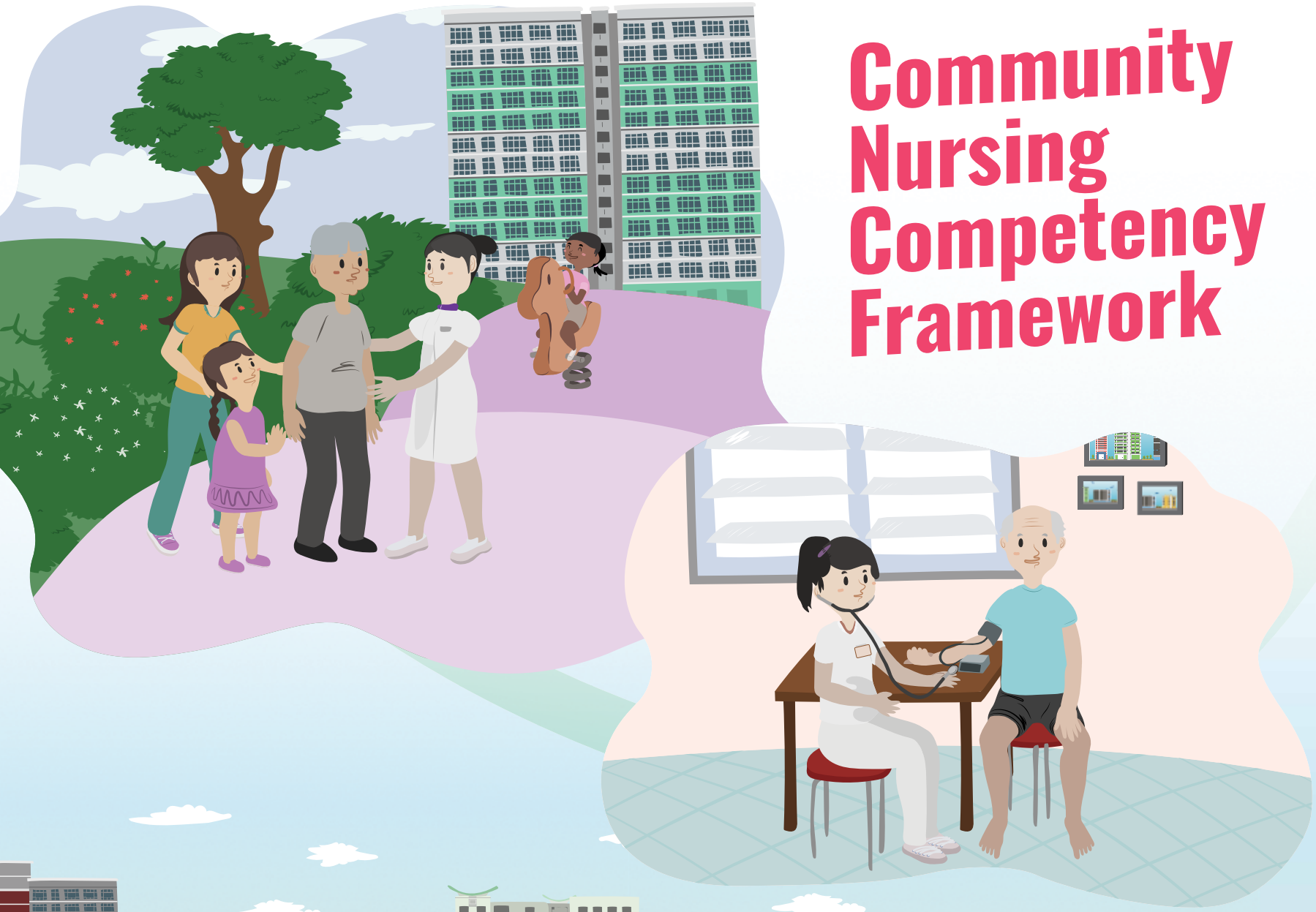
Community Nursing Competency Framework



FOREWORD

With the ageing population in Singapore, our healthcare system is evolving to shift care beyond the hospital to the community. This necessitates the integration of health and social care, and places greater emphasis on developing Singapore's community nursing sector, to meet the care needs of the population. The Ministry of Health (MOH) set up a Community Nursing Competency Framework development workgroup, comprising professionals and nursing leaders to develop a framework that defines the expectations of community nurses by clarifying the scope of work, roles and professional competencies.

The Community Nursing Competency Framework is applicable to all settings and institutions outside of acute hospitals. Current and aspiring community nurses may refer to these documents to understand the roles in community nursing. Organisations would also be able to use these documents to encourage nurses to join the community care sector. The framework could also guide training providers and academic institutions in strengthening their training programmes.

I would like to thank all who have helped develop the Community Nursing Competency Framework and hope that stakeholders will find it useful.

Tan Soh Chin
Chief Nursing Officer
Ministry of Health

INTRODUCTION

COMMUNITY NURSING IN SINGAPORE

"Community nursing" is broadly defined as the autonomous and collaborative care for individuals of all ages, families, and population groups outside the acute hospitals. Community nursing in Singapore focuses on the promotion of health and wellness, prevention of illness, and the care for people with differing abilities, the sick, and the dying, building on a philosophy of care that is characterised by person-centredness, client and family empowerment and continuity of care.

Care provided by community nurses goes beyond the treatment of medical conditions and includes care in other aspects of a client's life such as personal well-being and inculcating long-term health behaviours. With Singapore's changing demographic, client needs and technological advancements, the importance of community nursing is magnified due to the need for more personalised and long-term care. The expectations of nurses working in the community setting are multi-pronged and have increased significantly.

Apart from being adept in the clinical aspects of nursing and providing person-centred care, community nurses should adopt innovative approaches to engage with clients, families and other stakeholders. The growing importance of co-ordinated care and collaboration with relevant stakeholders involved in the delivery of care necessitates the need for community nurses to be strong communicators in order to function effectively. They should possess independent decision-making skills and demonstrate adaptability when faced with different types of situations and stakeholders. They should utilise all available resources and methods to empower clients, families and/or caregivers with the ability to self-manage their health and/or caregiving as well as remain resilient if challenges arise. They need to be empathetic to the needs of clients, families and/or caregivers and endeavour to provide holistic care in collaboration with various care partners. In essence, the key attributes of community nurses are:

- **Innovative**
- **Collaborative**
- **Autonomous and adaptable**
- **Resilient and resourceful**
- **Empathetic**

OBJECTIVES OF THE FRAMEWORK

The Community Nursing Competency Framework (CNCF) has been developed with the support of key stakeholders such as community nursing professionals, employers, certification and professional bodies, and training providers. It is envisaged that the CNCF will serve as a repository that provides up-to-date and forward-looking information on existing and emerging job roles, skills and competencies. Furthermore, the CNCF will guide the enhancement of education and training programmes for the sector. The framework also provides a basis for sector-wide analysis of skills and manpower gaps as well as insights to support the design of programmes to guide the planning and capability building of the community nursing workforce.

Specifically, the framework aims to support and benefit current and aspiring employees, employers, certification and professional bodies, and training providers as follows:

- Provide clarity on their roles and responsibilities, and associated competencies
- Provide a reference for the training and development of nurses in the community care settings
- The training roadmap will allow training providers to:
  - Review and identify the training needs of community nurses
  - Review and update training programmes for community nurses

KEY COMPONENTS

The framework consists of the following key components:

1) Job Role Profiles (JRPs)
2) Professional Competencies (PCs)

Each job role is detailed and defined using a JRP document. This document encompasses a job role description that summarises key contributions and responsibilities, workplace context as well as necessary attributes of an incumbent to be able to perform the job. It also includes the Key Responsibility Areas (KRAs) and Key Activities (KAs) for each job role and the list of PCs at the required proficiency levels.

