



BMJ Open Stakeholder involvement in care transition planning for older adults and the factors guiding their decision-making: a scoping review

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ABSTRACT

Objective To synthesise the existing literature on care transition planning from the perspectives of older adults, caregivers and health professionals and to identify the factors that may influence these stakeholders' transition decision-making processes.

Design A scoping review guided by Arksey and O'Malley's six-step framework. A comprehensive search strategy was conducted on 7 January 2021 to identify articles in five databases (MEDLINE, Embase, CINAHL Plus, PsycINFO and AgeLine). Records were included when they described care transition planning in an institutional setting from the perspectives of the care triad (older adults, caregivers and health professionals). No date or study design restrictions were imposed.

Setting This review explored care transitions involving older adults from an institutional care setting to any other institutional or non-institutional care setting. Institutional care settings include communal facilities where individuals dwell for short or extended periods of time and have access to healthcare services.

Participants Older adults (aged 65 or older), caregivers and health professionals.

Results 39 records were included. Stakeholder involvement in transition planning varied across the studies. Transition decisions were largely made by health professionals, with limited or unclear involvement from older adults and caregivers. Seven factors appeared to guide transition planning across the stakeholder groups: (a) institutional priorities and requirements; (b) resources; (c) knowledge; (d) risk; (e) group structure and dynamic; (f) health and support needs; and (g) personality preferences and beliefs. Factors were described at microlevels, mesolevels and macrolevels.

Conclusions This review explored stakeholder involvement in transition planning and identified seven factors that appear to influence transition decision-making. These factors may be useful in advancing the delivery of person and family-centred care by determining how individual-level, group-level and system-level values guide decision-making. Further research is needed to understand how various stakeholder groups balance these factors during transition planning in different health contexts.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ This review considered transition planning among the care triad (defined as older adults, caregivers and healthcare professionals).
- ⇒ A wide range of transition experiences were described across the records, involving various care settings and patient conditions.
- ⇒ The identification of factors required subjective interpretation, as few records specifically focused on identifying the factors that guided participants' decision-making.
- ⇒ Participant characteristics were lacking in several records, making it difficult to assess participant diversity.
- ⇒ Some relevant information may have been missed, as inclusion criteria were focused on describing transitions from institutional care settings.

INTRODUCTION

Increased interest in person and family-centred care (PFCC) has emerged over the past several decades.¹ PFCC is an approach to healthcare, whereby care decisions are driven by the individual's needs, preferences and desired outcomes.² In this value-based approach, patients and families are considered partners in their care and contribute important knowledge and experience to care and treatment decisions. The growing popularity of this approach represents an ideological shift from the biomedical model to one that emphasises a holistic view of the individual with specific medical, social, mental, emotional and spiritual needs.³ PFCC policies and practices are now widely recognised as an important indicator of healthcare quality, and many healthcare systems globally are making progress towards achieving a higher standard of PFCC.⁴

While many believe that a PFCC approach is justified on moral grounds,⁵ the benefits of adoption include improved individual-level

and system-level outcomes as demonstrated by studies showing greater self-efficacy, levels of satisfaction and individual well-being⁶⁻⁸ among patients and families. Additionally, PFCC interventions have been associated with a better use of resources and decreased health system costs in certain therapeutic areas.^{6 9 10}

The successful delivery of PFCC may be a particularly important contributor to enhanced management of complex health processes like care transitions. Care transitions are broadly defined as the transfer of patients between different settings, services or care providers.^{11 12} They represent periods of high vulnerability and risk due to the potential for adverse events and breakdowns in communication.¹³ Despite the promise of PFCC, a recent review on care transitions reported a mixed effect of the impact of PFCC on patient-oriented outcomes leading the authors to reflect on the core components of the approach, and conclude that PFCC interventions must incorporate several core components to successfully improve transition outcomes.¹⁴

Shared decision-making (SDM) is often viewed as one of the core components of PFCC.¹⁵ SDM is a collaborative approach to decision-making, whereby health professionals and patients consider options and evidence together before making joint decisions.¹⁶ This approach may be particularly useful in the context of care transitions, since the decisions will likely impact caregivers and health professionals in addition to the patient. Specifically, the outcomes of transition decision-making can influence health professionals' planning and resource allocation, as well as caregivers' responsibilities for care coordination and delivery.

