospitals
Data Collection	Interviews: Audio-taped and transcribed verbatim in local language, with a jointly decided standardised format. Focus groups: Led by trained moderator, with one or two observers making field notes and adding questions. Grounded Theory.
Results	Three themes: patient positioning in the handover process; prerequisites for patient participation and patient preferences for the handover process. Patients' participation in transition communication range from taking a leadership (key actor) role, through to sharing responsibility with health professionals to having a passive role. Active participation required personal and social resources, information and respect. Patients preferred to act in all three ways at various times
MMAT	1.Qualitative: ***

Study ID	**Flink, Ohlen 2012**
Reference	Flink M, Ohlen G, Hansagi H, Barach P and Olsson M. Beliefs and experiences can influence patient participation in handover between primary and secondary care - A qualitative study of patient perspectives. *BMJ Quality and Safety*. 2012; 21: i76-i83.
Purpose	To improve the knowledge and understanding of patients' perspectives using Swedish patients exemplars, about their participation in handover communication between primary and secondary care at the time of hospital admission and at discharge.
Design	Qualitative
Setting	Emergency departments and primary healthcare centres, Sweden.
Subjects	Swedish adults with chronic illness
Sample size	N = 23
Intervention	Handovers at two transitions: from primary care to hospital via the ER, and back to the primary care
Data Collection	Semi structured interview, with a previous piloted schedule. Performed 1-7 weeks post discharge, at home or back at hospital.
Results	Patients participated both within and across health services. Enablers for participation included positive encounters with health professionals, patient empowerment, beliefs about organisational factors, patients' trust in health professionals, and health professionals' attitudes. Patients who thought medical records were already shared gave less information to health professionals. Patients took more leadership in transition communication when they had experienced poor handovers in the past.
MMAT	1. Qualitative: ***

Study ID	**Friesen 2013**
Reference	Friesen MA, Herbst A, Turner JW, Speroni KG and Robinson J. Developing a patient-centered ISHAPED handoff with patient/family and parent advisory councils. *Journal of Nursing Care Quality*. 2013; 28: 208-16.
Purpose	To explore patient perceptions of the ISHAPED bedside change-of-shift report process via survey and patient interviews and to identify opportunities for improvement
Design	Multiple Methods
Setting	8 hospital units across a multihospital system - 1 obstetric, 2 pediatric, and 5 medical units. United States of America.
Subjects	Survey: Convenience sample 93 adult patients and 14 parents of paediatric patients. Interviews: Subset of survey sample - 16 patients and 6 parents
Sample size	Survey: n = 107 Interviews: n = 22
Intervention	ISHAPED bedside change-of-shift report process. Recommendation that IPED elements always occur at the bedside, while SHA elements may occur elsewhere with discretion. Detailed flow diagram of method is included in article.
Data Collection	Paper based surveys: 11 Likert based questions (not reproduced in article). Individual semi-structured interviews: conducted face to face with 8 interview guide questions (reproduced in full in article)
Results	Both patients and parents agreed or strongly agreed with 9 of the 11 survey questions. Five themes: introducing the new nurse, knowing through collaboration and communication, engaging the patient to participate and provide their perspective, educating health care providers and managing privacy.
MMAT	1.Qualitative: ** 4.Quantitative descriptive: **

Study ID	**Glenny 2013**
Reference	Glenny C, Stolee P, Sheiban L and Jaglal S. Communicating during care transitions for older hip fracture patients: family caregiver and health care provider's perspectives. *International Journal of Integrated Care* 13: e044 (2013, accessed March 2014).
Purpose	To explore issues related to information sharing during transitional care for older hip fracture patients through the perspectives of both health care providers and family caregivers
Design	Qualitative
Setting	Health services in a single local area. Canada.
Subjects	Family caregivers and healthcare providers.
Sample size	N = 32 (Health care providers: n= 26, Family caregivers: n = 6)
Intervention	Care transitions
Data Collection	Semi structured interviews.
Results	Families and health professionals recognise the important benefits of family involvement in transition communication. However, this involvement can frequently be limited by poor information sharing. Barriers include limited staff time, patient privacy regulations and lack of a clear structure for information sharing. The receipt of information was the focus for both families and health professionals.
MMAT	1.Qualitative: ***

Study ID	**Groene 2013**
Reference	Groene RO, Orrego C, Sunol R, Barach P and Groene O. "It's like two worlds apart": An analysis of vulnerable patient handover practices at discharge from hospital. *BMJ Quality and Safety*. 2012; 21: i67-i75.
Purpose	To explore handover practices at discharge and to focus on the patients' role in handovers and on the potential additional risks for vulnerable patients
Design	Qualitative
Setting	Hospitals and primary care centres, Spain.
Subjects	Patients: > 18 years of age and had a diagnosis of chronic obstructive pulmonary disease, diabetes, asthma or cardiac failure, or were prescribed more than five drugs at discharge, limited language comprehension or health literacy, or a lack of social resources or support. Hospital health professionals (ie, doctors, nurses, social workers and intercultural mediators) and primary care health professionals (ie, doctors, nurses and social workers).
Sample size	N = 34. Patients: n = 12. Hospital physicians: n = 6. Hospital nurses: n = 5. Primary care physician: n =7. Primary care nurses: n = 4.
Intervention	Clinical handovers at admissions (handovers from primary to secondary care) and discharge (handovers from secondary to primary or follow-up care).
Data Collection	Semi structured interview, with a previous piloted schedule. Audio-recorded and transcribed. Grounded theory.
Results	Handover practices at discharge are potentially risky, as patients do not feel empowered but are expected to transfer critical information. Health professional raised concerns about lack of medication reconciliation at discharge, loss of discharge information, and absence of plans for follow-up care. While it occurred with all patients, those with language issues and/or lack of family and social support systems were particularly at risk.
MMAT	1.Qualitative: ***

