**Required Organizational Practice (ROP):** Information relevant to the care of the client is communicated effectively during care transitions

| 9.10.1 | The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge. |
| 9.10.2 | Documentation tools and communication strategies are used to standardize information transfer at care transitions. |
| 9.10.3 | During care transitions, clients and families are given information that they need to make decisions and support their own care. |
| 9.10.4 | Information shared at care transitions is documented. |
| 9.10.5 | The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:  
- Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer  
- Asking clients, families, and service providers if they received the information they needed  
- Evaluating safety incidents related to information transfer. |

**ON TRAC (Transitioning Responsibly to Adult Care):**
Transfer from Pediatric to Adult health care Services

- Transition Clinical Practice Guideline
- Transition Clinical Pathway
- Medical Transfer Summary
- Notification of completed transfer to adult service
- Youth Quiz and Parent Checklist
- Online Toolkit at [www.ontracbc.ca](http://www.ontracbc.ca)
- Evidence of documentation in patient health record
- ONTRAC audits clinical practice assessments, stakeholder readiness tools
- Online patient and family feedback
- Staff feedback and evaluation