Accreditation Canada defines a Required Organizational Practice (ROP) as an essential practice that organizations must have in place to enhance patient/client/resident safety and reduce risk.

**ROP: The team transfers information effectively among service providers at transition points.**

Test for Compliance:
- ✓ The team has established mechanisms for timely and accurate transfer of information at transition points.
- ✓ The team uses the established mechanisms to transfer information.

Patient and family-centred care is a key area of focus in accreditation. Tracers look at our programs through the lens of our patients and their families by following their journeys. Surveyors will be looking for evidence that we communicate well both within the care team and with other partners to ensure continuity of care. Particular attention is spent on key information areas, such as:

- ✓ Descriptors of spinal cord injury
- ✓ Best-practice risk assessment areas, such as skin integrity, autonomic, respiratory...
- ✓ Medications
- ✓ Pain assessment and management
- ✓ Supporting self-management and preventing complications
- ✓ Functional status and activities of daily living
- ✓ Quality of life and right to live at risk
- ✓ Advance directives
- ✓ Infection prevention and control
- ✓ Potential risks to staff (i.e. aggressive behaviour, unsafe home environment...)

**Meeting this ROP: what compliance looks like:**

1. **We have developed effective communication processes for transferring information between members of the care team.**
   
   There are many examples of how teams have improved their internal communication to ensure everyone on the care team works toward the same integrated care plan, goals and outcomes. Structured handover tools like SBAR and IDRAW, Patient Status at a Glance boards, interdisciplinary charting and rounding are all ways to ensure that critical information is not missed. As a result, our patients experience care that is coordinated, patient-centred, and confidence-inspiring.

2. **We have improved how we transfer information with other points in the continuum**
   
   We have worked tirelessly to break down department silos and create strong partnerships to ensure a smoother journey for our patients as they transition into the next phases of their recovery. We have improved access and flow through our services to ensure transitions are timely and patient-centred. We have developed better systems to document and ensure that all the pertinent information about our patients is passed on to their next providers so their care can continue seamlessly. We have reached out
to other partners in the community to ensure that our patients always have a point of reference as they reintegrate into the community.

3. **We engage and share information with our patients and their loved ones as our partners in care**
   We believe in proactively engaging patients and their families as early and often as possible. We tell patients what they can expect, who is on their care team, and what they can do to help us help them. We develop the care plan collaboratively with our patients, their family/supporters, and other providers in the patient’s circle of care. We provide clear instructions around discharge and transition, follow-up care, and self-management. We refer our patients to a wealth of community partners and reputable sources of evidence-based information.

**What You May Be Working On:**

- **Continuing to improve the whole patient journey** – working as an integrated continuum of care to support patients and their loved ones throughout their journey to reintegrate into the community and enjoy the best possible health and quality of life outcomes. Breaking down traditional department silos to enhance access and continuity of care at transition points.
- **Enhancing our communication, both internally and externally** – using interdisciplinary documentation and structured communication tools to ensure that critical patient information is not missed when we hand over to each other or to other teams.
- **Encouraging questions** – when our patients and their loved ones feel comfortable asking questions about their care, they gain confidence in playing an active role.

**Surveyors could:**

- Review interdisciplinary care plans
- Talk to any discipline about how they communicate the care plan
- Observe interdisciplinary team meetings (i.e. rounds or huddles)
- Talk to partners who refer to, or receive patients from our programs about how well we communicate with them
- Review transfer forms, checklists, protocols, interdisciplinary notes
- Talk to patients and their loved ones about their experience of care, involvement in decision-making, and continuity at transition points

**We want to hear from you!**
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