Study ID	**Henderson 2004**
Reference	Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K and Szmukler G. Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. *BMJ.* 2004; 329: 136. **(primary reference)** [*3] Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K and Szmukler G. Views of service users and providers on joint crisis plans. *Social Psychiatry and Psychiatric Epidemiology*. 2009; 44: 369-76.
Purpose	RCT: To evaluate the effectiveness of joint crisis plans (JCPs) at reducing use of inpatient services and objective coercion (compulsory admission or treatment) at and during admission" for people with severe mental illness. Qualitative study: To test the following hypotheses 1. At 15 month follow up, holders, nominees and case managers will welcome the use of the joint crisis plan (JCP) in the following ways: 1a. an improvement in the relationship between team and holder will be perceived; 1b. greater holder control over mental health problem will be perceived; 1c. the holders' overall feelings about himself or herself will be improved; 1d. the likelihood that the holder will continue with care will be perceived as increased. 2. Persistence of positive views between immediate and 15 month follow up would reflect a lasting impact of developing the JCP.
Design	Quantitative
Setting	Clients of community mental health teams, United Kingdom.
Subjects	People with psychosis or bipolar disorder
Sample size	N = 160 RCT: Intervention group (n=80), Control group (n=80) Quantitative study (intervention group): N= 65 JCP holders. Audit n=13 (38% of all JCP holders admitted to hospital (N=34)). Initial questionnaire - n=45 JCP holders. 15 month follow-up questionnaire- n=52 JCP holders, n= 39 case managers(case managers partially or fully completed questionnaire represents 60% of all JCP holders).
Intervention	Intervention: Formulation of Joint Crisis Plans (JCP) Control: Provided information leaflets and written copy of their care plan within the care programme approach.
Data Collection	RCT: Primary Outcomes – 1. Admission to hospital, 2. Length of hospital stay. Secondary Outcome – 3. objective coercion (compulsory treatment under the Mental Health Act 1983). Follow up period - at 15 months after randomisation. Baseline data included clinical details, history of adverse events e.g. self-harm and violence to others, and compliance with mental health treatment (rated by the care coordinator on a 7 point rating scale adapted for use with outpatients). Quantitative exploratory study: Audit of JCP use in hospital. Two questionnaires - on receipt of final JCP and at 15 months with comparison 1) between JCP holders at initial JCP receipt and at 15 months follow-up, and 2) between JCP holders and

	case managers at 15 months follow-up.
Results	RCT: Primary outcomes 1) a smaller proportion of the intervention group were admitted (Intervention 30% (n=24) vs. Control 44% (n=35), risk ratio 0.69, 95% confidence interval 0.45 to 1.04, χ2 = 3.25, P = 0.07). 2) No significant difference in mean bed days for the whole sample (Intervention mean 32 days vs. Control mean 36 days, difference 4, -18 to 26, P = 0.15). No significant difference in mean bed days for those admitted (Intervention mean 107 days vs. Control mean 83 days. difference -24, -72 to 24, P = 0.39). "Overall about a quarter of patients were admitted for more than one month (23% in the intervention group and 29% in the control group). Secondary outcome: 3) Compulsory admission and treatment were significantly less common in the intervention group (Intervention 10 (13%) patients vs. Control 21 (27%) patients had at least one compulsory admission, risk ratio 0.48, 0.24 to 0.95, χ2 = 4.84, P = 0.03, table 3). Sensitivity analyses did not alter this conclusion. Mean time on section (days) for whole sample (Intervention 14 days vs. Control 31 days, difference 17, 0 to 36, P = 0.04). Mean time on section (days) for those on section (Intervention 114 days vs. Control 117 days, difference 3, -61 to 67, P = 0.98). Qualitative Study: Between 46–96% of JCP holders thought the plans were valuable at immediate follow up. This dropped to 14–82% at 15 months. Many case managers (39% - 85%) were also positive at 15 months, more so than patients. Between the immediate questionnaire and those completed at 15 months, attitudes changed from positive to neutral. Two items received higher endorsement - whether the patient would recommend the JCP to others, and whether they felt more in control of their mental health problem.
MMAT	2.Quantitative randomized controlled: *** 4. Quantitative descriptive: ***

Additional reports of the same study published prior to 2003:

*1 Sutherby K and Szmukler G. Crisis cards and self-help crisis initiatives. *Psychiatric Bulletin*. 1998; 22: 4-7.

*2 Sutherby K, Szrnukler GL, Halpern A, et al. A study of ‘crisis cards' in a community psychiatric service. *Acta Psychiatrica Scandinavica*. 1999; 100: 56-61.

Footnote: *1 Description of the Intervention *2 Pilot Study, *3 Qualitative Study (intervention group of RCT).

Study ID	**Johnson, Cowin 2013**
Reference	Johnson M and Cowin LS. Nurses discuss bedside handover and using written handover sheets. *Journal of Nursing Management*. 2013; 21: 121-9.
Purpose	To explore nurses perspectives on the introduction of bedside handover and the use of written handover sheets
Design	Qualitative
Setting	Acute hospital. Australia.
Subjects	Nurses. Excluded if working in closed specialty units (e.g. ICU, neonatal, operating theatres) because communication in these units was felt to be substantially different to general wards.
Sample size	N = 30
Intervention	Bedside handoff
Data Collection	Six focus groups held at the hospitals
Results	Three themes: bedside handover and the strengths and weaknesses; patient involvement in handover, and good communication is about good communicators.
MMAT	1.Qualitative: ***

Study ID	**Johnson, Forbes 2013**
Reference	Johnson H, Forbes D, Egan MY, Elliott J, Stolee P and Chesworth BM. Hip-fracture care in rural southwestern ontario: An ethnographic study of patient transitions and physiotherapy handoffs. *Physiotherapy Canada*. 2013; 65: 266-75.
Purpose	To examine information exchange by physiotherapists during care handoffs of patients with hip fracture in a rural health care setting
Design	Qualitative
Setting	Acute care ward. Canada.
Subjects	English-speaking patients, care providers, and family members
Sample size	N = 43 (Patients: n = 11, Family: n = 8, Health care providers: n = 24)
Intervention	Handoffs of patients
Data Collection	Ethnography: Semi structured interviews, observations, field notes, analytic memos, document analysis
Results	Handovers were less successful when information transfer was untimely or incomplete. Family experienced many challenged in getting information during transfer conversations, particularly when they couldn't directly meet the physiotherapist.
MMAT	1.Qualitative: ****

Study ID	**Lepore 2013**
Reference	Lepore M, Wild D, Gil H, et al. Two useful tools: to improve patient engagement and transition from the hospital. The Journal of Ambulatory Care Management. 2013; 36: 338-44.
Purpose	To examine (1) the range of needs and diverse experiences of 520 hospitalized adults in transition and (2) the factors most strongly associated with their self-reported health confidence.
Design	Quantitative
Setting	Acute hospitals. United Stated of America.
Subjects	Patients older than 18 years from 2 sources: a hospital recognized with Patient-Centred Care Designation and "at large" hospitalized respondents who chose to use this publically available Web site. Between 2nd and 7th day of admission.
Sample size	N = 520
Intervention	Communications and style of communications received in the hospital
Data Collection	Responses to Internet-based assessments from HowsYourHealth.org. After completion, the assessment system automatically provides (a) a summary report for the patient and the care team, (b) information tailored to each patient's needs, and (c) a personal portable health plan.
Results	Patient's prior experiences and the quality of care coordination and communication during admission were greatly influential on the success of transition back to home.
MMAT	3.Quantitative descriptive: ***

