Box 1: Transitions of Care Checklist

Support for patient, families and caregivers may include:

- ☐ Written discharge instructions and recommendations that identify collaborative actions plans, follow-up care and goals
- ☐ Access to a designated contact person in the hospital or community for care continuity and queries
- ☐ Ongoing access to and advice from health and social service organizations appropriate to needs and stage of transition and recovery
- ☐ Links to and information about local community agencies such as stroke survivor groups, peer survivor visiting programs, meal provider agencies, and other services and agencies
- ☐ Shared decision making/participation regarding transitions between stages of care
- ☐ Counseling, preparation and ongoing assessment for adjustment to change of living setting, change in physical needs and increased dependency, change in social roles and leisure activities, impact on other family members (e.g., spouse or partner, children), loss of home environment, and potential resource issues
- ☐ Access to restorative care and active rehabilitation to improve and/or maintain function based on the individualized care plan
- ☐ Advance care planning, palliative care and end-of-life care as applicable
- ☐ Where possible, access to peer (survivor/family), who has experienced the transition and who can help the patient better understand the transition
- ☐ Accurate and up to date information about the next care setting, what the patient and family can expect, and how to prepare.