Despite the significant impact that care transition decisions can have on the lives of these stakeholders, there is considerable evidence that patients and families are not included in, and have limited influence over, transition planning and decision-making.¹⁷⁻²⁵ This may be particularly true for older patient populations, as SDM becomes more complex due to their higher health needs and reduced ability to self-manage.²⁶ This lack of involvement is further problematised by the reality that different stakeholders may have conflicting goals during the transition.^{13 27} The absence of patient and family voice during care transitions may therefore result in system goals being prioritised over the goals of the individual patients and their families.¹³

A lack of patient and family involvement in care transition planning and decision-making raises important questions about the quality of care during transitions and the extent to which they are person centred. Therefore, the aim of this review is to synthesise the available literature on care transition planning from the perspectives of older adults, caregivers and health professionals, and identify the core factors that appear to influence transition decision-making. By identifying these factors, we may better determine the extent to which care transitions are person centred, and how they may be strengthened in the future.

METHODS

This scoping review examined care transition planning and decision-making from the perspectives of older adults, caregivers and health professionals. We followed the methods outlined by Arksey and O'Malley²⁸ and adhered to Tricco *et al's*²⁹ Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews checklist to report our findings. Arksey and O'Malley²⁸ advanced a six-step framework for conducting scoping reviews: (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting the data; (5) collating, summarising and reporting; and optionally (6) consulting and translating knowledge. A copy of the review protocol can be accessed by contacting the authors. This scoping review did not involve any direct collection of data from participants; therefore, informed consent was not required.

Inclusion criteria

We included all published literature where the record: (1) reported empirical peer-reviewed research; (2) described a care transition from an institutional care setting (eg, hospital, rehabilitation facility, nursing home) to any other care setting; (3) described decision-making and/or planning related to the transition; and (4) included data collected from the multiple perspectives of older adults, caregivers and health professionals. Data from these multiple perspectives were necessary in order to better understand the extent to which the stakeholder groups were involved in decision-making and the different factors that they considered during their transition experiences. No study type or design restrictions were implemented; however, due to the focus on reporting of stakeholder experiences, included records often adopted qualitative methodologies. Differences in qualitative methodologies and approaches were not accounted for during analysis. Only records published in English were included. Records were excluded when their methodology was unclear and when the perspectives of older adults could not be clearly identified or differentiated from younger participants. A small selection of records describing hypothetical transitions were excluded due to potential differences in predicted and actual transition decisions. Records focused on transitions at the end of life were excluded due to the unique nature of this type of transition and the factors that may be considered by stakeholders. Consistent with scoping review methodology, a critical appraisal to assess the quality of the included records was not undertaken.³⁰

Search strategy

A comprehensive search strategy was developed in consultation with a health sciences librarian at the University of Toronto (online supplemental file 1). The search was designed to retrieve records that described all of the following concepts: (1) a care transition; (2) decision-making or care planning; and (3) the triad perspectives of older adults, caregivers and health professionals (see [table 1](#)). Relevant search terms relating to these concepts

Table 1 Operational definitions of core concepts

Concept	Definition
Institutional care setting	Communal facilities where individuals may dwell for short or extended periods of time and have access to healthcare services. Examples may include: hospitals, rehabilitative centres, nursing homes, long-term care facilities, assisted living facilities, aged care homes, personal care homes, residential facilities, etc.
Care transition	The transfer of patients between different services, providers and/or settings.
Transition planning and decision-making	The process of preparing for a care transition and choosing between multiple options.
Older adult	Person aged 65 years or older.
Caregiver	A family member or friend who provides unpaid care to another person, either at home or in a care institution.
Health professional	A licensed or unlicensed care provider who offers paid medical, treatment or support services to a patient.

were drawn from published reviews and expanded on through a preliminary literature search and using the research teams' existing knowledge. The search strategy was executed in the following databases due to their focus on health research: MEDLINE, AgeLine, Embase, PsycINFO and CINAHL Plus. No date or study design restrictions were imposed. The search strategy was validated by ensuring the retrieval of a selection of key publications identified through a preliminary literature search.