Study ID	**Liu 2012**
Reference	Liu W, Manias E and Gerdtz M. Medication communication between nurses and patients during nursing handovers on medical wards: A critical ethnographic study. *International Journal of Nursing Studies*. 2012; 49: 941-52.
Purpose	To examine dominant and submissive forms of communication and power relations surrounding medication communication among nurses, and between nurses and patients during handover.
Design	Qualitative
Setting	Two medical wards (General Medical Ward & Medical Assessment Ward) of a metropolitan teaching hospital. Australia
Subjects	Registered nurses. Patients - eligible if able to communicate competently with nurses about medication management, able to speak English, to be medically stable and cognitively competent, and to be on at least one medication.
Sample size	N = 103 (Nurses: n = 76, Patients: n = 27).
Intervention	Not applicable
Data Collection	Ethnography: Participant observations, field interviews, video-recordings and video reflexive focus groups. Fieldwork comprised 290 hours of participant observations, 72 field interviews, 34 hours of video-recordings and 5 reflexive focus groups. All data collected by single researcher
Results	Nurses wanted to be discrete during bedside handovers. However, disjunctions of medication communication tended to occur when transitions between wards happened.
MMAT	1.Qualitative: ***

Study ID	**Maxson 2012**
Reference	Maxson PM, Derby KM, Wrobleski DM and Foss DM. Bedside nurse-to-nurse handoff promotes patient safety. *Medsurg Nursing*. 2012; 21: 140-4.
Purpose	To: 1. determine if bedside nurse-to nurse handoff increases patient satisfaction with the plan of care and increases patient perception of teamwork. 2. determine if bedside nurse-to nurse handoff increases staff satisfaction with communication and accountability.
Design	Quantitative
Setting	Surgical unit. United Stated of America.
Subjects	Patients (pre-implementation and post-implementation): age 18 or older, no cognitive impairment, and the ability to understand and speak English. Nurses working on the unit.
Sample size	N = 75 (Patients: n = 30 (before), n=30 (after); Nurses: n = 15)
Intervention	Bedside handoff
Data Collection	Pre-post implementation surveys with patients and nurses
Results	Majority of health professionals unsatisfied with current shift change reports, but significant improvement achieved after practice change. Significant improvement also achieved for patients' satisfaction with involvement in their plan of care.
MMAT	4.Quantitative descriptive: *

Study ID	**McMurray 2011**
Reference	McMurray A, Chaboyer W, Wallis M, Johnson J and Gehrke T. Patients' perspectives of bedside nursing handover. *Collegian*. 2011; 18: 19-26.
Purpose	To examine patients' perspectives of participation in shift-to-shift bedside nursing handover
Design	Descriptive
Setting	Two medical units in a hospital. Australia.
Subjects	Patients admitted to one of these two units during 2009. English speakers, hospitalised on ward at least overnight, able to tolerate a 30-60 min interview.
Sample size	N = 10
Intervention	Shift to shift bedside handovers
Data Collection	Semi structured interview, with full list of prompt questions included in the article
Results	Four themes: patients appreciated being acknowledged as partners in their care; patients viewed bedside handover as a chance to correct inaccurate information; some preferred passive engagement; most patients appreciated the inclusive focus of bedside handover
MMAT	1.Qualitative: ***

Study ID	**McTier 2013**
Reference	McTier L, Botti M and Duke M. Patient participation in medication safety during an acute care admission. *Health Expectations*. 17: Epub ahead of print Dec 17 2013.
Purpose	To explore patient participation in the context of medication management during a hospital admission for a cardiac surgical intervention of patients with cardiovascular disease
Design	Multiple Methods
Setting	Cardiothoracic ward of tertiary referral hospital. Australia
Subjects	Patients
Sample size	Interviews: n = 98 Observation: n = 48
Intervention	Clinical practices surrounding medication management
Data Collection	Semi-structured interviews (Including cognitive screen post discharge) to reconcile admission and discharge medications. Naturalistic observations of interactions between nurses and patients coinciding with handover and shift of change.
Results	All patients had their medication changed as a result of their surgery. Very little evidence that nurses used opportunities such as medication administration times and/or handovers to engage patients in medication discussions during admission.
MMAT	1.Qualitative: *** 4.Quantitative descriptive: **

Study ID	**Merrill 2012**
Reference	Merrill KC and Brown K. Nursing handoff at the bedside: does it improve outcomes? *Communicating Nursing Research*. 2012; 45: 311-.
Purpose	To describe nurses and patients experience with implementation of a standardised bedside handoff and to measure its effects on patient satisfaction, falls and adverse events.
Design	Multiple Methods
Setting	Adult inpatient departments across six hospitals. United Stated of America.
Subjects	Nurses and patients
Sample size	N = 149 (Nurses: n = 119 survey, n = 11 focus groups, Patients: n = 30 interviews)
Intervention	Handoff communication
Data Collection	Quantitative: Nurse survey. Qualitative: Interviews with patients and focus groups with nurses
Results	Nurses felt their current practices were effectives, and felt change was unnecessary at baseline. Nurses ‘warmed up’ to bedside report after 9 months, but it was still not perceived as being effective. Patients reported high levels of satisfaction (80%) with the effectiveness of the reports. Patients involved at end of handover, by being asked 'is that right?' and 'do you have any questions', but could contribute more if they 'butted in'.
MMAT	1.Qualitative: * 4.Quantitative descriptive: **

Study ID	**Renehan 2013**
Reference	Renehan E, Haralambous B, Galvin P, Kotis M and Dow B. Evaluation of a transition care cognitive assessment and management pilot. *Contemporary Nurse*. 2013; 43: 134-45.
Purpose	The purpose of this study was to evaluate the implementation and effectiveness of the Transition Care Cognitive Assessment and Management Pilot (TC CAMP).
Design	Multiple Methods
Setting	A Health Service in Victoria, Australia
Subjects	TC CAMP staff, staff from the health service, carers and representatives of the facility to which clients were discharge. Family/carers.
Sample size	Interviews: N=11 clients, N=7 family/carers Two focus groups, N=7 participants (included personal care attendants, diversional therapist, team leaders and managers).
Intervention	Transition care program
Data Collection	File audits and the Cohen Mansfield Agitation Inventory (CMAI) scale scores, focus groups and individual interviews with nursing staff and carers.
Results	Significant group differences in CMAI scores between clients in acute hospital setting and the first CMAI result recorded in the TC CAMP facility. The staff and families found the program to provide appropriate transition care to people with cognitive impairment who exhibited behavioural and psychological symptoms of dementia.
MMAT	1.Qualitative: *** 4.Quantitative descriptive: **

