TSC Category	Patient Care					
TSC	Care Transition in Nursing					
TSC Description	Provide continuity of care to patients across different settings to ensure smooth transition within teams and across settings					
TSC Proficiency Description	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
			HCE-PTC-3003-1.1	HCE-PTC-4003-1.1	HCE-PTC-5003-1.1	
			Support transitional care plans for patients	Develop transitional care plans and review effectiveness of transitional care	Manage effectiveness of transitional care management programmes to empower patients on active participation of their care	
Knowledge			• Care assessment methods • Integrated care management strategies and/or methods • Patient coaching and behavioural change strategies • Care navigation and coordination skills • Health promotion strategies • Community resource management • Common issues during the transition period • Bio-psychosocial screening • Chronic illnesses management guidelines • Patient-centred interventions to improve chronic diseases outcome • Behaviour change models and practices • Communication strategies for establishing rapport with patients and gaining trust • Resources for patients on continuity of care	• Bio-psychosocial assessment methods • Evidence-based risk factors for hospital readmission • Transitional care management frameworks and strategies • Key indicators of success of transitional care management programmes • Discharge planning and post-discharge follow-up • Management of patients' behavioural change • Learning needs analyses • Patient education guidelines on continuity of care • Resources for patients on continuity of care	• Up-to-date evidence-based transitional care management trends and efficacies in specialty areas • International best standards or practices for behavioural management • Network of professionals across other disciplines and with professional organisations or bodies • Technologies supporting transitional care management especially in the aspect of monitoring progress and continuing education	
Abilities			• Plan patient visits that focus on prevention and care management	• Assess patients who require transitional care management for continuity of care	• Set key performance indicators for transitional care management programmes	

			• Educate family members on available communication programmes and resources according to patients' care needs to aid in recovery post discharge • Support caregivers or significant others in patient care • Provide tailored education and skills training using materials appropriate for different cultures and health literacy levels to prepare patients and caregivers for post-discharge care	• Develop comprehensive care plans • Coordinate care between settings to support care continuity • Review care transition plans • Assess ability of family towards self-management • Identify early signs of deterioration and institute early interventions to avoid hospital admissions • Monitor health outcomes • Refer patients to community programmes and resources to aid in recovery	• Develop transitional care management approaches, frameworks or guidelines in collaboration with expert panel or professional organisations • Introduce innovative strategies in transitional care management to achieve desired outcomes • Lead the appropriate implementation of up-to-date technologies to enhance effectiveness of transitional care management programmes	