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

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Purpose

This practice advice provides guidance to registered nurses (RNs), graduate nurses (GNs), certified graduate nurses (CGNs), nurse practitioners (NPs) and graduate nurse practitioners (GNPs), herein referred to as **REGISTRANT(S)**[1]. The purpose of this document is to provide guidance for the **COORDINATION** of care that applies to registrants working in diverse roles and practice settings.

This practice advice is grounded in existing RN and NP Standards of Practice.

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 reduced overall costs (World Health Organization (WHO), 2016). Through assessment, clinical judgement, and **COLLABORATION**, registrants support coordination and ensure care remains aligned with the values, goals, and preferences of the people receiving care.

When coordination is not effective, care is experienced as fragmented. 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). In Canada, approximately 30% of people report experiencing gaps in coordination during transitions between providers or settings (Canadian Institutes of Health Research, 2019).

Registrants have a central role in coordination of care because of their close and ongoing relationships with people receiving care and their understanding of clinical, social, and system factors that influence health.

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

This document focuses on how care is organized and connected, and the College of Registered Nurses of Alberta's (CRNA's) *Collaborative Care: Practice Advice* focuses on how providers work together. This document will be updated as practice evolves.

Principles

A Person-Centred Care Approach

PERSON-CENTRED CARE is an approach to care that enables and encourages the **CLIENT** to actively engage in the design, planning, implementation, and evaluation of care. Coordination begins with a clear understanding of the person's goals, values, preferences, and context.

Registrants gather and interpret information to develop a comprehensive understanding of the person's health needs, risks, and desired outcomes. Registrants share information in ways that are understandable, responsive to an array of needs, and supportive of informed participation in decision-making, including consideration of the language of choice of the person receiving care (Canadian Patient Safety Institute & Health Standards Organization, 2020). Registrants ensure that care provided is **EVIDENCE-INFORMED**, individualized, and aligned with what matters most to the person receiving care.

When applying a person-centred care approach, registrants:

- Seek to understand the unique values, goals, and preferences of the client.
- Engage the client as a member of the care team.
- Share information in ways that are 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 identify risks of negative outcomes.
- Anticipate the need for ongoing assessment, **EVALUATION**, and adjustment.
- Provide education about the care coordination efforts being made, and how people can participate in decision-making.

Provider-to-Provider Communication to Support Coordination

Effective communication is foundational to coordination of care and underpins all coordination activities. Frequent, timely, accurate, and problem-solving communication strengthens relational coordination by supporting knowledge exchange, shared goals, and mutual respect across the care team (Bolton et al., 2021).

Handovers and transitions of care are particularly vulnerable to communication breakdowns and gaps in information sharing, making deliberate and structured communication practices

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critical during these moments. Effective communication, including the appropriate use of digital tools and communication technologies, helps ensure information flows consistently across providers and settings. Registrants are accountable for ensuring the timely transfer of relevant clinical and contextual information, maintaining ongoing information exchange, and documenting care clearly with the client and the broader care team.

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

- Communicate in a transparent, respectful, and understandable manner.
- Ensure timely, accurate, and complete transfer of relevant clinical and contextual information.
- Confirm shared understanding of exchanged information, including clarity around roles, responsibilities, and next steps.
- Use data sharing tools, and communication technologies appropriately.
- Apply structured tools and processes for care transitions and handovers, where appropriate, and evaluate them for continuous improvement.
- Maintain clear, consistent, and accessible documentation to support continuity across providers and settings.

Coordination for Continuity of Care

Coordinated care is achieved through collaborative approaches that integrate services across care settings and along the care pathway. Coordination involves jointly identifying and prioritizing care needs, fostering shared understanding across roles, and supporting evidence-informed and shared decision-making to enable person-centred care (Khatri et al., 2023).

Effective coordination is central to continuity of care. Unplanned hospital readmissions often signal that follow-up processes or information exchanges have broken down, revealing persistent challenges in ensuring safe transitions (Health Quality Alberta, n.d.). Registrants contribute to continuity across all encounters by strengthening connections across providers, settings, and services, including the person receiving care.

When coordinating amongst providers, registrants:

- Confirm that policies (employer/organizational/self-employed), including those that outline roles and responsibilities, support the coordination of care activities.
- Maintain collaborative relationships with the client and members of the care team.
- Clarify and align roles and responsibilities for next steps, follow-up, and ongoing coordination.
- Engage in shared decision-making and co-design approaches that value an array of knowledges and experiences.
- Support safe handovers and transitions of care by aligning plans, next steps, and follow-up across providers and settings.

