Coordination of Care: Practice Advice for Registered Nurses and Nurse Practitioners

PUBLISHED DATE: SEPTEMBER 25, 2026

Purpose

This practice advice provides guidance to **REGISTRANT(S)**[1] practising in diverse roles and settings when engaging in **COORDINATION** of care. It applies when registrants are working with **CLIENTS**, their caregivers and other members of the **HEALTH-CARE TEAM** to provide health services that are tailored to the client's needs across the health system.

This document complements existing CRNA standards and guidance. It does not replace regulatory requirements or create additional obligations. Registrants remain responsible for meeting all applicable CRNA standards, code of ethics and legislative requirements. Registrants remain accountable to practice setting policies that outline roles and responsibilities and further direct coordination of care activities.

The purpose of this guidance is to support registrants in coordinating care through a person-centred approach, effective provider to provider communication, planning for continuity across systems, assessment of environment and context, and monitoring and evaluation of care.

Introduction

Coordinated care helps people navigate complex health and social systems by ensuring that care remains connected across providers, settings and time. Effective coordination can benefit all people, including providers, by improving access to care, health outcomes, health literacy and self-care, job satisfaction, efficiency of services and overall cost (World Health Organization (WHO), 2016).

In Canada, approximately 30 per cent of people report experiencing gaps in coordination during transitions between providers or settings (Canadian Institutes of Health Research, 2019). Breakdowns in communication, information sharing, medication reconciliation and **CARE TRANSITIONS** can lead to safety risks, duplication of services and poor health outcomes including avoidable hospital admissions and readmissions (WHO, 2018).

[1] Words and phrases displayed in BOLD CAPITALS upon first mention are defined in the Glossary.

Because of their close and ongoing relationships with clients and their understanding of clinical, social and other determinants of health, registrants have a central role in coordination of care whether that role is formal or not. Through therapeutic relationship building with clients and **COLLABORATION** with other health-care providers, registrants support coordination of care.

This document focuses on how care is organized and connected, and the CRNA's *Collaborative Care: Practice Advice* focuses on how providers work together. The two practice advice documents are complementary and can be used together to support safe, integrated and person-centred care that is accessible across providers, settings and services. This document will be updated as practice evolves.

Guiding Principles

See page 7, *Applying the Guiding Principles: Questions to Consider*, for reflective questions that support the application of the guiding principles in practice. These questions should be considered in relation to the client, the practice setting and the care situation.

A Person-centred Care Approach

PERSON-CENTRED CARE is an approach that supports and encourages the client and their caregivers to actively engage in the design, planning, implementation and evaluation of care. Coordination begins with a clear understanding of the client's individual circumstances, preferences, communication needs, and health goals.

When using a person-centred care approach, registrants:

- Seek to understand the individual circumstances, preferences, communication needs, and health goals of the client.
- Engage the client and their caregivers (with the client's consent) as active participants in their care.
- Consider health literacy, language preferences, accessibility needs, safety and respect when engaging clients and caregivers.
- Share information in ways that are understandable and supportive of informed participation in decision making.
- Develop and contribute to **EVIDENCE-INFORMED** plans for care aligned with the client's individual circumstances and preferences.
- Establish intended outcomes and risks of negative outcomes, identifying what would be the most meaningful for the client.
- Anticipate the need for ongoing assessment, **EVALUATION** and care adjustment.
- Provide education about the care coordination efforts being made, and how the client and their caregivers can participate in decision making and planning.

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Example: Asking the client, “what matters most to you?” and centering their expressed health goals when making decisions together about how care will be coordinated.

Provider-to-provider Communication to Support Coordination

Effective provider-to-provider communication is foundational to coordination of care and underpins all coordination activities. Handovers and care transitions are particularly vulnerable to communication breakdowns and gaps in information sharing, making deliberate and structured communication practices critical during these moments.

Frequent, timely, accurate and problem-solving communication supports knowledge exchange, shared goals and mutual respect across the health-care team. Registrants help ensure information flows consistently across providers and settings, balancing access to relevant client information with protection of client privacy.

When engaging in provider-to-provider communication, registrants:

- Use and disclose health information in accordance with the Health Information Act (2000), *Privacy and Management of Health Information Standards,* and practice setting policies and procedures.
- Communicate in a transparent, respectful and understandable manner.
- Ensure relevant clinical and contextual information follows the client.
- Confirm shared understanding of exchanged information, including clarity around roles, responsibilities and next steps.
- Maintain clear, consistent and accessible documentation to support continuity across providers and settings.
- Apply structured tools and processes for care transitions and handovers where possible (see Table 1. Examples of Structured Communication Tools). Consult setting-specific policies and procedures as required.

Example: During a care transition, the sending and receiving providers use a structured handover tool to guide the exchange of information. The tool creates a shared process for asking questions, clarifying concerns and confirming next steps, helping all team members contribute regardless of differences in role, experience or position.

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Table 1. Examples of Structured Communication Tools

S B A R [1]	
Communicating information for immediate attention	
S	**Situation:** What is going on with the person receiving care?
B	**Background:** What is the clinical background or context?
A	**Assessment:** What do I think the problem is?
R	**Recommendation or Request:** What would I do to correct it?