Selection of sources of evidence

The search was executed in January 2021 and all records retrieved were imported into Covidence, a web-based software platform designed to facilitate screening. Duplicates were removed and records were screened in two stages. First, 90% of titles and abstracts were independently reviewed by two authors (SC, KMK) based on preidentified selection criteria. Discrepancies were resolved between the authors through periodic discussions. The remaining 10% of records were screened by one author (SC) as a high degree of screening consistency was observed. In the second stage of screening, two authors (SC, KMK) independently screened and discussed the full text of all remaining records.

Data extraction and synthesis

Two authors (SC, KMK) independently reviewed and charted the data from included records into a detailed data abstraction form. Data charting was used to summarise, organise and interpret the data from the records according to key themes. For each record, the following types of data were extracted: general record information (ie, journal, author, publication date, country of publication, title) and research methods and design (ie, study objective, settings, participant characteristics, methods of data collection and analysis). Information on the factors that influenced transition planning and decision-making was also extracted. Factors were defined as any ideas or circumstances that stakeholders considered when making transition decisions and selecting subsequent care arrangements. Although the authors of some records had explicitly identified these factors (eg, perceived costs of care deterring participants from certain options),

in many cases they were identified iteratively using the central themes reported in the research. To determine the themes, two authors (SC, KMK) identified an initial list of factors that were clearly expressed in the records. Each extracted factor represented a theme, as it was a recurring idea presented across multiple records (online supplemental file 2). The factors were then reviewed by all members of the research team who then refined the list of factors by making suggestions for further grouping or ungrouping. Once the parameters of each factor were defined, one author (SC) reviewed all included records again to ensure that the factors were extracted consistently. One author (SC) then explored and compared these factors by participant type and demographics (eg, sex and ethnicity, when available) and discussed these findings with the research team.

To present an overview of all information retrieved, and to establish the breadth and scope of the literature, the results of the review are reported in two formats: (1) a simple numerical description of the distribution of the records coupled with data visualisations; and (2) a narrative synthesis and content mapping of core topics of interest (online supplemental file 3). Data synthesis and mapping was an iterative process facilitated through multiple team meetings. In these meetings, team members discussed, refined and defined the final list of factors. Due to limited time and resources, the optional sixth step of Arksey and O'Malley's scoping review framework, 'consulting and translation knowledge', was not completed.

Patient and public involvement

No patient was involved.

RESULTS

The initial search resulted in 10 356 records. After deduplication, 7198 records remained for title and abstract screening. A total of 266 full-text records were reviewed, and 39 were included in this review (figure 1). A summary of the characteristics of the included records is presented in table 2. Records were published between

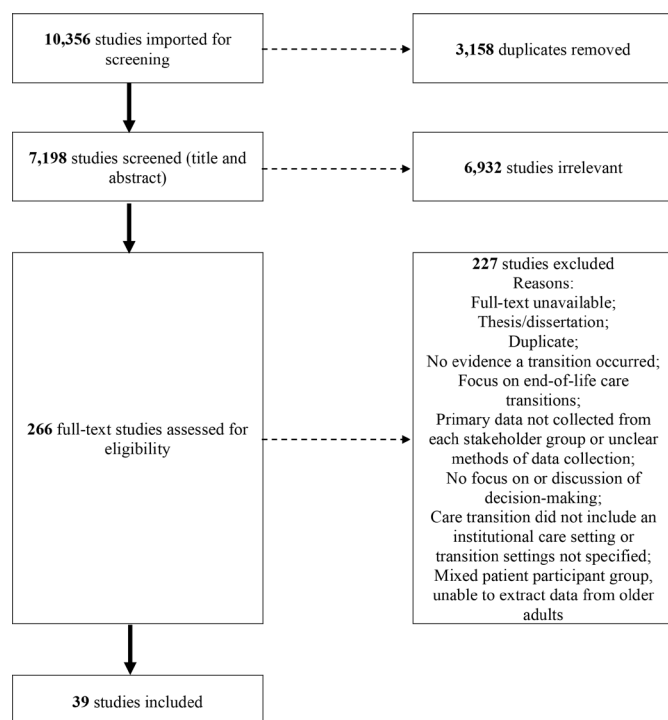


Figure 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram depicting record identification and selection.