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- Participate in team processes that encourage reflection, shared learning, and continuous improvement.

NURSE PRACTITIONERS AND SELF-EMPLOYED REGISTRANTS HAVE ADDITIONAL CONSIDERATIONS TO ENSURE CLIENTS EXPERIENCE COORDINATED CARE

Assess Environment & Context

Coordination of care includes connecting people with services across health, social and community sectors. Health care is delivered in dynamic clinical, organizational, and community environments that vary across practice settings and over time. Registrants assess the broader context and adapt coordination approaches to support safe and efficient access.

Integrated models of care emphasize opportunities for intersectoral action to address the social determinants of health (WHO, 2018). Registrants consider how system factors, including access to promotive, preventive, and community resources influence care coordination and outcomes.

When assessing the environment and context, registrants:

- Evaluate the overall safety of the practice environment for people receiving care and members of the care team.
- Identify the human, material, and organizational resources required to provide safe and efficient care.
- Support connections between health, social, and community resources to address broader needs.
- Identify and address barriers that may limit access to health care, supporting equitable and innovative solutions.
- Communicate concerns about resource limitations or risks to safety and collaborate to adjust plans and priorities to minimize harm.

Monitor and Evaluate Coordination of Care

Coordination of care is a dynamic and ongoing process that requires continuous monitoring, evaluation, and adaptation to support optimal outcomes. In complex systems, care coordination requires continuous reflection and adaptation informed by real-time information to address barriers, improve appropriateness, and sustain care delivery (Malakellis et al., 2026). Registrants assess the effectiveness of coordinated care and work with the client and the care team to adjust approaches in response to changing needs, contexts, and goals.

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When monitoring and evaluating coordination of care, registrants:

- Use the nursing process to assess, monitor, and evaluate the effectiveness of the plan of care in relation to the client's goals, preferences, and desired outcomes.
- Engage the client in evaluating their experiences and outcomes, and in identifying opportunities for improvement.
- Determine an appropriate plan for ongoing monitoring, re-assessment, and evaluation of the plan of care, including for **EPISODIC CARE** encounters.
- Identify emerging risks, gaps, or changes in needs, and adjust coordination approaches proactively.
- Participate in **QUALITY IMPROVEMENT**, patient safety and evaluation initiatives.
- If a concern arises, assess the situation:
  - 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.
  - Collaborate to address or resolve concerns as soon as possible.
  - Report and document any concerns in accordance with legislation, regulatory standards, and employer policies.

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Decision-Making Framework

When making coordination of care decisions, three key factors must be assessed.

Factor	Questions
Person-Centred Care	What are the values, goals, and preferences of the person receiving care?
	What are the intended health outcomes? What is the plan of care for achieving the intended outcomes? What are the risks of negative outcomes?
	Do people understand the plan, their role, and what to expect in the coordination of care?
	Has relevant information followed the person across settings? Do people understand the information being exchanged?
Continuity of Care	Does legislation, regulation, scope of practice, and policy authorize the performance of required activities by the provider?
	Are roles, responsibilities, and accountabilities clearly defined and aligned across providers?
	Do providers have the knowledge, skills, experience, and support required to provide safe and coordinated care?
	How will communication and coordination be maintained across handovers, transitions, and changes in care needs?
Care Environment	What are the human, material, and organizational resources required to provide safe and efficient care?
	Can the broader care context including caregivers, social networks, and community resources be incorporated into care planning?
	What are the barriers that may limit access to care? Can equitable and innovative solutions be identified?
	What processes are in place to support planning for continuous monitoring, diagnostic test follow-up, re-assessment, and evaluation of the plan of care?

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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, 2016b)

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 SERVICE(S) – "A service provided to people

(i) to protect, promote or maintain their health, (ii) to prevent illness,

(iii) to diagnose, treat or rehabilitate, or

(iv) to take care of the health needs of the ill, disabled, injured or dying" (*Health Professions Act*, 2000).

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

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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) and RN or NP courtesy registrants on the College of Registered Nurses of Alberta (CRNA) registry.

RESTRICTED ACTIVITIES – High risk activities that require specific competencies and skills to be carried out safely and are listed in the *Health Professions Act* (2000) and the *Health Professions Restricted Activity Regulation* (Alta Reg 22/2023, s 60) that are part of providing a health service. Restricted activities are not linked to any particular health profession and a number of regulated health practitioners may perform a particular restricted activity.

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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