Study ID	**Sand-Jecklin 2013**
Reference	Sand-Jecklin K and Sherman J. Incorporating bedside report into nursing handoff: evaluation of change in practice. *Journal Of Nursing Care Quality*. 2013; 28: 186-94.
Purpose	To evaluate both the process and outcomes of this change in terms of effectiveness, efficiency, patient and staff satisfaction, and impact on patient safety.
Design	Quantitative
Setting	Seven medical/surgical units in a hospital. United States of America.
Subjects	Patients, family members and nurses.
Sample size	Pre-implementation: N=232 patients and N=70 family members on behalf of the patients Post-implementation: N=178 patients and N=72 family members on behalf of the patients Pre-implementation: N=148 nurses Post-implementation: N=98 nurses
Intervention	Bedside handover process
Data Collection	Pre- and post-implementation survey with the Patient Views on Nursing Care instrument (17 questions, Likert-scale).Pre- and post-implementation survey with the Nursing Assessment of Shift Report (17 questions, Likert-scale) Number of falls, medication errors and nurse overtime data were collected for a month, pre- and post-implementation.
Results	The results show that patients/family members perceive bedside reporting positively, however it was not accomplished consistently. A significant differences between pre- and post-implementation for the 7 survey items was identified, but the results was inconsistent across units and may indicate an inconsistencies in implementation of the change.
MMAT	4.Quantitative descriptive: ***

Study ID	Street 2011
Reference	Street M, Eustace P, Livingston PM, Craike MJ, Kent B and Patterson D. Communication at the bedside to enhance patient care: A survey of nurses' experience and perspective of handover. *International Journal of Nursing Practice*. 2011; 17: 133-40.
Purpose	To identify strengths and limitations in current practices of handover at the change of shift by nursing staff and implement a new bedside process to improve patient safety.
Design	Quantitative
Setting	Large public hospital. Australia.
Subjects	Nurses (survey) across 18 wards, and 10 randomly selected handovers from each of these wards
Sample size	N = 259
Intervention	Current handover practices and pilot implementation of a new bedside handover process
Data Collection	Cross sectional survey (current handover practices) and file audit (new bedside handover process)
Results	Diversity in handover duration, location and method recorded. Part time nurses were less likely to be included in team handovers. After implementation of bedside handover, significant improvements found in patient involvement, use of Situation-Background-Assessment-Recommendation format, active patient checks and checking of documentation.
MMAT	4.Quantitative descriptive: ***

Study ID	**Tidwell 2011**
Reference	Tidwell T, Edwards J, Snider E, et al. A nursing pilot study on bedside reporting to promote best practice and patient/family-centered care. *Journal of Neuroscience Nursing*. 2011; 43: E1-5.
Purpose	To determine if implementation of bedside reporting had an effect on patient/family satisfaction, nursing satisfaction, and hours of nursing overtime.
Design	Quantitative
Setting	Paediatric Neuroscience Unit, United Stated of America.
Subjects	Patients/families and nurses
Sample size	N not specified. (Patient/Family: n not stated, Nurses: n = 23)
Intervention	Bedside nursing report
Data Collection	Pre-post survey. Satisfaction survey for patients/family - already in use at the hospital. Satisfaction survey for nurses - designed especially for this study
Results	Increased satisfaction reported by patients, families and nurses after implementation of bedside reporting. Health professional overtime decreased, with an associated potential cost saving of nearly $13,000 per annum.
MMAT	4.Quantitative descriptive: *

Study ID	**Tobiano 2013**
Reference	Tobiano G, Chaboyer W and McMurray A. Family members' perceptions of the nursing bedside handover. *Journal of Clinical Nursing*. 2013; 22: 192-200.
Purpose	To explore families’ perceptions of shift-to-shift bedside handover
Design	Qualitative
Setting	Rehabilitation ward. Australia.
Subjects	Family members of inpatients
Sample size	N = 8
Intervention	Shift to shift bedside handovers
Data Collection	Case study: Semi structured interviews, observations and field notes
Results	Three themes: understanding the situation (feeling informed, understanding the patient’s condition and understanding patient’s treatment); interacting with nursing staff (sharing information, clarifying information, assisting in care, asking questions and interpreting for the patient); and finding value (feeling at ease, feeling included, valuing individualisation, preparing for the future and maintaining patient privacy).
MMAT	1.Qualitative: ***

Study ID	Weingart 2013
Reference	Weingart C, Herstich T, Baker P, et al. Making good better: Implementing a standardized handoff in pediatric transport. *Air Medical Journal*. 2013; 32: 40-6.
Purpose	To assess handoff communication and staff satisfaction pre and post-implementation of a standardized and scripted handoff process that incorporates parental input and was used by transport and care teams following a paediatric admission.
Design	Quantitative
Setting	Main tertiary hospital of a 303-bed freestanding paediatric hospital system (2 inpatient locations, multiple satellite emergency departments/clinics), United States of America.
Subjects	Staff participating in handoffs
Sample size	Baseline (Pre-implementation): 85 respondents Implementation (Phase 1): 87 respondents Post-implementation (Phase 2): Not specified
Intervention	Phase 1 implementation: Standardized process for handoff (reproduced in full in article). Parents involved at end of handover, being asked 'was the report you heard accurate or did we miss something?' Phase 2 implementation: same as phase 1, with changes made following analysis of phase 1, including transport nurse education of their leadership role in the handover process and improvements in physician notification.
Data Collection	Survey with Likert scale (1-5) and an overall hand-off score of 0-100 completed by staff after each handoff. Likert score of 3 or less was identified as area of deficiency.
Results	Ratings of all items of the Likert scale survey were presented in Bar graphs for each phase, including baseline. Occasional scores of 1 to 2 were reported. There was no statistical significant difference in overall handover scores between baseline and phase 1., but overall handover score improved during phase 2 from baseline and statistical significance was reached.
MMAT	4.Quantitative descriptive: *

Abbreviation: Standard deviation (SD)

Appendix F: Case Summaries

A narrative description of five cases provides exemplars for engaging patients in communication about their care transitions. In order to ensure anonymity of participants, these case summaries have purposely been presented in a different order to the cases in Table 4. Included in these case summaries is a description of the context and how patients are engaged, an identification of tools that were used and participant quotes.