Table 2 Overview of included record characteristics (n=39)

Characteristic	n (%)
Year	
1980–1989	1 (2.5)
1990–1999	9 (23)
2000–2009	9 (23)
2010–2015	8 (20.5)
2016–2021	12 (31)
Country	
Australia	1 (2.5)
Canada	15 (38)
Finland	1 (2.5)
Multiple (European)	1 (2.5)
Sweden	3 (8)
USA	13 (33)
UK	5 (13)
Average number of participants	
Older adults	16
Caregivers	19
Health professionals	37
Other	20*
*Only three records included participants categorised as ‘Other’. In all three cases, these participants were described as key informants.	

1981 and 2019, with the majority published in the last 11 years (n=20; 51.3%). Included records described studies conducted in North America (n=28; 71.8%), Europe (n=10; 25.6%) and Australia (n=1; 2.6%).

Nearly all of the included records described qualitative studies (n=37; 94.9%). The remaining two records used mixed methods (5.1%). Common study designs included: ethnography (n=14; 35.9%); case study (n=6; 15.4%); exploratory qualitative (n=6; 15.4%); interpretive research (n=4; 10.3%); and grounded theory (n=3; 7.7%). Interviews were the predominant method for collecting data across the studies (n=37; 94.9%). Records also described observational data collection (n=22; 56.4%), document review (n=13; 33.3%) and focus groups or group workshops (n=4; 10.3%). The majority of included records described studies with more than one method of data collection (n=24; 61.5%).

All studies collected data from the perspectives of older adults, caregivers and health professionals. Many studies included health professionals from the initial transition setting as well as the final transition destination or community (n=16; 41.0%). Three records describing two studies included data from key informants throughout the health system (7.7%). In general, the study populations included more women than men. Only seven studies reported the participants’ ethnicities (17.9%), the majority of whom were white.

A variety of patient populations and transition types were described. Nearly all records described transition experiences from a hospital setting (n=34; 87.1%). Transition destinations varied across the studies; however, in most cases at least a portion of the older adults transitioned home (n=30; 76.9%). Other transition destinations included: nursing homes; retirement homes; skilled nursing facilities; rehabilitation facilities; rest homes; long-term care; and convalescent care homes. In many cases, the older adult participants transitioned between more than two locations.

Degree of stakeholder involvement

The degree of stakeholder involvement in transition planning and decision-making varied across the records. In many cases, there was evidence that health professionals made transition decisions with limited communication with the patients and families.^{18 23 31–50} Decisions were generally made by health professionals in team meetings or through exchange of informal communications. A few records mentioned cases where family conferences were held to include the patient or family in planning.^{34 40 44 49 51–57} Although it was not clearly stated in the records, the authors implied that many decisions were made through informal conversations between health professionals, patients and families. Jewell⁴⁰ noted that although this style of communication was often preferred by health professionals, ‘patients and/or carers felt poorly served by such an approach’ (p 1293). Several records also described limited involvement and knowledge of, communication with and recognition of the role

Table 3 Factors that influence transition planning and decision-making

Factor	Description
Institutional priorities and requirements	Policies and objectives of the organisation or care institution.
Resources	Individual, group or organisational-level supports or assets. These may be tangible (eg, financial) or intangible (eg, time) in nature.
Knowledge	Information and awareness of the patient, the healthcare system and the variety of options available for transition.
Risk	Perceptions of risk and safety associated with a decision.
Group structure and dynamic	The extent to which stakeholders are involved (or not involved) in planning, their agreed-upon roles and responsibilities and the quality of their interpersonal relationships and communication.
Health and support needs	Perceived current and future physical and mental capacity of the patient and their anticipated support needs.
Personality, preferences and beliefs	The individual's unique pattern of thinking, feeling or behaving, and what they want and hope to achieve.

of community health professionals during transitions, creating challenges during and after transitions.^{31 40–42 52} Despite this, there was recognition that involvement of community health professionals could strengthen transition planning and decision-making.¹⁸

Records reported conflicting views on transition planning between stakeholders.^{18 35 36 40 43 58} When patients and families disagreed with health professionals' recommendations, their capacity to make decisions was questioned.^{23 35 56 59} In one study, Durocher *et al* noted that all participants associated ageing with a gradual loss of agency and decline in capacity.³⁴ This led to the expectation among participants that older adults' engagement in decision-making would decline over time. Similarly, other records suggested that some health professionals held paternalistic or ageist attitudes,^{23 32–34 49 52 60} which compromised patients and families' capacity to influence transition planning.