In addition, a glossary is included at the end of the document.

THE COMMUNITY NURSING COMPETENCY FRAMEWORK

JOB ROLES AND CAREER MAP

The Community Nursing Competency Framework (CNCF) includes 12 Job Roles. These are:

- **Enrolled Nurse**
- **Senior Enrolled Nurse**
- **Principal Enrolled Nurse**
- **Staff Nurse**
- **Senior Staff Nurse**
- **Assistant Nurse Clinician**
- **Nurse Clinician**
- **Senior Nurse Clinician**
- **Assistant Director of Nursing**
- **Deputy Director of Nursing**
- **Director of Nursing**
- **Advanced Practice Nurse (APN)***

The career map shows the progression of community nurses. It indicates the requirements of a diploma or degree in nursing before an Enrolled Nurse can progress to become a Staff Nurse. It also reflects that the APN is not a promotional grade, but rather a professional title reflecting the clinical expertise attained. The career map for community nurses is shown on the next page:

**The term "Advanced Practice Nurse" (APN) is both a job role and professional title that is regulated by the Singapore Nursing Board (SNB). An APN is a Registered Nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for extended practice. APNs, who must have a Master degree in Nursing and attained APN certification from SNB, are trained in the diagnosis and management of common medical conditions, including chronic illnesses. APNs provide a broad range of healthcare services. They work collaboratively with doctors and other healthcare professionals to provide nursing care to patients with complex needs. APNs may also be privileged to prescribe medications if they have completed the National Collaborative Prescribing Programme (NCPP).*

Community Nursing Clinical Career Map

Director of Nursing

Deputy Director of Nursing

Assistant Director of Nursing

Senior Nurse Clinician

Nurse Clinician

Assistant Nurse Clinician

Senior Staff Nurse

Staff Nurse

Advanced Practice Nurse (APN)
Masters prepared and certified by SNB

Nurses are able to hold an additional professional designation as an APN provided they meet the requirements

An Enrolled Nurse has to complete a degree or diploma in nursing to become a staff nurse

Principal Enrolled Nurse

Senior Enrolled Nurse

Enrolled Nurse

NITEC in Nursing

Source: Ministry of Health National Nursing Taskforce, 2014

JOB ROLE PROFILES

There are Job Role Profiles (JRPs) for all 12 job roles identified in the community nursing sector. Each JRP includes the following:

- ***Job Role Title***
- ***Job Role Description***
- ***Key Responsibility Areas***
- ***Key Activities***
- ***List of Professional Competencies (PCs) at required proficiency levels for each job role***

The JRPs developed for the framework are shown below:

ENROLLED NURSE

Job role description	The Enrolled Nurse assists in the delivery of person-centred care and health promotion activities. S/He assists in biopsychosocial assessments and performs basic nursing interventions for clients in collaboration with the healthcare team in accordance with the established policies, procedures and guidelines. S/He assists to communicate care plans to clients, families and/or caregivers and report needs and conditions of the clients to the care team. S/He serves as an advocate for the clients and families/caregivers. S/He assists in the provision of client, family and caregiver training, health coaching and care coordination. The Enrolled Nurse maintains professional competency within the scope of practice. S/He recognises the limits of his/her competence and personal strengths and develops strategies to enable continuous learning and development.

	Key responsibility areas	***Key activities***
Responsibilities and activities	Person-centred Care	Assist in biopsychosocial and environmental assessment of clients
		Perform basic individualised nursing interventions for clients as planned
		Assist in communicating care plans and report clients, families and/or caregivers' needs and goals to the care team
		Provide support to clients in activities of daily living in consideration of their abilities
		Assist in medication administration and education for medication adherence
		Monitor and report changes/abnormalities of clients' health and social condition(s)
		Maintain timely and accurate documentation
		Maintain conducive environment for clients' health and safety
	Client and Community Engagement and Empowerment	Build rapport with clients, families and/or caregivers and the community
		Maintain therapeutic relationships and professional boundaries when dealing with clients, families and/or caregivers, and community partners
		Assist in providing training and health coaching for clients, families and/or caregivers
		Support the implementation of teaching strategies to promote clients' self-management

	Key responsibility areas	***Key activities***
Responsibilities and activities (Cont'd)	Client and Community Engagement and Empowerment (cont'd)	Motivate clients in appropriate health seeking behaviours
		Assist in health promotion and preventive health activities for individuals and the community
	Care Transition and Integration	Assess the clients' needs for care and support services and inform the nursing team for appropriate follow-up
		Assist in referring and linking clients, families and/or caregivers to other care providers in the care team
		Assist in the facilitation of follow-up care for clients
	Nursing Practice Management and Operational Excellence	Participate in quality assurance activities
		Assist in quality improvement, evidence-based practice or research projects
		Participate in peer sharing sessions on nursing-related issues
		Comply to personal safety measures while practicing in various community care settings
		Identify and report risks and barriers to the safety of clients
		Practise infection control precautionary measures
		Execute responsibilities as per emergency protocols in the event of public health threat or emergency
		Comply with guidelines and policies to ensure client confidentiality and personal data protection
	People and Personal Development	Attend continuing professional development courses based on learning needs
		Supervise and teach support care staff and/or students
		Set personal development goals and plans for career progression

	Competency domains	***Competency elements (Proficiency Level)***
Professional Competencies	D1. Person-centred Care	E1. Client Assessment and Care Planning (Level 1) E2. Management of Individuals with Health Conditions (Level 1) E3. Medication Management (Level 1) E4. Client, Family and Caregiver Education and Empowerment (Level 1) E5. Care Transition Across Care Continuum (Level 1) E6. Communication, Collaboration and Teamwork (Level 1) E7. Client and Environment Safety and Risk Management (Level 1)
	D2. Population-based Practice	E8. Population-based Practice (Level 1)
	D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 1) E10. Develop and Lead Others (Level 1)
	D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 1) E12. Evidence-based Practice and Research (Level 1)

SENIOR ENROLLED NURSE

Job role description	The Senior Enrolled Nurse contributes to the assessment, planning and delivery of person-centred care based on clients' needs and preferences. S/He provides client, family and caregiver training, health coaching and assists in care coordination. The Senior Enrolled Nurse also supervises, teaches and assesses junior staff members and support care staff. The Senior Enrolled Nurse is adept at inter-professional collaboration and communication skills to navigate the health and social ecosystems to provide care for the clients.