Case Summary 1

This private hospital has a strong leadership culture that values PCC throughout all wards and service areas. Their mission, philosophy and core values revolve around PCC, which is facilitated by Pastoral Care practitioners, some are part of the volunteer staff; others are employed by the hospital. Pastoral care practitioners are able to encourage patient disclosure of needs, help with counselling, and liaise with staff on issues of importance to patients, such as expected discharge date (EDD), home supports, and social work issues. They also organize memorial and bereavement services for former patients and families. Staff know each other, work closely, and pride themselves on advocacy'. The roles of the consumer liaison officer, volunteers, and case managers also have a strong focus on PCC. As with other private hospitals the facility has some limitations in services, such as the lack of Registered Medical Officers (RMOs), which increases the responsibility of nursing and allied health staff for managing patient transitions. Despite being a relatively small private hospital there are many transitional patients because the hospital provides emergency care from a broad catchment. The ED attracts many mental health clients who, because of a lack of inpatient mental health services are unable to transfer for inpatient care as it is unavailable. The ED service requires staff to have greater patient and family engagement in identifying needs than in planned admissions where patient needs have been assessed in pre-admission clinic. Patients are generally older medical patients, particularly because of a lack of rehabilitation beds nearby, and there are large numbers of patients from migrant cultures.

Tip: Strong leadership and an organisational culture that values PCC promotes patient engagement.

Their resourcefulness in terms of tailoring patient care to individual needs reflects greater opportunity for discretionary decision-making, relative to public hospital staff. As a small organisation, staff believe they assume greater accountability for patient care than in some public hospitals because of their strong local networks of external resources and relationships that have, out of necessity, been cultivated by managers and other staff.

> *"I think it's more proactive…we get the information at an earlier stage [than the public system]. Patients who are carers for somebody, a wife or husband, can sometimes be a little bit cagey about having services come into the home. If there's a female patient who's a carer for a husband they're generally more open about getting supports…I don't know whether it's the fear from male patients that if the wife has dementia or something, they feel if they get services in, there's a risk that the wife might have to go into care." (Social Worker)*

Managers pride themselves on maintaining a 'proactive service', where they have considerable discretion over processes and flexibility in discharging or transitioning patients from one service to another. This goal is achieved through ward specific models of care. Discharge planning (DP) is expedited by case management coordinators rather than DP nurses. This has led to a system where all nurses participate in DP, and therefore have ongoing liaison with members of the multidisciplinary team (MDT). Staff often have close engagement with patients and families in the context of discharge planning, which is non-computerised and therefore requires in-depth discussion of patient needs, resources and preferences. A barrier to effective DP is the fact that the written discharge plans are carried by patients to their medical practitioners, who do not always have the opportunity to provide feedback on patients, which can, at times, hamper continuity of care.

Tip: Case Management Coordinators proactively facilitate patient transitions as compared to the traditional reactive approach of discharge planners.

The hospital also has episodic rather than regular post-discharge follow-up phone calls because of the financial pressures of staffing the service. There is a strong commitment to patient evaluation, using Press Ganey Satisfaction surveys, which is believed to provide genuine evaluative data, possibly more authentic than data gathered at the ward level. Staff act on feedback, discussing any ‘discharge failures’ or other issues identified by patients. Other tools used include patient care boards, which encourage engagement by patients and families on some wards, and whiteboards for patient review that are used in conjunction with handover sheets used in bedside handovers. They also conduct hourly rounding with documentation that includes rounding logs. Communication strategies also include a carer’s chart on the ward where updates are provided on the patient’s condition to promote better understanding and prevent carer stress. Carers’ booklets (developed by Home and Community Care HACC) are also distributed to family members as a resource for follow-up care and contacts as well as explanations of clinical terms and conditions.

Tools: Patient care boards, hourly rounding and bedside handover encourage patient and family engagement.

> *“Our handover sheet is the most detailed in the hospital with a specific focus on multi-disciplinary discharge…it’s all about teamwork. If you’ve got a happy culture where everyone gives and nobody’s territorial, it makes a huge difference. We have spiritual and other medical input and the social input…it makes for a complete, really patient centred care in all senses of the word and not just you know, theory.” (Focus Group)*

The goals of PCC are described as continuity of care, safe, successful discharge, informed staff, patients and family, illness recovery, support, comfort, emotional safety, spiritual care and informed decisions. Barriers to PCC include patient diagnosis of mental ill health, confusion, memory loss, delirium, medication problems, co-morbidities that include sepsis, hearing loss, hypoxia, febrile state or neutropenia, cultural or language problems or in some cases, older age and a preference to avoid participation because of cultural issues or a lack of funds or available services. Family conflicts or family absence can also be a barrier to PCC. As is typical in private hospitals, the patient-medical consultant relationship can be a barrier to staff providing PCC, especially for surgical patients, who make arrangements and communicate more directly with medical staff than public patients. This relationship can impede engagement with nursing and allied health staff.

> *“We had a [regional] patient who had an amputation and was here for quite a long time, and it took us quite a bit of effort to get the [regional] hospital on board with the dressing we were using. Our wound care nurses put together a photographic care plan, we did some skyping back and forth. The patient was desperate to get back home as his wife was in a nursing home and not doing too well. We had to get some funding… Transitional Care Packages(TCPs) are out the window.” (Focus Group)*

Lessons Learned

There are different constraints on private and public hospitals relative to their resource capacity and opportunities to engage with patients during transitions.

Organisational commitment to PCC and strong leadership can ensure that private hospital staff develop appropriate networks and innovative ways of maintaining supportive communication strategies for patient and family engagement.

Case Summary 2

This health service has developed a number of strategies to embed PCC across all hospitals and wards, focusing on communicating their patient-centred culture from the leadership to staff, patients and families. Appointment of an Innovation Facilitator and various patient care coordinators have ensured consistency of staff development and widespread dissemination of the Quality and Safety and PCC culture throughout the health service. Among the tools that have been disseminated to wards is the Studer 'Healthcare Flywheel' for evidence-based leadership, focused on connecting the organisation's core purpose and consistent execution of activities through 'Aligned Goals, Aligned Behaviours, and Aligned Processes'.

The PCC agenda is integral to their excellence framework for staff standards of care 'above and below the line'. This is a strategy to encourage collaboration, openness, respect, empowerment and a proactive ward culture, wherein staff are taught to 'speak up' for 'safety, curiosity and concerns'. The service has also integrated the HAIDET system (Hand hygiene, Acknowledgement, Introduction, Duration, Explanation, Thank you) for quality communication to patients and carers to create respect, trust, understanding and predictability in the patient journey. This tool guides staff through the six major steps of patient care: hand hygiene, acknowledge, introduction, duration, explanation, thank you. They also use ISBAR (Introduction, situation, background, assessment, recommendations) for bedside handover, hourly rounding, leader rounding and bi-weekly multidisciplinary rounds and case conferences to achieve timely communication and feedback to patients and staff. A major goal has been to shift the focus from 'documentation to communication' for safe transfer of care, information safety (including medications), comprehensive and patient inclusive assessment of needs, preferences and home capability. Some of this information is gathered from the Medical Assessment Ward as pre-admission information. Communication tools include an admission booklet and communication folder for initial and ongoing patient and staff information.

Tip: Shifting the focus from documentation to communication promotes patient engagement.