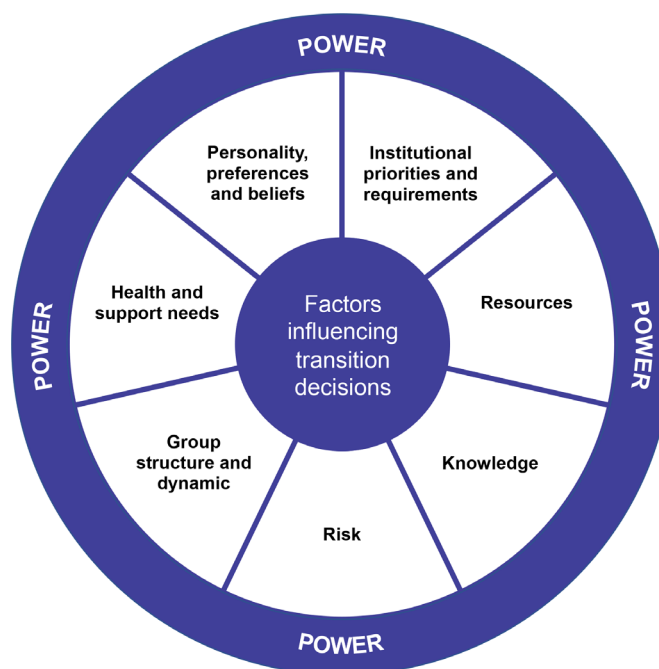
Factors influencing transition planning and decision-making

A variety of factors influencing transition planning and decision-making processes across stakeholder groups were described and are summarised in [table 3](#). These factors included: (a) institutional priorities and requirements; (b) resources; (c) knowledge; (d) risk; (e) group structure and dynamic; (f) health status and support needs; and (g) personality, preferences and beliefs ([figure 2](#)). Typically, the factors were described at the level of the individual (microlevel); however, in some cases, the factors were described at the group levels or system levels (mesolevels and macrolevels).

Institutional priorities and requirements

Several records described how institutional-level and system-level priorities and requirements influenced transition options and decision-making. These institutional priorities were sometimes privileged over the priorities of the patients and families.^{36 49 54} Challenges emerged in transition planning due to requirements of the initial transition settings and the transition destinations. Records

noted that institutions were under pressure to discharge patients as quickly as possible in order to comply with insurance requirements and free up beds.^{32 44 46 49 59 61 62} As a result, discharge planning often began on admission; however, this early focus hindered the process of preparing patients for discharge.^{42 46 47 49 53} In one record, health professionals reported trying to conserve resources by discharging patients on certain days to maximise insurance usage.⁶³ Transition options were further constrained by the admission criteria set by the discharge destinations.^{37 47 63} Lack of space and availability of services in the community exacerbated challenges by limiting transition options.^{41 48} Finally, privacy and confidentiality concerns restricted communication between different stakeholders


Figure 2 Visual display of the factors influencing stakeholders' transition decisions.

both within and between settings, complicating transition planning.^{43 47 62}

Resources

Transition decisions were influenced by the decision support resources available to the patient and family, as well as in the community. Social, psychological, financial and familial resources were identified.^{40 49 59} The most critical resource influencing transition decisions was the availability and support of a caregiver. Caregivers acted as an advocate for the patients during transition planning, ensuring that their interests were upheld.^{18 31 37 46 51 58 64} Lack of caregiver involvement sometimes resulted in care arrangements that the patients did not prefer.^{18 33 65} Caregivers also helped to share information and knowledge with the patient, ensuring that they understood what was happening.³⁹ Despite this, it was important not to over-rely on caregivers, as there were limits to the support that they could provide.^{46 58} Several records also described how financial resources influenced transition decisions. In particular, perceived costs of care might shift the older adults and families' decisions,^{58 63} while availability of health insurance might alter health professionals' recommendations.⁶³ Ultimately, without sufficient social and financial supports, certain transition 'options' were not executable.²³