Responsibilities and activities	***Key responsibility areas***	***Key activities***
	Person-centred Care	Perform biopsychosocial and environmental assessment of clients
		Assist in planning and delivering individualised nursing interventions for clients
		Communicate care plan and address concerns from clients, families and/or caregivers
		Provide support to clients in activities of daily living in consideration of their abilities
		Administer non-parenteral medication, monitor medication adherence and provide relevant education in accordance with the institution's protocol and guidelines
		Escalate changes/abnormalities of clients' health and social conditions in a timely manner and initiate appropriate interventions within his/her scope of practice
		Maintain timely and accurate documentation
		Maintain conducive environment for clients' health and safety
	Client and Community Engagement and Empowerment	Build rapport with clients, families and/or caregivers and the community
		Maintain therapeutic relationships and professional boundaries when dealing with clients, families and/or caregivers, and community partners
		Provide training and health coaching to clients, families and/or caregivers
		Assess individuals' learning needs and implement teaching strategies to promote self-management
		Motivate clients in appropriate health seeking behaviours
		Participate in health promotion and preventive health activities within the scope of practice
	Care Transition and Integration	Provide information to clients and families on available community resources, services and programmes
		Suggest referrals for care and support according to needs and/or preferences
		Facilitate follow-up care for clients with inter-disciplinary care team

Responsibilities and activities (Cont'd)	***Key responsibility areas***	***Key activities***
	Nursing Practice Management and Operational Excellence	Participate in quality assurance activities
		Participate in quality improvement, evidence-based practice or research projects
		Conduct peer sharing sessions on nursing-related issues
		Identify and report risks/hazards in various community care settings to ensure safety of self and other team members
		Monitor compliance to infection control precautionary measures
		Initiate appropriate measures to minimise actual or potential risks and barriers to the safety of clients
		Execute responsibilities as per emergency protocols in the event of public health threat or emergency
		Comply with guidelines and policies to ensure client confidentiality and personal data protection
	People and Personal Development	Attend continuing professional development courses based on learning needs
		Provide supervision, teaching and assessment of junior staff of the care team and/or students
		Contribute to the development of goals and career progression plans of junior nurses

Professional Competencies	***Competency domains***	***Competency elements (Proficiency Level)***
	D1. Person-centred Care	E1. Client Assessment and Care Planning (Level 1)
		E2. Management of Individuals with Health Conditions (Level 1)
		E3. Medication Management (Level 1)
		E4. Client, Family and Caregiver Education and Empowerment (Level 2)
		E5. Care Transition Across Care Continuum (Level 1)
		E6. Communication, Collaboration and Teamwork (Level 2)
		E7. Client and Environment Safety and Risk Management (Level 1)
	D2. Population-based Practice	E8. Population-based Practice (Level 1)
	D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 1)
		E10. Develop and Lead Others (Level 1)
	D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 1)
		E12. Evidence-based Practice and Research (Level 1)

PRINCIPAL ENROLLED NURSE

Job role description	The Principal Enrolled Nurse assesses, plans, delivers and evaluates person-centred care. S/He ensures that basic care interventions and support are delivered and coordinated for the clients. S/He is expected to make relevant care decisions while reporting back for client care planning and evaluation. S/He participates in broader service development and quality improvement projects. The Principal Enrolled Nurse possesses a good understanding of the healthcare system and community resources. S/He has strong interpersonal and communication skills to navigate the ecosystem, collaborate and coordinate care with various stakeholders.

Responsibilities and activities	***Key responsibility areas***	***Key activities***
	Person-centred Care	Assess biopsychosocial and environmental care needs of clients
		Evaluate individualised nursing interventions for clients
		Plan individualised care plan for clients using assessment of clients' needs
		Evaluate client's, families and/or caregiver's understanding of the proposed care plans and goals
		Administer medication, promote medication adherence and provide relevant education in accordance with institution's protocol and guidelines
		Manage changes/abnormalities of clients' health and social conditions and escalate appropriately
		Maintain timely and accurate documentation
		Maintain conducive environment for clients' needs and preferences
	Client and Community Engagement and Empowerment	Build rapport with clients, families and/or caregivers and the community
		Build therapeutic relationship and maintain professional boundaries when dealing with clients, families and/or caregivers, and community partners
		Provide and evaluate training and health coaching to clients, families and/or caregivers
		Assess individuals' learning needs and plan teaching strategies to promote self-management
		Motivate clients in appropriate health seeking behaviours and evaluate effectiveness of the approach
		Plan health promotion and preventive health activities within the scope of practice
	Care Transition and Integration	Recommend the community resources, services and programmes required by the clients with increasing needs
		Provide feedback on the effectiveness of recommended care referrals and suggest improvements
		Coordinate follow-up care for clients in collaboration with the interdisciplinary care team
		Promote interdisciplinary care delivery in collaboration with relevant community partners

Responsibilities and activities (Cont'd)	***Key responsibility areas***	***Key activities***
	Nursing Practice Management and Operational Excellence	Participate in quality assurance activities
		Support quality improvement, evidence-based practice or research projects
		Plan peer sharing sessions on nursing-related issues
		Identify and report risks/hazards in various community care settings to ensure safety of self and other team members
		Monitor compliance to infection control precautionary measures
		Provide guidance to junior nurses on measures to prevent actual or potential risks and barriers to the safety of clients
		Execute responsibilities as per emergency protocols in the event of public health threat or emergency
		Comply with guidelines and policies to ensure client confidentiality and personal data protection
	People and Personal Development	Attend continuing professional development courses based on learning needs
		Support development of training programmes for junior nursing staff
		Provide supervision, teaching and assessment of junior staff of the care team and/or students
		Participate in formulating career progression of junior nurses

Professional Competencies	***Competency domains***	***Competency elements (Proficiency Level)***
	D1. Person-centred Care	E1. Client Assessment and Care Planning (Level 2) E2. Management of Individuals with Health Conditions (Level 1) E3. Medication Management (Level 1) E4. Client, Family and Caregiver Education and Empowerment (Level 2) E5. Care Transition Across Care Continuum (Level 1) E6. Communication, Collaboration and Teamwork (Level 2) E7. Client and Environment Safety and Risk Management (Level 2)
	D2. Population-based Practice	E8. Population-based Practice (Level 1)
	D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 2) E10. Develop and Lead Others (Level 1)
	D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 1) E12. Evidence-based Practice and Research (Level 1)

STAFF NURSE

Job role description	The Staff Nurse is responsible for performing care assessment, planning and management in accordance with established community nursing policies, standards and evidence-based practices. S/He collaborates with the interdisciplinary team and community partners to achieve quality holistic care. S/He facilitates care transition of clients and coordinates with various stakeholders and community resources. S/He initiates service development and quality improvement projects. The Staff Nurse provides client, family and/or caregiver education as well as promotes health and well-being. S/He guides and supervises the support care team, junior staff and students. S/He recommends initiatives and implements quality improvement, evidence-based practice or research projects.

Responsibilities and activities	***Key responsibility areas***	***Key activities***
	Person-centred Care	Perform biopsychosocial and environmental assessments to identify strengths and needs of clients, families and/or caregivers
		Communicate with the client's healthcare providers, families and/or caregivers to understand clients' needs
		Develop person-centred nursing care plans with consideration of clients' needs and preferences
		Communicate care plans and address concerns from clients, families and/or caregivers
		Perform evidence-based nursing interventions as prescribed in the care plan
		Perform medication administration, titration in accordance with organisational guidelines and protocols
		Support clients' ability for medication self-management and medication adherence and escalate to relevant care team members for medication reconciliation and optimisation
		Manage and escalate appropriately in the event of unexpected and/or abnormal changes
		Facilitate Advance Care Planning discussions
		Maintain timely and accurate documentation
	Client and Community Engagement and Empowerment	Involve clients, families, caregivers and/or relevant others as active partners, to identify needs, preferences and expectations of the clients
		Build therapeutic relationships and maintain professional boundaries when dealing with clients, families, caregivers and/or community partners
		Provide effective training and education to clients, families and/or caregivers according to self-management needs
		Identify clients, families and/or caregivers who are suitable to adopt technologies, and support relevant training
		Engage relevant stakeholders to educate and/or empower clients, families and/or caregivers for self-management
		Utilise various motivational techniques to engage clients, families and/or caregivers in health improvement and disease management
		Implement health promotion and preventive care activities for individual or population groups
	Care Transition and Integration	Assist clients in navigating care systems based on needs, resources and preferences of clients, families and/or caregivers
		Initiate care referrals based on client's needs, readiness, preferences and care goals in consultation with the interdisciplinary team
		Coordinate care among the interdisciplinary health and social care team with the involvement of clients, families and caregivers
		Assist clients, families and/or caregivers in transitioning between care settings according to the available framework