Tools: HAIDET (Hand hygiene, Acknowledgement, Introduction, Duration, Explanation, Thank you) and ISBAR (Introduction, Situation, Background, Assessment, Recommendations) are two mnemonics that facilitate patient engagement.

> *"We have a structured framework to hold our managers accountable and in the monthly accountability meetings they will look at operations, complaints, compliments and all the initiatives. There is an expectation that all clinical managers will speak to patients every day, asking 'do you know what's happen…what's going to happen. Is discharge planning clear? Are there any concerns that you have? Who is doing a really good job? It's actually connecting and being very proactive of patients. If it's good stuff they need to feed that back to the staff. If it's a system process they need to fix up they need to put that in place. For staff there are structured purposeful conversations. You speak up out of curiosity, you speak up out of concern."*
> *(Innovation Facilitator)*

Most wards have discharge planning nurses, while others have DP nurses on call. Some wards have patient-led discharges, notably, the maternity ward. The DP process includes having patients and carers agree to program goals, discharge dates and services such as hospital in the home (HITH) or other regional support services. Most wards have a system of follow-up phone calls to patients within 24 hours of discharge to ensure continuity of care and appropriate referrals. A major feature of patient communication is the patient white boards that are located above all beds. These have been designed with patient input, to prompt two-way sharing of information (staff to patient, family and vice versa), and an opportunity for staff to identify themselves or any imminent appointments or contacts; recording of estimated date of discharge (EDD); and for patients to record pertinent information such as prompts for queries to medical staff, or notes from family members who may have visited. Communication via the boards is encouraged during nursing rounds. The service's commitment to PCC has resulted in reduction in falls, pressure injuries, and improved patient satisfaction with appropriate referrals and having been 'listened to'. Their outcomes are evaluated through the PETS (Patient Experience Tracking System) for patient and also staff experience tracking.

> *"People have been at pains to try and make sure that they know what's happening for me and how I'm feeling and what needs to happen. With the board I find that if it's something you might not remember, or that you need to ask, then it is useful for that…Having the information to contact, especially if it changes, that's really good. I've noticed that [name] wife over there, she's a busy young mum with a couple of tiny little kids and she lets them know through the board in case anything happened, where she would be and how she could be contacted." (Patient)*

Barriers to PCC include a large number of rural and regional patients, many of whom tend to defer to medical advice rather than be full participants in transition decisions. Age, dementia, critical illnesses, fatigue, illiteracy, Non-English Speaking Background (NESB), speech difficulties are also barriers. Some patients have differential insurance or a lack of proximity to appropriate services and some tend to express preferences for services without recognising the limitations of regional services. Other barriers to patient participation have been difficulties in using the patient boards because of privacy concerns, missing equipment, or disinterest, or to avoid being misunderstood. Having no home phone service is also a barrier to continuity of care when the discharge follow-up calls are made by nursing staff. Staff barriers to PCC occur occasionally because of lack of familiarity with local services, workloads that prohibit follow-up, or weekend insufficiency of staff for multidisciplinary rounds.

A unique initiative developed within the health service is the Virtual Hospice, which is a website for all stakeholders (patients, families, health professionals and the community). This innovation, with a shift from 'end of life care to comfort care', has been championed by a medical oncologist with input from other staff to personalise the patient and family journey in way that will help alleviate death anxiety. The inpatient patient care boards have been redesigned for dying people to record what they wish to record, while outpatient or home care is focused on a patient passport for the transition. The website encourages patients and families to interact with the materials, using humorous messages conveyed through the site mascot (Morpheus), to help them cope with the various stages. The service encourages all staff to be part of comfort care rather than outsourcing palliative care, which is believed to promote equity in access to hospice care, as well as achieve economy in service delivery.

> *"The Virtual Hospice engages transition between hospital, home and age care facilities to ensure a smooth patient experience. We have worked on transition points, built up a series of tools and experiences to make the transition flow much better. I spend a lot of time enlisting people in learning about end of life care…every stakeholder involved in moving in a physical sense and in an intellectual sense…so the patient doesn't have futile investigations and can move through the system quicker and in a different way. Vulnerable people need to have a voice…so we have a passport we give them to carry with them between facilities and the front part is a section purely about them…the back bit is the nursing handover issues. They have a journal and access to community events so they are skilled up very gently and empowered a bit." (Medical Oncologist)*

Lessons Learned

PCC can be embedded throughout large, multi-service organisations with leadership commitment and champions who motivate others with their creativity and initiative, especially where the organisation has realistic expectations and a focus on communication.

An evidence-based approach to PCC can identify outcomes of adopting PCC.

Using a structured approach to planning ensures consistency in PCC during all transitions.

Case Summary 3

This hospital service has a major commitment to PCC that is evident at the organizational, service and individual staff level. All staff and volunteers are encouraged to role model a team culture. They rely on the guidelines of 'Team STEPPS', within which they have a multidisciplinary Collaborative Practice Team (CPT) to ensure inclusiveness (staff, patients and family), and consistency of information and the way it is communicated. A number of tools are embedded in the Team STEPPS approach, including ISBAR for handovers and formal discharge planning processes that keep patients aware of their expected date of discharge (EDD).

Tip: Unit-level multidisciplinary collaborative practice teams that include a patient advocate assist in maintaining a patient centred focus.

The leaders in this service convey a commitment to organizational clarity, which is crucial in a service with high turnover and 'massive amounts of information'. Their goals are to develop 'trust-based discussion and collaboration' to achieve continuity of care, to 'pause' long enough to give patients the opportunity to enter discussions, and to create 'spaces for patient to get into the conversation'. Challenges that can become barriers to PCC include maintaining the culture of PCC, which can require dealing with the time pressures of high workloads; bed block or a lack of space; the need to integrate staff goals, especially for those who may be only intermittently employed in the unit; and accommodating numerous, often rapid patient transitions across services. There is also the challenge of encouraging participation among patients and families with cultural and linguistic diversity, Indigenous patients, children, and those with mental health issues or who are distressed.

'Engaged nurses' who are good listeners, are 'enablers' of PCC by including patients in conversations about analgesia, access to care, comfort, nutrition, and social support. Staff use checklists and protocols to ensure that processes and patient information are provided for all transitions, with the goals of safe transfer, building rapport with patients and families, developing trust and providing care and comfort. One of the strategies for maintaining PCC focuses on continuity of care, where patients are seen by staff on the ward that may be the patient's next destination. Inviting ward staff to the service helps familiarize patients with the new staff members, thereby reassuring them of multi-service as well as multidisciplinary communication and care.

Tools: Using checklists and protocols that have prompts to engage patients help to ensure patients understand plans for their care transitions.