Time also influenced transition planning, both in terms of its availability as a resource, and identifying the most appropriate timing for decisions. In a few records, health professionals described insufficient time to prepare and plan for the transition.^{33 59 62} Depending on the type of service, different amounts of time were required to prepare.⁵² Similarly, patients and families found that decisions needed to be made rapidly, creating a challenge for transition planning.^{41 46 48} However, limited time was not universal, as Rhynas *et al*¹⁸ found that time pressure had no influence on transition decisions. The success of the care transitions was sometimes dependent on the timing of the decisions being made. Robinson *et al*⁶¹ described how discharge dates may be manipulated by health professionals in order to ensure that relevant staff and services were available. Additionally, since many patients' care needs and capacity fluctuated over time, it was important to make decisions when the patients' condition had stabilised and they could participate effectively.^{40 49 51 56–58 65}

Knowledge

Knowledge of the patient and the various options for transition settings influenced planning. Several records described how patients and families were insufficiently informed and prepared to make or follow a transition plan.^{18 37 38 40 44 46 47 49 54 57} Further, the authors noted that patients and families at times lacked the knowledge to prepare themselves to participate in decisions, or felt ambivalent or reluctant to seek information.^{37 42} This reality constrained decision-making by limiting the patients and families' capacity to participate. Conversely, health professionals' medical expertise garnered them

power and authority when making decisions on behalf of patients and families.²³ Health professionals' confidence in their decisions was strengthened with knowledge of the patients themselves⁶¹ and a clear understanding of their role in transition planning, as well as the roles of others.^{42 46 47 51 62} One record described how health professionals privileged their own knowledge above the knowledge of the patients and families when making decisions.⁵³ Similarly, two records described how health professionals used the knowledge imbalance between themselves and the patients by withholding information about different options.^{37 38} Finally, in some instances, patients, families and health professionals each lacked knowledge and awareness of the benefits and resources available in the community.^{41 51} This impeded transition planning by restricting the number of options under consideration.

Risk

Perceptions of risk and safety had an important influence on how different stakeholders viewed the transitions and justified their decisions. In some cases, health professionals and caregivers delayed or interrupted transitions due to concerns that the older adult was not ready.^{33 50 52} As a result, they sometimes prioritised the older adults' safety over the older adults' preferences.^{18 23 34 53 56} A language of risk was used to justify the transition decisions being made or recommended.¹⁸ In one record, a caregiver 'defined capacity as being capable of making a decision that was safe' (Poole *et al*, p8).⁵⁶ However, stakeholders appeared to weigh the risks associated with each transition option differently. In particular, while older adults were often comfortable transitioning home, health professionals and caregivers sometimes expressed concern with this option. These conflicting views meant that certain transition options could not be executed by the older adults due to the perceived risks that others held.²³

Group structure and dynamic

The quality of the relationships and communication between different stakeholders had an important influence on transition planning. Several records suggested that poor communication and coordination between health professionals challenged transition planning.^{31 40 42 46 51 52 57 61} In particular, limited communication between institutional providers and community providers resulted in poor continuity in care. Unclear responsibilities and roles within teams were also a challenge, therefore some participants suggested having one health professional in charge of coordinating transition efforts.^{33 51 52} It was often unclear whether patients and families were recognised as equally valuable team members during transition planning. Further, several records described how caregivers were often responsible for navigating the health system and arranging services.^{39 41 65 66} Thus, their inclusion in the team was important to ensure successful planning. In fact, Robinson *et al*⁶¹ noted that strong

relationships between family and health professionals led to greater likelihood that all stakeholders would agree on decisions. Ultimately, trust was a recurring theme across the records, as it helped to strengthen all stakeholders' comfort and confidence with the decisions.^{37 44 52 61 62 64}

Health status and support needs

Although a patient's health status and support needs should logically influence their involvement in transition decisions, few records described consideration of this factor. Two records described how the patients' current health statuses impeded their capacity to participate in decision-making.^{37 38} Specifically, patients with sensory loss, language barriers or high medication use had limited opportunities to share their perspectives during planning. Records also referenced discordance between the individuals' preferences for care, and their medical and social needs.^{18 23} In these cases, the patients' health needs were typically prioritised over their preferred choice of care arrangement. Finally, higher health needs influenced transition planning by reducing the number of executable options.^{18 23 48 64} Patients who required complex care needed more health professionals and services to be involved.⁶² For example, Mead *et al*⁶⁴ described how patients were transferred between assisted living facilities as a result of their shifting care needs.