Closed Loop[1] Communication:
Verbal feedback during time-critical moments
Call Out: Sender initiates a message with clear, specific instructions naming the task and the actor.
Check Back: Receiver repeats the message to confirm understanding.
Teach Back: Sender acknowledges correctness or restates the message until accurate.

I - P A S S [1]	
Handover tool for care transitions	
I	**I**llness Severity: Stable, watcher, unstable.
P	**P**atient Summary: Events leading to admission, hospital course, ongoing assessment, plan of care.
A	**A**ction List: To-do list, timelines and ownership.
S	**S**ituation Awareness & Contingency Planning: Know what's going on, plan for what might happen.
S	**S**ynthesis by Receiver: Summarize what was heard, ask questions, restate key actions.

I - D R A W [2]	
Handover tool for care transitions	
I	**I**dentify patient and most responsible health practitioner.
D	**D**iagnosis, current problems, relevant history and risks.
R	**R**ecent changes in the last few hours or days (assessment, vital signs, etc.).
A	**A**nticipated changes or care needs, outstanding tasks or tests.
W	**W**hat to watch for, identify concerns, ask questions and clarify.

Note. [1]Adapted from *TeamSTEPPS 3.0 Team Strategies and Tools to Enhance Performance and Patient Safety* by Agency for Healthcare Research and Quality. (2023). [2]Adapted from *IDRAW Handover Communication Tool* by Alberta Health Services. (2020).

Coordination for Continuity of Care

Effective coordination is central to continuity of care. Coordination refers to the activities that connect care, while continuity refers to the client's experience of care remaining connected over time. Continuity of care is achieved through collaborative approaches (see *Collaborative Care Practice Advice*) that integrate services across care settings and along the care pathway. It means strengthening ongoing relationships between clients and their care

providers, sharing information including the client's preferences and health goals, and coordinating a plan of care to meet the client's needs.

When coordinating for continuity of care, registrants:

- Review setting specific policies, including those that outline roles and responsibilities, to learn how they support the coordination of care activities. A registrant who has concerns that the policies do not support the coordination of care activities is encouraged to raise those concerns using established channels.
- Ask clients to provide their primary care providers (PCP) name and location during initial interactions, if they do not have a primary provider registrants assist clients in identifying available options (see https://albertafindaprovider.ca/)
- Discuss the potential benefits of establishing an ongoing relationship with a PCP and health-care team.
    - NP registrants and self-employed registrants must ensure policies and procedures are in place for continuity of care (see *Self-Employed Practice Advice*).
- Contribute to the plan of care in accordance with their respective scope of practice.
- Engage the client and their caregivers to contribute to the plan of care and check in on their ability to meet with their health-care team as needed.
- Provide information tailored to the client and their situation during care transitions or discharges to enable ongoing care, encourage the client and their caregivers to raise questions.
- Complete documentation and transfer of information, following practice setting requirements, to ensure that relevant information will follow the client across settings and providers.

Example: Explaining to a client that building a relationship with a PCP can lead to earlier detection and better management of illnesses, improved coordination to other health and social services, and better quality of health and overall satisfaction.

Assess Environment and Context

Coordination of care occurs within clinical, organizational, community and social contexts. Registrants assess factors that may influence the delivery and coordination of care, including the safety of the practice environment and available resources. Registrants recognize that factors such as housing, income, transportation, education and social support, among others, can influence health outcomes and access to care. Coordination efforts consider these factors when planning, connecting and evaluating services.

When assessing the environment and context, registrants:

- Assess the overall safety of the practice environment for clients receiving care and members of the health-care team.
- Identify the human, material and organizational resources required to provide safe and efficient care.

- Support connections between available health, social and community services and resources that may support the client's health goals and needs.
- Recognize barriers that may limit access to care and work with the client, their caregivers, and health-care team to identify and implement accessible solutions.
- Communicate concerns about resource limitations or risks to safety to the client, health-care team and appropriate organizational contacts, as needed, and collaborate to adjust plans and priorities to minimize harm.

Example: Recognizing that a client's social isolation may be affecting their health and well-being, the registrant helps the client access local community services and coordinates with other providers to incorporate these into the client's overall plan of care. Registrants can use or direct clients to a resource like 211 Alberta https://ab.211.ca/

Monitor and Evaluate Coordination Activities

Coordination of care is a dynamic and ongoing process that requires monitoring, evaluation and adaptation to support better care experiences and improved client outcomes. Registrants assess the effectiveness of coordinated care and work with the client and the health-care team to adjust approaches in response to changing needs, contexts and goals.

When monitoring and evaluating coordination activities, registrants:

- Engage the client in evaluating their experiences and outcomes, and in raising opportunities for improved care coordination.
- Determine an appropriate plan for ongoing monitoring, re-assessment and evaluation of the plan of care.
    - Registrants practising in **EPISODIC CARE** environments consider how relevant information will be communicated to the client's PCP.
- Identify emerging risks, gaps or changes in needs, and adjust coordination approaches proactively in accordance with their respective scope of practice.
- Participate in **QUALITY IMPROVEMENT**, patient safety and evaluation initiatives.
- If a concern arises:
    - Consider what happened or what did not happen, that jeopardized or created a risk to acceptable outcomes.
    - Disclose safety concerns and incidents to the client and other team members (See *Addressing Unsafe Practice Situations Practice Advice*).
    - Collaborate to address or resolve concerns as soon as possible.
    - Report and document any concerns in accordance with legislation, regulatory standards and setting-specific policies.