Responsibilities and activities (Cont'd)	***Key responsibility areas***	***Key activities***
	Nursing Practice Management and Operational Excellence	Assess his/her practices against established organisational guidelines and standards to improve self-efficiency
		Support quality audits to maintain and improve standards of care
		Recommend initiatives and implement quality improvement, evidence-based practice or research projects
		Identify risks/hazards and take appropriate measures as per established policies and procedures to ensure his/her safety at the workplace
		Practise safety and infection control precautionary measures
		Support early identification of health threat risks to clients and/or population through information and/or data gathered
		Identify and report risks and barriers to the safety of clients in accordance with organisational protocols
		Execute responsibilities as per emergency protocols in the event of public health threat or emergency
		Comply with guidelines and policies to ensure client confidentiality and personal data protection
	People and Personal Development	Attend continuing professional development activities based on learning needs
		Acquire practice-based learning through applying and reflecting on his/her knowledge and practice
		Identify and highlight actual and/or potential non-adherence to standards of nursing practices
		Provide feedback on the effectiveness of training programmes implemented
		Embrace a positive learning culture within the nursing team
		Participate in development of training roadmap for career progression

	Competency domains	***Competency elements (Proficiency Level)***
Professional Competencies	D1. Person-centred Care	E1. Client Assessment and Care Planning (Level 2) E2. Management of Individuals with Health Conditions (Level 2) E3. Medication Management (Level 2) E4. Client, Family and Caregiver Education and Empowerment (Level 2) E5. Care Transition Across Care Continuum (Level 2) E6. Communication, Collaboration and Teamwork (Level 2) E7. Client and Environment Safety and Risk Management (Level 2)
	D2. Population-based Practice	E8. Population-based Practice (Level 1)
	D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 2) E10. Develop and Lead Others (Level 1)
	D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 2) E12. Evidence-based Practice and Research (Level 2)

SENIOR STAFF NURSE

Job role description

The Senior Staff Nurse is responsible for performing care assessment, planning and management for clients with multiple care needs. S/He collaborates with the interdisciplinary team and community partners to develop holistic care plans. S/He facilitates care transition and care coordination for clients with health and social care needs. S/He initiates and participates in quality improvement and evidence-based projects and implements quality improvement activities within own area of work.

The Senior Staff Nurse contributes in the planning of client/caregiver education and health promotion programmes. S/He precepts junior nurses and contributes to continuing professional development activities.

Responsibilities and activities

Key responsibility areas	Key activities
Person-centred Care	Analyse biopsychosocial and environmental assessment to prioritise needs and leverage strengths of clients, families and/or caregivers
	Engage the interdisciplinary team to gain insights for clients with complex care needs and align care goals
	Review person-centred care plans and recommend appropriate modifications according to clients' changing needs
	Explain care plans to clients, families and/or caregivers for clients with complex needs
	Perform evidence-based nursing interventions
	Perform medication administration, titration in accordance with organisational guidelines and protocols
	Facilitate medication self-management and medication adherence for clients and escalate to relevant care team members for medication reconciliation and optimisation
	Manage unexpected and abnormal changes of clients' health and social conditions and ensure appropriate reporting and/or escalation
	Facilitate Advance Care Planning discussions
	Maintain timely and accurate documentation
Client and Community Engagement and Empowerment	Assess clients, families, caregivers and/or the community's needs and readiness for community care interventions
	Build therapeutic relationships and professional boundaries when dealing with clients, families, caregivers and/or community partners
	Provide individualised training and education to clients, families and/or caregivers according to prioritised self-management needs
	Introduce technology appropriate for clients, families and/or caregivers to support self-management and caregiving
	Assess clients' response and provide feedback on the interventions recommended by relevant care team members
	Tailor appropriate motivational techniques to engage and activate clients, families or population groups
	Coordinate health promotion and preventive care activities for individuals or population groups
Care Transition and Integration	Equip clients to navigate care systems based on needs, resources and preferences of clients, families and/or caregivers
	Prioritise and recommend referrals based on clients' needs, preferences and care goals in consultation with the interdisciplinary team
	Coordinate care among interdisciplinary health and social care teams for clients with complex care needs
	Empower clients, families and/or caregivers to encourage independence in managing care transitions

JOB ROLE PROFILES

Responsibilities and activities (Cont'd)

Key responsibility areas	Key activities
Nursing Practice Management and Operational Excellence	Assess the practices of junior nurses against established organisational guidelines and standards to improve efficiency and cost-effectiveness
	Perform quality audits to maintain and improve standards of care
	Recommend initiatives and implement quality improvement, evidence-based practice or research projects
	Identify risks/hazards and take appropriate measures as per established policies and procedures to ensure safety of self and other team members
	Practice and supervise other team members on safety and infection control precautionary measures to reduce the risk of errors, complications and infections
	Identify and report potential health threat risks to clients/population groups with similar characteristics through information and/or data gathered
	Identify and pre-empt actual or potential risks and barriers to the safety of clients in accordance with organisational protocols
	Execute responsibilities as per emergency protocols in the event of public health threat or emergency
	Comply with guidelines and policies to ensure client confidentiality and personal data protection
People and Personal Development	Attend continuing professional development courses based on learning needs
	Supervise the nursing team to ensure that approved standards of nursing practices are followed at all times
	Provide feedback on performance to the junior members of the care team
	Promote a learning culture among junior nurses for the improvement of client and staff safety
	Co-facilitate a training programme for skill development
	Participate in development of training roadmap for career progression
	Provide in-service education to the healthcare team

Professional Competencies

Competency domains	Competency elements (Proficiency Level)
D1. Person-centred Care	E1. Client Assessment and Care Planning (Level 3) E2. Management of Individuals with Health Conditions (Level 2) E3. Medication Management (Level 2) E4. Client, Family and Caregiver Education and Empowerment (Level 2) E5. Care Transition Across Care Continuum (Level 2) E6. Communication, Collaboration and Teamwork (Level 2) E7. Client and Environment Safety and Risk Management (Level 2)
D2. Population-based Practice	E8. Population-based Practice (Level 2)
D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 2) E10. Develop and Lead Others (Level 2)
D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 2) E12. Evidence-based Practice and Research (Level 2)

ASSISTANT NURSE CLINICIAN

Job role description

The Assistant Nurse Clinician is responsible for leading her/his team and ensuring the delivery of safe and quality care. S/He provides guidance in the coordination of care among the interdisciplinary care teams and across care settings for clients with complex care needs. S/He contributes to the development of the community nursing policies, standards and evidence-based practices. S/He assesses outcomes of quality improvement, evidence-based practice and/or research projects. S/He supports the quality audits within the team.

The Assistant Nurse Clinician assists in overseeing the delivery of client, family and/or caregiver education and health promotion programmes. S/He provides clinical supervision, precepts the junior nurses, and contributes to community nursing training.