> *"I think the high turnover of health care professionals and the need for continuity of patient care and collaboration about how they contribute to their care planning are very difficult because relationships are much harder to form in the hospital setting. Clear organisational processes that support transitions…that cause everybody to pause and give patients an opportunity to enter the discussion…and a structured, multidisciplinary bedside handover with families at the bedside…helps involve patients in transitions." (Physician)*
>
> *"The documentation we have in [the service] is different to the ward, so we have to start the process earlier than the actual day. We have a high demand for beds and high turnover… we use checklists [for tasks] but I communicate each step, what I am doing and why, where they are going to and approximate time…so maybe they'll feel more comfortable being informed…talking to them and having a conversation with them and building up a rapport so they have a sense of trust and fell comfortable and at ease with the transition and are happy to put that in your hands. I think families find a comfort in knowing a plan, they like to be given a bit of a scenario for the next step and after." (RN)*

A major feature of the PCC service is the role of the consumer advocate who collects patient 'stories' that keep the patient central by validating the importance to patients of their experience throughout the hospital journey, decoding medical information to patients and families, and feeding back authentic information to staff. Her role is sanctioned by the hospital executive who are committed to maintaining the centrality of the 'patient's authentic voice'.

Tip: Sharing patient stories is a powerful way to help health professionals understand the patient experience.

Patient stories are reviewed by the clinical services coordinator (CSC) then the Quality and Safety Executive, then information is conveyed to the service managers and leaders to provide a basis for service improvement where necessary or to validate PCC actions that have worked well. The consumer advocate and other volunteers also communicate feedback and information to patients and families in an information pack that they receive in pre-admission clinic. Tools in the information pack include a business card for ongoing contact, information on visiting hours, maps, bus routes, social work issues, treatments and procedures.

> *"It's about engaging their relatives or their carers so they can fill in the gaps, and engaging the consumer at the coal face and ensuring their experience is positive as possible…providing them with information at the right time and that is carefully done through the volunteer service, also through our nursing and medical staff. I think people are given a load of information, and we give them one information brochure with clear succinct information. We have a patient information pack in pre-admission clinic and a 'tell us what you think' survey with the patient stories flyer, and a consumer's patients' rights and responsibilities handbook." (Volunteer).*

Lessons Learned

In environments with multiple patient transitions and staff pressures a major key to PCC lies in valuing the important role of volunteers and patient advocates.

PCC requires multidisciplinary leadership and engagement.

Case Summary 4

This case represents a public health service with a number of state-wide specialist services. The organisational culture and plan is guided by the Patient Charter of Healthcare Rights and Responsibilities, with strong leadership and consumer input, as indicated in positions such as the Manager, Patient Experience and Consumer Participation, and a broad range of volunteers with diverse responsibilities. The major focus of the service is on PCC and meeting the 10 Safety and Quality Standards which 'keep tapping in, like a virus, attaching to everything'. The service also promotes six 'good ward management principles'. These include having all patients reviewed within two hours of admission; decision-making by senior multidisciplinary team members; daily interdisciplinary rounds for all patients; allocation of patients to a designated team; active management of patients to ensure they are hospitalized for only as long as clinically necessary; and appropriate transfer of care at discharge. Staff manage a multitude of complex transitions, from community to hospital, transfer from ED to acute, to sub-acute (with aged care or geriatric streams) internal rehabilitation, residential care, home and community. An electronic clinical communication system provides consistency of information and frees nursing staff up for patient engagement. The type and extent of patient engagement depends on the transitions and the age, status, ability and preferences of the patients.

> *"The first thing is there's a multitude of complex transitions – from community to hospital, transfer from sub-acute to acute to transition care to community or residential care. Sub-acute encompasses a number of streams of care including aged care with geriatric medicine and rehabilitation. It can be quite difficult to engage the patients, in which case you have to work through the family. With a younger cohort of patients it's more straightforward. Inpatient care transitions are about involving the patient from day one, being open and transparent, setting goals, reality checks about where we've got to, and having a key liaison or 'go to' person so there's always someone the patient can interact with in terms of the evolution of their discharge plan. It's the go-to backwards and forwards." (Gerontologist)*

The health service has instituted a range of models of care and tools for service delivery. Bedside handover is used throughout the service, but with wide variability in the processes used in different wards. The 'Patients Come First' (PCF) strategy encompasses five areas, each with its own specific objectives. These include the patient charter of healthcare rights and responsibilities; patient information; patient-centred care education; patient feedback and consumer and carer engagement. A number of other initiatives are aimed at patient engagement. For example, 'Let me Know' has staff wear 'let me know' buttons to prompt patients and families for feedback on their care or to encourage them to call back with any post-discharge needs. The message is also visible on rental TV messages, screensavers and other materials.

Tools: 'Let me know' buttons worn by staff invite patients and families to share their thought, ideas and preferences for care.

The service uses tools for consumer feedback where volunteers are trained to gather electronic and paper-based feedback from patients in multiple languages. A Project Manager for Consumer Participation collects patient stories as a 'powerful teaching tool for change', celebrating positive experiences and identifying service gaps. A Volunteer Manager audits the input from volunteers twice a year as part of patient feedback, working with the Patient Liaison 'Go to' person who communicates patient and family concerns at weekly team meetings via 'journey board discussions' at ward level. The service also uses a toolkit for PCC developed jointly by the state and commonwealth governments to focus on PCC for older people, which was designed to 'do things with rather than for people'. There is also a care service for family members to stay overnight, and flexible visiting hours that promote family engagement in care.

Tip: Volunteers can be used to gather authentic patient and family feedback on care but this feedback requires a subsequent plan to address issues that may emerge.

The pre-admission tool is a multidisciplinary assessment that prompts patient inclusion in goal setting for care, including advanced care planning, preferences and values related to what is to be achieved, 'tempered with what is possible and realistic'. Staff engage patients in 'goal-directed transitions' where they are included in open and transparent goals, timeframes, and realistic achievements for their rehabilitation or discharge.

Tip: Engaging patients in plans for their transitions in care requires not only understanding patient preferences but also providing information on what is realistic to expect.

Patient whiteboards are used to engage patients in two-way communication. A system of scheduled daily multidisciplinary rounds are provided in general medical wards to include patient and family participation and ensure that information is provided in plain English, demystifying medical jargon. Prior to the rounds a 'daily journey board huddle' is conducted with team members to make sure 'everyone is on the same page'. Discharge planning is variable in different wards, but patients are provided a 24 hour post-discharge hotline to communicate their concerns back to the hospital. General medical wards also provide videos and USBs with discharge information that patients can take home to check the information provided in hospital to ensure they understand instructions by doctors or pharmacists or other members of the team.