Personality, preferences and beliefs

Many records emphasised the importance of recognising the older adults and families' personalities and incorporating their preferences into transition planning; however, it was unclear whether this occurred in practice. Several records described conflicting stakeholders' views towards transitions, which challenged planning processes.^{35 36 43 58 61} Health professionals in two studies specifically noted difficulty incorporating family preferences into transition decisions.^{43 59} Finally, two records described how older adults' mindsets and attitudes influenced transition planning, suggesting that more positive mindsets led to greater autonomy in decision-making and subsequent care.^{51 60}

DISCUSSION

This review explored stakeholder involvement in transition planning and identified seven key factors that appeared to influence stakeholders' decision-making. Findings were analysed with a specific focus on PFCC to determine the extent to which SDM occurs during care transition planning. SDM is an approach to care planning that is expected to strengthen healthcare experiences and outcomes by better aligning care with the preferences and needs of patients and families; however, it can be challenging to implement in practice due to conflicting stakeholder expectations.

Across the included records, transition decisions were largely made by health professionals. While there was evidence that some patients and families were involved

in the transition planning, their involvement varied on a case-by-case basis. This finding is consistent with existing literature on transition planning,¹⁷ which shows that 'although the majority of older people would wish to be involved in decision-making in practice they are often not encouraged, or enabled, to participate in SDM' (Bunn *et al*, p10).²⁶ Transition decisions were influenced by a variety of microlevel, mesolevel and macrolevel factors. These factors included: (a) institutional priorities and requirements; (b) resources; (c) knowledge; (d) risk; (e) group structure and dynamic; (f) health status and support needs; and (g) personality, preferences and beliefs. The factors both influenced, and were influenced by, the broader context in which decision-making occurred, including who was involved, to what extent and what options were considered.

In reflecting on the range of factors that influenced transition decisions, it appears that power may also play a role. Power impacted the extent to which each factor influenced the transition decisions. Power has been previously defined as 'the degree of control over material, human intellectual and financial resources by different sections of society'⁶⁷ (p 41). In this review, it appeared that power permeated factors like resources, time, knowledge and group structure to impact the transition options under consideration. As Joseph-Williams *et al*⁶⁸ point out, if patients do not know or understand the options available, then they are unable to participate in SDM. To date, many scholars have written about the deep-rooted power imbalances between patients, families and health professionals during clinical encounters. This review affirmed the existence of a power imbalance during transition planning, as health professionals' knowledge and training was often privileged over the patients and families' perspectives. As Kaminskiy⁶⁹ notes, power in SDM can be so pervasive that 'certain groups do not question, but instead accept certain situations without conflict' (p 24). This reality was reinforced in this review, as in many cases patients and families willingly deferred decision-making authority to the health professionals. Similarly, although health professionals appeared to lead decision-making in many cases, their decisions were often impacted by structural factors beyond their control. These included, for example, institutional goals to discharge patients as quickly as possible, and a lack of available bed spaces in the community. According to Thomas *et al*,⁷⁰ these structural factors can have a profound impact on SDM by constraining the control health professionals have over their decisions, and prioritising health system efficiencies over PFCC.

It also appeared that factors were weighed differently depending on the broader context of the transitions. In several records, the older adults' available resources and anticipated health needs took precedence over their preferences for the transition. This was most apparent in records where the older adults expressed a clear preference to return home, and their caregivers or health professionals resisted this transition due to lack of available

supports and perceived risks involved. In several records, factors like health and support needs, risk and resources also influenced health professionals' recommendations for transitional care. The subjective weighting of these factors sometimes led to disagreements between stakeholders. This reality illustrates the lasting influence of the biomedical model, where medical outcomes are valued more highly than other outcomes that might be more meaningful to the individual (eg, quality of life).