Responsibilities and activities

Key responsibility areas	Key activities
Person-centred Care	Analyse biopsychosocial and environmental assessment results of clients to identify complications and initiate follow-up actions
	Facilitate interdisciplinary team discussions to gain insights for clients with complex care needs and align care goals
	Evaluate person-centred care plans and prioritise care goals
	Communicate care plans to clients, families and/or caregivers for clients with complex needs
	Perform evidence-based practice for complex and/or specialised nursing interventions
	Perform medication administration, titration and address factors related to medication adherence in collaboration with the interdisciplinary team
	Manage unexpected and abnormal changes of clients' health and social conditions and provide guidance to the team accordingly
	Facilitate Advance Care Planning discussions
	Maintain timely and accurate documentation
Client and Community Engagement and Empowerment	Advocate for clients', families', caregivers' and/or the community's needs and their readiness for community care interventions
	Build therapeutic relationships and professional boundaries when dealing with clients, families, caregivers and/or community partners
	Evaluate effectiveness of client, family and/or caregiver training and education and recommend follow-up actions
	Introduce technology to promote self-management and well-being of clients
	Collaborate with care team members and community partners to recommend appropriate interventions for clients
	Propose strategies to engage clients, families, population groups and/or the care partners for health improvement and disease management within the community
	Organise health promotion and preventive care activities for individuals or population groups
Care Transition and Integration	Guide care navigation for clients with complex care needs
	Streamline and recommend referrals based on clients' needs, preferences and care goals in consideration of resource availability and efficiency
	Provide guidance in the coordination of care among the interdisciplinary care teams and across care settings for clients with complex care needs
	Address gaps in care transitions encountered by clients, families and caregivers, or the junior nurses

Responsibilities and activities (Cont'd)

Key responsibility areas	Key activities
Nursing Practice Management and Operational Excellence	Review team's practices against established organisational guidelines and standards to improve efficiency and cost-effectiveness
	Facilitate quality audits within the organisation
	Evaluate quality improvement, evidence-based practice or research projects for follow-up/implementation
	Guide the nursing team on techniques to mitigate risks to personal safety when working in unpredictable environments using established policies and procedures
	Execute corrective actions to improve safety and infection control practices
	Analyse gathered information and/or data to identify health threat risks for clients and/or clusters for escalation
	Use appropriate measures to identify and report actual or potential risks and barriers to the safety of clients in accordance with organisational protocols
	Execute responsibilities as per emergency protocols in the event of public health threat or emergency
	Provide guidance to junior staff to ensure client confidentiality and personal data protection
People and Personal Development	Attend continuing professional and leadership development courses based on learning needs
	Supervise the nursing team to ensure adherence to standards of nursing practice
	Provide feedback on performance to the care team members
	Promote a learning culture within the team
	Assist in the development and delivery of training programmes
	Participate in the development of training roadmap for career progression
	Provide in-service education to the healthcare team
	Support initiatives for staff welfare to encourage and motivate the care team

Professional Competencies

Competency domains	Competency elements (Proficiency Level)
D1. Person-centred Care	E1. Client Assessment and Care Planning (Level 3) E2. Management of Individuals with Health Conditions (Level 3) E3. Medication Management (Level 2) E4. Client, Family and Caregiver Education and Empowerment (Level 3) E5. Care Transition Across Care Continuum (Level 2) E6. Communication, Collaboration and Teamwork (Level 2) E7. Client and Environment Safety and Risk Management (Level 2)
D2. Population-based Practice	E8. Population-based Practice (Level 2)
D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 3) E10. Develop and Lead Others (Level 2)
D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 2) E12. Evidence-based Practice and Research (Level 2)

NURSE CLINICIAN

Job role description	The Nurse Clinician is responsible for providing clinical supervision, evaluating care standards and integrating evidence-based practice into community nursing practice. S/He demonstrates clinical expertise and manages clients with complex care needs through direct care or by coaching the care team members. The Nurse Clinician has an understanding of the health profile and population needs to ensure service alignment. S/He manages a team of community nurses and is responsible for their professional development. S/He leads quality improvement and research projects within the organisation. S/He cultivates a collaborative team culture and effective learning environment for the community nurses to achieve clinical excellence and positive client experiences.

Responsibilities and activities	***Key responsibility areas***	***Key activities***
	Person-centred Care	Analyse biopsychosocial and environmental assessment findings to identify actual and potential complications and evaluate follow-up actions of the team
		Facilitate interdisciplinary team discussions to align and prioritise care goals
		Evaluate person-centred care plans, incorporating anticipatory care needs, in consultation with the interdisciplinary team
		Manage clients with complex care needs in collaboration with the interdisciplinary care team and the larger community care systems
		Perform medication management including administration, titration, reconciliation and education in accordance with organisational guidelines and protocols
		Recognise early signs of deterioration in clients, intervene and escalate appropriately
		Engage clients, families and caregivers for Advance Care Planning in collaboration with primary care teams
		Ensure timely and accurate documentation is performed by the care team as per organisational standards and guidelines
	Client and Community Engagement and Empowerment	Build partnerships with the available formal and informal care partners in the community
		Maintain therapeutic relationships and professional boundaries when dealing with clients, families, caregivers and/or community partners
		Tailor education and training activities for clients, families and/or caregivers according to their learning styles and readiness
		Develop plans to raise awareness and adoption of new technologies to promote self-monitoring and management of health conditions
		Implement population-based interventions for health promotion and disease prevention
	Care Transition and Integration	Anticipate and recommend initiatives to address common transitional care needs of the clients
		Prioritise referrals based on clients' needs, preferences and care goals with consideration of resource availability and efficiency
		Build strong relationships with the health and social care partners particularly for clients receiving shared care to ensure an effective flow of care information

Responsibilities and activities (Cont'd)	***Key responsibility areas***	***Key activities***
	Nursing Practice Management and Operational Excellence	Understand health profiles and needs of clients and/or population groups and implement services to meet these needs
		Assist in developing community nursing guidelines and protocols to guide clinical and professional practices
		Monitor the community nursing team's practice on resource management and recommend strategies to reduce waste in service delivery, care and treatment
		Ensure the appropriateness and cost-effectiveness of practices, equipment and products used for the clients
		Lead quality audits, quality improvement and evidence-based projects
		Identify and report potential threats to the practice of ethical and legal principles in community nursing service delivery
		Conduct risk assessment to identify risks and safety hazards of community nursing practice and implement measures to mitigate risks identified
		Execute responsibilities as per emergency protocols in the event of public health threat or emergency
	People and Personal Development	Attend formal and informal continuing education and training based on his/her learning and professiona development needs
		Define and communicate the team's purpose and individual's roles and responsibilities
		Identify and support the learning needs of individuals or the team in response to personal development needs or service needs
		Develop training roadmap for the community nurses in his/her area of community practice
		Encourage the care team to adopt strategies for reflective learning
		Provide clinical supervision and coaching in his/her area of community practice
		Implement strategies to improve welfare and well-being of the community nurses

Professional Competencies	***Competency domains***	***Competency elements (Proficiency Level)***
	D1. Person-centred Care	E1. Client Assessment and Care Planning (Level 3) E2. Management of Individuals with Health Conditions (Level 3) E3. Medication Management (Level 3) E4. Client, Family and Caregiver Education and Empowerment (Level 3) E5. Care Transition Across Care Continuum (Level 3) E6. Communication, Collaboration and Teamwork (Level 3) E7. Client and Environment Safety and Risk Management (Level 3)
	D2. Population-based Practice	E8. Population-based Practice (Level 3)
	D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 3) E10. Develop and Lead Others (Level 3)
	D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 3) E12. Evidence-based Practice and Research (Level 3)

SENIOR NURSE CLINICIAN

Job role description

The Senior Nurse Clinician is responsible for monitoring and evaluating the effectiveness, safety and efficiency of community nursing practices. S/He develops evidence-based practice guidelines and policies, and defines care standards in collaboration with others. S/He supports the development of new models and strategies to improve care delivery and integration, incorporating inter-professional and inter-agency collaborative approaches. S/He is highly experienced in her/his areas of community practice, and manages clients through direct care or by providing consultation to the community nursing team.

