## 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

<table>
<thead>
<tr>
<th>TSC Proficiency Description</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>Level 6</th>
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</thead>
<tbody>
<tr>
<td>TSC Category</td>
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<td>HCE-PTC-3003-1.1</td>
<td>HCE-PTC-4003-1.1</td>
<td>HCE-PTC-5003-1.1</td>
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<tr>
<td>TSC Description</td>
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<td>Support transitional care plans for patients</td>
<td>Develop transitional care plans and review effectiveness of transitional care</td>
<td>Manage effectiveness of transitional care management programmes to empower patients on active participation of their care</td>
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### 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 | • Develop comprehensive care plans |
| Support caregivers or significant others in patient care | • Coordinate care between settings to support care continuity |
| 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 | • Review care transition plans |
| • Develop transitional care management approaches, frameworks or guidelines in collaboration with expert panel or professional organisations | • Assess ability of family towards self-management |
| • Introduce innovative strategies in transitional care management to achieve desired outcomes | • Identify early signs of deterioration and institute early interventions to avoid hospital admissions |
| • Lead the appropriate implementation of up-to-date technologies to enhance effectiveness of transitional care management programmes | • Monitor health outcomes |
| • Refer patients to community programmes and resources to aid in recovery |