Future research might explore the relative weighing of these different factors during transition planning from the perspectives of patients, families and health professionals. As Kaminskiy⁶⁹ comments, SDM is a complex process and power imbalances, conflict between stakeholders and resource constraints have served to limit its uptake in practice. Therefore, greater understanding of how each stakeholder weighs these factors when making transition decisions may offer an opportunity to address these tensions prioritise them and move towards more person and family-centred transition planning.

Although SDM has emerged as a high priority in many health settings, concerns have been raised over the value of the approach and its implementation. For example, some scholars have questioned the assumption that all patients wish and are able to participate in SDM.⁷¹ This finding was also observed in this scoping review as some health professionals and caregivers questioned the capacity of the older adults to safely participate in decision-making. A recent systematic review by Waddell *et al*⁷² observed similar attitudes among health professionals and suggested that these perspectives can act as a barrier to successful SDM implementation. Other clinician-related, patient-related, organisational-level and system-level characteristics can also negatively influence the implementation of SDM, and Elwyn *et al* have argued that recognition of SDM as the 'right thing to do' may not be sufficient to support its implementation in practice.⁷³ Rather, specific strategies from the field of implementation science and evaluation of the broader, long-term outcomes associated with SDM may be required. Some strategies to support the implementation and maintenance of SDM include: training stakeholders in the use of decision support tools, engaging champions to raise awareness and support for SDM, embedding SDM in policies and clinical practice guidelines, offering incentives to participate in SDM and monitoring performance related to SDM.^{74 75} Future research may focus on evaluating the effectiveness of each of these strategies and the short-term and long-term consequences of implementing SDM overall.

Stakeholders' specific social and cultural contexts should also be explored as prior research has shown that patient characteristics (eg, ethnicity, gender) can influence healthcare experiences.⁷⁶ Records included in this review had inconsistent reporting of participant demographics, and often did not offer an in-depth analysis of experiential differences based on participants' age, sex, gender or ethnicity. However, existing literature suggests

that there may be gendered differences in care transition pathways,⁷⁷ and that minority groups may experience enhanced difficulties during care transitions.⁷⁶ This review did find some potential differences in transition planning and decision-making between urban and rural geographies. Specifically, some records reported that rural institutions faced challenges related to access to community care and nuanced differences between rural and urban transition practices and cultures. Yet, while healthcare inequities facing rural populations are often described in health research, further exploration of the multidimensional and heterogeneous healthcare experiences of older adults in rural settings is warranted.⁷⁸

Further research on how the broader context shapes transition planning is also needed. During the COVID-19 pandemic there has been evidence that the factors influencing transition decisions may have been altered or reweighted. For example, in April 2021 the Government of Ontario, Canada issued emergency orders to allow hospitals to transfer patients without consent in an effort to alleviate pressure on the healthcare system.⁷⁹ Additionally, there is evidence that some older adults and families left care institutions like long-term care, a decision that was rarely executed prepandemic.^{80–83} These examples show the significant impact that the broader social and political contexts can have on transition decision-making. Research in this area may help emphasise the complexity of transition planning, and which factors are most critical for guiding decision-making in different contexts. Research may also focus on examining the unique roles of older adults, caregivers and institutional and community health professionals in these new care contexts.

Limitations

This review has some limitations. First, some relevant articles may have been missed due to the complexity of care transitions, the breadth of literature on the topic and limiting records to the English language. Second, while the included records all described transition planning and decision-making, they did not focus specifically on the factors influencing this process. Therefore, the identification of factors required the subjective interpretation of the authors. Despite this, common factors persisted across the records, all of which had been previously described in the literature on care transitions. Third, records included in this review adopted a myriad of designs, approaches and methodologies which result in subtle differences in data and reporting. Although we did not account for these differences when synthesising findings across the records, we focused on consistently defining and extracting our findings across all records. Fourth, there was no patient or family involvement in the identification of factors for this review. Including patient and family representation on the authorship team may have added further nuance to the interpretation of factors and served to validate our findings. Finally, the included records often lacked demographic information on the

sex and ethnicity of participants making it impossible to assess participant diversity across the records.

CONCLUSION

This review described stakeholder involvement in transition planning and identified key factors influencing transition decisions. Findings may be useful for developing a framework on transition planning, guiding future research, raising awareness of the variation in stakeholder involvement during care transitions and supporting the successful implementation of PFCC.

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