Example: The client reflects that they are receiving conflicting information about next steps from providers across their health-care team. The registrant works with the client and health-care team to clarify the plan, improve information sharing and evaluate whether the changes improve the client's experience of coordinated care.

Applying the Guiding Principles: Questions to Consider

Person-centred Care
What matters most to the client? Have the client's goals, preferences and circumstances informed coordination decisions?
Do the client and their caregivers understand the plan of care and how they can participate in the coordination of care?
Have intended outcomes and potential risks been discussed with the client?
Communication
What information needs to be shared to support safe and coordinated care?
Do all providers have a shared understanding of the plan, next steps and responsibilities?
Are structured communication processes used to support a handover or transition?
Continuity of Care
Does the client have a primary care provider? Do they know how to find one?
How will care remain connected across providers, settings and services?
Does the client know who to contact if questions or concerns arise?
Has relevant information followed the client?
Environment and Context
What factors in the client's life may support or limit access to care?
What health, social or community supports may help achieve the client's health goals?
Are there safety concerns or resource limitations that need to be addressed?
Monitoring and Evaluation
Have the client and their caregivers been asked about their experience of care coordination?
Have changes in needs, risks or circumstances been identified?
What adjustments are needed to better support the client's health goals and outcomes?

Related Documents

Code of Ethics

Documentation Standards

Privacy and Management of Health Information Standards

Scope of Practice for Nurse Practitioners

Scope of Practice for Registered Nurses

Addressing Unsafe Practice Situations: Practice Advice

Collaborative Care: Practice Advice

Self-Employed Practice: Practice Advice for Registered Nurses

External Resources

Alberta Find a Provider Home | Alberta Find a Provider

Alberta 211 (Find programs and services in your community) 211 Alberta - Help Starts Here

Alberta Health Services Navigating Your Healthcare Journey

Healthcare Excellence Canada Patient Engagement Framework

Health Quality Alberta Framework for an Integrated People-Centred Health System

Health Quality Alberta Tips for Talking to your Healthcare Team

Institute for Safe Medication Practices Canada Hospital Readmissions Associated with Medication Incidents during Transitions of Care

World Health Organization Continuity and Coordination of Care

Glossary

CARE TRANSITION – The points when a client moves to, or returns from, a particular physical location or contact with a particular health-care professional to ensure safe and effective coordination and continuity of care. This includes between home, hospital, long-term care, outpatient clinic, etc. It is more than a clinical handover (World Health Organization, 2016)

CLIENT(S) – The term client(s) refers to patients, residents, families, groups, communities and populations who receive medical care, treatment or professional services from a registrant.

COLLABORATE (OR COLLABORATION) – Client care involving joint communication and decision making processes among the client, the nurse, and other members of a health-care team who work together to use their individual and shared knowledge and skills to provide optimum client-centred care. The health-care team works with clients toward the achievement of identified health outcomes, while respecting the unique qualities and abilities of each member of the group or team. (Canadian Nurses Association, 2010)

COORDINATION – The deliberate and accountable organization and integration of health services through effective communication and shared decision making with the client and care team to support the safe and person-centred delivery of care that is responsive to evolving needs across time and settings.

EPISODIC CARE – A single clinical encounter with the client for a defined health-care need, where neither the registrant nor the client has the expectation of continuing care and the therapeutic and professional relationship.

EVALUATION – The assessment of actual versus expected outcomes of care for the purpose of adjusting one's actions as required towards achieving the best potential health outcomes for clients.

EVIDENCE-INFORMED – The process of combining the best available evidence through a variety of sources such as research, grey literature, experience, context, experts, and client experiences and perspectives.

HEALTH-CARE TEAM – Members of the intraprofessional and/or interprofessional team and/or community supporting patient care. This also includes students, new learners, Indigenous and traditional healers (College of Nurses of Ontario, 2023)

PERSON-CENTRED CARE – An approach to nursing and health care in which the individual's values, preferences, needs, and life context are respected and responded to, engaging them as an active partner in planning, decision-making, and delivery of holistic, safe and compassionate care (adapted from World Health Organization, n.d.).

REGISTRANT(S) – Includes registered nurses (RNs), graduate nurses (GNs), certified graduate nurses (CGNs), nurse practitioners (NPs), graduate nurse practitioners (GNPs), neonatal nurse practitioners (NNPs), graduate neonatal nurse practitioners (GNNPs) and RN, NP or NNP courtesy registrants on the College of Registered Nurses of Alberta registry.

QUALITY IMPROVEMENT – A systematic, data-guided approach to improving processes and outcomes in health care by identifying gaps, testing changes, and implementing evidence-based strategies to enhance safety, effectiveness and patient experience (Institute for Healthcare Improvement, 2024).

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