The Senior Nurse Clinician proactively reviews, identifies and addresses care and service gaps. S/He advocates and develops innovative care interventions to meet the changing needs of individual clients and/or population groups. S/He assumes management responsibilities and oversees training and development of community nursing teams.

Responsibilities and activities

Key responsibility areas	Key activities
Person-centred Care	Analyse biopsychosocial and environmental assessment findings to identify actual and potential complications and recommend follow-up actions
	Evaluate person-centred care plans and re-prioritise care goals in consideration of the changing needs and support systems of the client
	Provide insights to the interdisciplinary care team on the management of clients with complex care issues
	Provide consultation on the escalated care management of client's health and social conditions
	Perform medication management including administration, titration, reconciliation and education in accordance with organisational guidelines and protocols
	Recognise early signs of deterioration in clients, intervene and escalate appropriately
	Develop strategies to involve and encourage client, family and caregiver in Advance Care Planning
	Ensure timely and accurate documentation is performed by the care team as per organisational standards and guidelines
Client and Community Engagement and Empowerment	Build networks to enhance community care systems for the clients and/or population groups by incorporating formal and informal care resources
	Maintain therapeutic relationships and professional boundaries when dealing with clients, families, caregivers and/or community partners
	Ensure availability and accessibility of self-management education and training for the clients, families and/or caregivers
	Identify and evaluate technology for self-management of health conditions by clients, families and/or caregivers
	Develop implementation plans for population-based interventions in collaboration with the interdisciplinary team
	Lead the community nursing team in the implementation of population-based interventions
Care Transition and Integration	Develop and implement frameworks to address common transitional care needs of the clients, families and/or caregivers
	Develop measures for the interdisciplinary and multi-agency teams to work collaboratively to support individual clients, families and/or caregivers

Responsibilities and activities (Cont'd)

Key responsibility areas	Key activities
Nursing Practice Management and Operational Excellence	Assess health priorities, needs and changing demographics of the population to proactively ensure service alignment
	Implement healthcare policies, legislations and professional regulatory framework
	Develop clinical care management and escalation frameworks for community nursing for his/her area of community practice
	Develop evidence-based guidelines and protocols for community nursing practice within the appropriate governance framework
	Manage the budgeting, acquisition and utilisation of resources by the community nursing team
	Evaluate outcomes and develop outcome indicators for community nursing practice
	Appraise current evidence, disseminate outcomes and provide appropriate recommendations
	Develop staff awareness on risk assessment and management especially when working in unpredictable environments
	Evaluate the effectiveness of measures to mitigate risks identified in community nursing practice
	Execute responsibilities as per emergency protocols in the event of public health threat or emergency
People and Personal Development	Attend formal and informal continuing education and training based on his/her learning and professional development needs
	Strategise purpose and goals for his/her team and align the development of roles and responsibilities across levels
	Identify and support the learning needs of individuals or the team in response to personal development needs or service needs
	Oversee the development of the training roadmap for the community nurses in his/her area of community practice
	Develop and promote platforms for reflective learning
	Develop effective team systems for ongoing supervision and preceptorship
	Implement strategies to improve welfare and well-being of the community nurses

Professional Competencies

Competency domains	Competency elements (Proficiency Level)
D1. Person-centred Care	E1. Client Assessment and Care Planning (Level 4) E2. Management of Individuals with Health Conditions (Level 4) E3. Medication Management (Level 4) E4. Client, Family and Caregiver Education and Empowerment (Level 3) E5. Care Transition Across Care Continuum (Level 3) E6. Communication, Collaboration and Teamwork (Level 3) E7. Client and Environment Safety and Risk Management (Level 3)
D2. Population-based Practice	E8. Population-based Practice (Level 3)
D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 3) E10. Develop and Lead Others (Level 3)
D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 3) E12. Evidence-based Practice and Research (Level 3)

ADVANCED PRACTICE NURSE

Job role description	The Advanced Practice Nurse is responsible for providing complex and extended nursing practice through direct care and/or consultation. S/He demonstrates highly specialised knowledge in her/his areas of community practice. S/He uses advanced clinical and decision-making skills to assess and diagnose health conditions. S/He prescribes treatments and therapies to manage actual or potential health issues in collaboration with the interdisciplinary team. S/He may practise across different care settings. S/He advances nursing roles in the community by undertaking new practices and innovating care models. S/He provides education and training to nurses and/or students in both practice and academic settings. S/He drives the development of evidence-based practice, integrating theoretical and practice-based knowledge to influence the development of community nursing practices and policies at local and/or national levels.

	Key responsibility areas	***Key activities***
Responsibilities and activities	Person-centred Care	Perform advanced health assessment incorporating history taking, physical examination and diagnostic reasoning skills
		Perform anticipatory care planning and management of clients in consideration of their biopsychosocial status and wider determinants of health
		Initiate therapies and interventions to manage actual or potential health issues in collaboration with the interdisciplinary team
		Provide recommendations to the interdisciplinary care team on management of clients with complex care needs
		Perform medication management including administration, titration and reconciliation in accordance with organisational and national guidelines and protocols
		Prescribe medication to clients based on identified health conditions in adherence to collaborative prescribing guidelines*
		Recognise early signs of changing health conditions and deterioration, and intervene in a timely manner and appropriately at the suitable place of care
		Facilitate appropriate Advance Care Planning discussions with clients, families and/or caregivers in accordance with their preferences, changing health status and needs
		Maintain timely and accurate documentation
	Client and Community Engagement and Empowerment	Develop evidence-based, population-focused health initiatives in collaboration with other health and social care experts
		Evaluate the effectiveness of population-based interventions for health promotion and disease prevention
	Care Transition and Integration	Initiate referrals according to clients' needs, preferences and care goals within the available clinical privileging framework

	Key responsibility areas	***Key activities***
Responsibilities and activities (Cont'd)	Nursing Practice Management and Operational Excellence	Innovate clinical care models and services based on the health profile and identified needs of the population
		Develop, review and update clinical policies, guidelines and protocols based on contemporary evidence
		Provide consultation to the team on performing clinical outcome evaluations and developing clinical outcome indicators for community nursing practice
		Lead the development and implementation of research projects and evidence-based practice related to community nursing
		Contribute to national and local policies and strategies related to community nursing practice
	People and Personal Development	Provide advanced practice-based training to community nursing team to address knowledge and skill gaps in clinical and professional practice
		Develop specialised community care training programmes for interdisciplinary learning
		Provide clinical supervision, coaching and assessment of junior Advanced Practice Nurses, students and interns

	Competency domains	***Competency elements (Proficiency Level)***
Professional Competencies	D1. Person-centred Care	E1. Client Assessment and Care Planning (Level 4) E2. Management of Individuals with Health Conditions (Level 4) E3. Medication Management (Level 4) E4. Client, Family and Caregiver Education and Empowerment (Follow JRP) E5. Care Transition Across Care Continuum (Follow JRP) E6. Communication, Collaboration and Teamwork (Follow JRP) E7. Client and Environment Safety and Risk Management (Follow JRP)
	D2. Population-based Practice	E8. Population-based Practice (Follow JRP)
	D3. Professional Development and Leadership	E9. Develop and Lead Self (Follow JRP) E10. Develop and Lead Others (Follow JRP)
	D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Follow JRP) E12. Evidence-based Practice and Research (Follow JRP)

NOTE: *Only applicable to APNs who have completed the National Collaborative Prescribing Programme (NCPP) and who are credentialed by their institution.