> *"It takes the team, the nursing team, the allied health team, the medical team and the family and patient. Everybody's on board. We're here for the patient." (Nurse manager).*

Barriers to PCC include patients of older age, those with cognitive impairment, dementia, stress or anxiety; people who are socially disenfranchised such as NESB or different cultural or social groups, patients stigmatized by diseases such as HIV, who do not want to participate in care decisions; those who are in conflict with family members, or who do not want to engage with staff for other reasons. Staff barriers include the time pressures of competing program priorities; variability in weekend services or the timing of the journey board huddle (e.g. scarcity or scheduling of allied health staff); a lack of 'wriggle room' when they have to attend daily rounds at a fixed time; staff resistance because of confidentiality concerns (at bedside handover or rounds); structural ward features, such as a lack of space for patient whiteboards; operational workforce restrictions (e.g. surgeons visiting patients early in the morning prior to surgery).

> *"Part of the problem is that particularly older rural people don't think they have a voice. And I still meet young people who don't seem to have a voice. We still have a cultural perception amongst many of our patients that they can't ask or can't be involved or they don't know what they don't know. My role is to think of strategies where we can actually teach and encourage our patient community to understand that they do have a role. That's the first step." (Patient participation coordinator)*

Lessons Learned

Large public organisations can embed PCC with strong leadership committed to PCC and by capitalising on multidisciplinary input.

When carefully managed, the voluntary workforce can provide invaluable input into quality care processes and ensure continuity of engagement with patients and families.

Goal-directed planning can make discharge plans more efficient.

PCC models that have been found to be effective on some wards need to be carefully evaluated for their applicability to other wards.

Case Summary 5

This is a large health and aged care provider with a major commitment to PCC. Many patients are NESB, some from regional and rural areas so networking with external services is important, especially for patients requiring stomal therapy or wound care specialist services. As a private hospital there is some restriction on Patient Transition and Patient Care Packages funded by the public health system. The hospital has a pre-admission clinic that uses the 'top five' as a strategy to encourage PCC for people who are cognitively impaired. This is an empirically effective program that prompts family members for the top five things the patient will respond to when they get restless or start to wander (e.g. being fed, reassuring them that their pets are taken care of, or other concerns).

Tip: Asking families to describe the top five things patients who are cognitively impaired generally respond to when they become restless helps staff to provide patient centred care.

The hospital has an extraordinary focus on communication systems. Staff use the Web De Lacy communication system to facilitate consistent written communication including the discharge plans, and they are committed to multidisciplinary teamwork and careful communication through the patient journey. The electronic system includes information from the pre-admission centre, with information provided to patients in a folder tailored to each ward or specialist service. Information is communicated through videos, brochures, and digital devices. Patient care journals kept by patients contain ward level information for each patient's progress. Patient whiteboards are also available as a means of patient-staff communication for patients who prefer this form of information exchange. Bedside handover and rounding (hourly and daily by NUMs) promote patient engagement from the beginning of the journey through hospitalization.

Tools: Patient care journals can be used to document patient progress and ward routines. Hourly rounding by nurses provides opportunities to seek patient input into care.

Informal medical and nursing networks are designed to ease the burden for regional patients through a 'gentle approach to care'. A young person's mental health service is designed to engage patients and families in weekly case reviews and discharge planning with consultants, nurses and other members of the multidisciplinary team.

> *"We don't get a cent additional funding from the Private Health Insurance Fund nor the government to implement a number of very worthy initiatives, including the pre-admission clinic." (Coordinator)*

The hospital has a team of DP nurses and social workers, but all nursing staff are expected to engage in DP. The DP nurses and social workers meet daily with NUMS on all wards to identify patients with complex care needs. Electronic discharge summaries are sent to local services, comprehensively explaining what education has been provided for the patient, and what type of supports and supplies they require (e.g. for stomal or wound care). For some regional and rural patients, discharge is difficult for family members, especially if extra services are required in the local area.

Tip: While discharge planning is part of all nurses' roles, assistance from specialist discharge planning nurses and social workers may be required for patients with complex care needs.

Patients are surveyed annually after discharge using the Press Ganey Patient Satisfaction survey, to see if they received accurate info through pre-admission and discharge services, including outpatients. The hospital also has an integrated patient experience and satisfaction survey monthly, with evaluative data reported to all units, benchmarked with national and international data quarterly. A Patient Care Journal is kept in the clinic area of the wards rather than in the patient room for reasons of confidentiality. As a private institution there is discretion to keep a patient when they need a longer stay or to rearrange services if required.

> *"As a NUM I would attend handover or get an update at the beginning of the shift. I'll ask how are they managing post-operatively, are they independent or needing assistance? What about the home environment? If they're elderly, are they in pain and do the discharge planners need to come and review them? I also find this information out from rounds, a conversation that you might have with the patient. If we have detected that there is some early signs of dementia or memory loss we'll identify them with our risk manager and I'll send her an email to come and assess a patient that maybe needs some extra things put in place." (Nurse unit manager)*

The goals of PCC are patient safety, continuity of care, physical comfort, emotional security, discharge when medically stable, adequate home supports, ability to cope, low risk of readmission, appropriate transfer or rehabilitation goals, ongoing treatment where required, bed management and real-time feedback. Patient goals include having comprehensive information appropriate to needs, answers to questions, preferred services, palliative protocols, individualized plans, and informed choices depending on what they want to know. Barriers to PCC include patient factors such as age, co-morbidities, language or cultural barriers, preferences to be engaged or not, memory loss, dementia, cognitive impairment, fearfulness, affordability of service, recognition of risks, and ability to negotiate services. Family barriers tend to revolve around understanding the fit between needs and available resources. Staff barriers can include a lack of knowledge, experience or understanding the importance of patient engagement, a lack of awareness of tools and materials such as those used for wound or stomal care, bed management and financial pressures, particularly for patients who may fall under differential rules for services from commonwealth or state governments. Other barriers include inter-professional communication problems such as a lack of trust or communication styles, particularly by medical doctors, or doctors' failure to use the electronic communication system, or misunderstanding of the capacity of rehabilitation systems.

> *"Every nurse close to a cohort of patients has responsibilities in relation to discharge planning. The DP planning team coordinates the more complex group of patients…they provide education, increase awareness, liaison internally and externally…to increase capacity and capability within the organisation so the nurses at the bedside can handle DP that is less complex." (Nurse unit manager)*

<u>Lessons Learned</u>

There are some advantages to integrated electronic communication systems, particularly in institutions that service large rural and regional areas. Advantages include comprehensive dissemination of accurate patient information for discharge planning, streamlined processes at the ward level tailored to individual patient and family needs, and greater consistency of information.

Even in well-resourced private hospitals the lack of services available to patients on discharge because of state-commonwealth relationships is a barrier to PCC.