ASSISTANT DIRECTOR OF NURSING

Job role description	The Assistant Director of Nursing is responsible for providing leadership and oversight for safe and competent community care delivery in alignment with the organisational strategic directions and national healthcare priorities. S/He oversees the development and implementation of evidence-based nursing guidelines and protocols within the available clinical governance framework. S/He evaluates the standards and outcomes of the community nursing service and drives continuous improvement on productivity, quality and client experience. S/He develops processes, systems and capabilities to support care transition and drive care integration in collaboration with key stakeholders. S/He advocates for the needs and well-being of community nurses, motivates them for personal and professional development through coaching and mentorship. She provides feedback on national policies and strategies related to community nursing practice.

	Key responsibility areas	***Key activities***
Responsibilities and activities	Client and Community Engagement and Empowerment	Partner with community care providers to expand the range of community services
		Gather and evaluate feedback from clients, families, caregivers and/or community partners on community nursing service design and outcome evaluations
		Reinforce nurses' practice in maintaining therapeutic relationships and professional boundaries with clients, families, caregivers and/or community care providers
		Implement best practices to enhance engagement with clients, families and/or caregivers for self-management, shared decision-making and client care support
		Define the community nursing role in client and community engagement and empowerment, and develop measures for enhancing health literacy, enabling informed choices and supporting community development
	Care Transition and Integration	Implement strategies for care integration to meet the health and social needs of individual clients and population groups
		Promote and implement a systems-approach to care transition and coordination
		Develop strategies for clients and the community to navigate care systems
	Nursing Practice Management and Operational Excellence	Translate healthcare policies, legislations and professional regulatory framework into practice
		Participate in the development and implementation of a person-centred care delivery model
		Support cultivating organisational culture and aligning strategies, goals and framework to enable the delivery of person-centred care
		Support and monitor the delivery of the nursing care model, processes and practices
		Lead the implementation of best practices and innovation in nursing care delivery
		Oversee the development and implementation of evidence-based nursing guidelines and protocols

	Key responsibility areas	***Key activities***
Responsibilities and activities (Cont'd)	Nursing Practice Management and Operational Excellence (Cont'd)	Manage the planning, allocation and efficient utilisation of resources by the community nursing team
		Oversee quality improvement activities within the department
		Assist in the development of organisational procedures and guidelines for risk management
		Manage the implementation of crisis interventions and emergency procedures in crisis situations
		Plan and implement strategies for the management of health threats
	People and Personal Development	Oversee performance management and appraisal outcomes of the nursing team
		Identify his/her and teams' performance gaps and recommend strategies to bridge those gaps
		Evaluate training and development programmes and identify areas for improvement
		Identify high potentials and provide mentorship to develop effective nursing leaders
		Implement strategies to promote staff welfare and raise staff morale
		Participate in opportunities to influence local and national policies on community care capacity and capability building

	Competency domains	***Competency elements (Proficiency Level)***
Professional Competencies	D1. Person-centred Care	E4. Client, Family and Caregiver Education and Empowerment (Level 4)
		E5. Care Transition Across Care Continuum (Level 3)
		E6. Communication, Collaboration and Teamwork (Level 3)
		E7. Client and Environment Safety and Risk Management (Level 4)
	D2. Population-based Practice	E8. Population-based Practice (Level 4)
	D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 4)
		E10. Develop and Lead Others (Level 3)
	D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 3)
		E12. Evidence-based Practice and Research (Level 3)

NOTE: *The incumbent is expected to have the capabilities reflected in PCs, E1. Client Assessment and Care Planning, E2. Management of Individuals with Health Conditions and E3. Medication Management at Level 4 in order to be able to guide and step in as required, even though the current JRP does not include active participation in direct Person-centred Care.

DEPUTY DIRECTOR OF NURSING

Job role description	The Deputy Director of Nursing is responsible for the development and advancement of community nursing practice in alignment with the organisational strategic directions and national healthcare priorities. S/He develops and reviews structures, systems and operations; and negotiates for resources to support safe, quality and value-based nursing care delivery. S/He innovates the community nursing practice, develops new roles and competencies of community nursing in response to the evolving health profile and needs of the clients and the population. S/He seeks opportunities and strategies for inter-professional and inter-sectoral collaborations to enable person-centred care and population-based practice. The Deputy Director of Nursing develops strategies for the professional development of the nursing team. S/He influences local and national policies and strategies on health and care for the community.

Responsibilities and activities	***Key responsibility areas***	***Key activities***
	Client and Community Engagement and Empowerment	Develop strategies to enhance client and community engagement
		Develop platforms to engage clients, families, caregivers and community partners on service design and outcome evaluations
		Implement measures to uphold professional standards in managing potential boundary issues with the clients, families, caregivers and/or community partners
		Develop interventions to enhance engagement with clients, families and/or caregivers for self-management, shared decision-making and care-giving support
		Develop strategies to empower clients and communities through enhancing health literacy, enabling informed choices and supporting community development
	Care Transition and Integration	Review and recommend strategies for care integration through inter-professional and inter-sectoral collaborations
		Develop systems-approach for care transition and coordination
		Develop community care networks or pathways with the understanding of the community care landscape and resources
	Nursing Practice Management and Operational Excellence	Promote healthcare policies, legislations and professional regulatory framework and articulate their relevance and applications to community practice
		Lead in the development and implementation of person-centred care delivery model
		Cultivate organisational culture and develop strategies, goals and framework to enable the delivery of person-centred care practice
		Evaluate effectiveness of the nursing care model, processes and practices
		Evaluate and recommend best practices and innovation in nursing care delivery
		Review and evaluate evidence-based nursing guidelines and protocols
		Plan and negotiate for the necessary resources required for care delivery

Responsibilities and activities (Cont'd)	***Key responsibility areas***	***Key activities***
	Nursing Practice Management and Operational Excellence (Cont'd)	Evaluate and spread best practices across departments
		Develop policies and procedures for risk management
		Plan the crisis interventions, emergency procedures and resources for the management of crisis situations
		Develop strategies to enhance the management of health threats
	People and Personal Development	Make recommendations to enhance talent development and performance management framework and process
		Develop and review organisational training and development policies and recommend changes in alignment with organisational goals
		Define and develop emerging roles and competencies to enhance capabilities of community nursing workforce
		Develop a talent pool for succession planning and provide mentorship to develop effective nursing leaders
		Develop and review strategies for promoting staff welfare and raising staff morale
		Seek opportunities to influence local and national policy on community care capacity and capability building

Professional Competencies	***Competency domains***	***Competency elements (Proficiency Level)***
	D1. Person-centred Care	E4. Client, Family and Caregiver Education and Empowerment (Level 4) E5. Care Transition Across Care Continuum (Level 3) E6. Communication, Collaboration and Teamwork (Level 4) E7. Client and Environment Safety and Risk Management (Level 4)
	D2. Population-based Practice	E8. Population-based Practice (Level 4)
	D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 4) E10. Develop and Lead Others (Level 3)
	D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 3) E12. Evidence-based Practice and Research (Level 4)

NOTE: *The incumbent is expected to have the capabilities reflected in PCs E1. Client Assessment and Care Planning, E2. Management of Individuals with Health Conditions and E3. Medication Management, at Level 4 in order to be able to guide and step in as required, even though the current JRP does not include active participation in direct Person-centred Care.

DIRECTOR OF NURSING

Job role description	The Director of Nursing is responsible for providing strategic direction on the development of community nursing in alignment with national healthcare priorities. S/He translates the organisational vision, mission and values into practice, behaviours and competencies for the community nurses in collaboration with various stakeholders. S/He maintains oversight and provides inputs to the professional standards of the nursing workforce within the organisation. S/He endorses the nursing care model and ensures availability of resources for safe, quality, person-centred and value-based care delivery. The Director of Nursing uplifts the community nursing image and motivates nurses to continuously strive for excellence in practice standards. S/He serves as the key advocate for the needs and well-being of the community nurses as well as the communities they serve. S/He influences local and national policies, strategies and systems to advance community nursing practice, and to improve health and integrate care for clients and the population.

Responsibilities and activities	***Key responsibility areas***	***Key activities***
	Client and Community Engagement and Empowerment	Evaluate the effectiveness of strategies for client and community engagement
		Evaluate and redesign community nursing services with inputs and reported-outcomes from clients, families, caregivers and/or community partners
		Ensure adherence to guidelines and protocols for maintaining professional boundaries and therapeutic relationships with clients, families, caregivers and/or community partners
		Drive a multi-pronged strategy for engaging clients, their families and caregivers, and the community
		Guide the development of strategies to empower clients and the community through enhancing health literacy, enabling informed choices and maximising health outcomes
		Set strategic directions to strengthen and extend community networking, build and maintain alliances to enhance population-focused practice
	Care Transition and Integration	Develop and drive strategies for multi-dimensional care integration to improve quality and cost-effectiveness of care for individual clients and the population
		Lead and spread collaborative improvement efforts to redesign and improve care coordination and integration
		Build relationships and connections for community care networks and resources to facilitate care transition and integration
	Nursing Practice Management and Operational Excellence	Engage with stakeholders to influence healthcare policies, legislations and the professional regulatory framework relating to community practice
		Drive the development and provide direction for the implementation of a person-centred care delivery model
		Establish the culture, strategic direction, organisational goals and framework to enable the delivery of person-centred care
		Set the direction for evolving or sustaining the nursing care model, processes and practices to support person-centre care

Responsibilities and activities (Cont'd)	***Key responsibility areas***	***Key activities***
	Nursing Practice Management and Operational Excellence (Cont'd)	Drive the adoption of best practices and innovation in nursing care delivery
		Establish the organisational and cross-institutional governance framework for community practice
		Advocate and obtain the necessary resources for care delivery
		Drive a culture of quality and safety in community care delivery
		Review and enhance risk management policies and procedures
		Lead crisis intervention and activation of emergency procedures in the event of crisis situations in collaboration with appropriate stakeholders
		Evaluate and approve the implementation of strategies to manage health threats
	People and Personal Development	Develop and evaluate talent development and performance management strategies within the organisation to build community nursing capability
		Evaluate organisational training and development policies and provide recommendations considering national needs and international developments in community nursing practice
		Identify changing trends and emerging roles to provide recommendations for capability and capacity building
		Develop strategies and sustain a talent pool for succession planning and mentorship to develop effective nursing leaders
		Evaluate strategies and recommend policy changes to improve staff welfare and morale
		Engage with stakeholders to influence local and national policies on community care capacity and capability building

	Competency domains	***Competency elements (Proficiency Level)***
Professional Competencies	D1. Person-centred Care	E4. Client, Family and Caregiver Education and Empowerment (Level 4) E5. Care Transition Across Care Continuum (Level 4) E6. Communication, Collaboration and Teamwork (Level 4) E7. Client and Environment Safety and Risk Management (Level 4)
	D2. Population-based Practice	E8. Population-based Practice (Level 4)
	D3. Professional Development and Leadership	E9. Develop and Lead Self (Level 4) E10. Develop and Lead Others (Level 4)
	D4. Improvement, Innovation and Research	E11. Innovation and Quality Improvement (Level 4) E12. Evidence-based Practice and Research (Level 4)

NOTE: *The incumbent is expected to have the capabilities reflected in PCs, E1. Client Assessment and Care Planning, E2. Management of Individuals with Health Conditions and E3. Medication Management, at Level 4 in order to be able to guide and step in as required, even though the current JRP does not include active participation in direct Person-centred Care.

PROFESSIONAL COMPETENCIES (PC)

A total of 12 PCs have been developed for the community nursing sector. All PCs that are developed for this framework are organised into 4 competency domains. The Person-Centred Care competency domain is further organised into 5 competency sub-domains which reflect the focus of this framework as aforementioned.

Overview of the Community Nursing Competency Framework (CNCF)

COMPETENCY DOMAIN	COMPETENCY ELEMENT		DEFINITION OF COMPETENCY ELEMENT
D1. Person-Centred Care			
D1.1 Clinical Care Management	**E1**	Client Assessment and Care Planning	Perform biopsychosocial and environment assessment of clients in order to develop an individualised care plan
	E2	Management of Individuals with Health Conditions	Implement holistic evidence-based nursing interventions to manage clients' heath conditions in consideration of care goals and preferences
	E3	Medication Management	Perform and advocate safe use, administration and prescription of medication in accordance with policies, procedures and regulations
D1.2 Engagement and Empowerment	**E4**	Client, Family and Caregiver Education and Empowerment	Enable clients, families and/or caregivers to recognise assets and responsibilities to promote self-management of health and wellbeing
D1.3 Care Transition and Integration	**E5**	Care Transition Across Care Continuum	Facilitate and manage the transition of clients across care settings and/or levels of care to ensure coordination and continuity of care
D1.4 Communication and Collaboration	**E6**	Communication, Collaboration And Teamwork	Utilise engagement strategies to work together on a common goal towards the health and well-being of clients and the community
D1.5 Safety and Risk Management	**E7**	Client and Environment Safety and Risk Management	Identify and mitigate factors affecting clients' care, well-being and safety
D2. Population-based Practice	**E8**	Population-based Practice	Assess and prioritise health risks, needs and resources to develop, implement and evaluate strategies for optimising health outcomes of population segments
D3. Professional Development and Leadership	**E9**	Develop and Lead Self	Develop awareness of one's role and abilities, enhance capabilities and manage behaviours and practice to achieve professional and/or organisational goals
	E10	Develop and Lead Others	Drive change, foster a collaborative culture; cultivate dynamic and competent care teams and networks to shape the community care landscape
D4: Improvement, Innovation and Research	**E11**	Innovation and Quality Improvement	Develop and implement new and improved technologies, services, delivery methods and processes to drive value-based care in the community
	E12	Evidence-based Practice and Research	Integrate best practices and research evidence in the delivery of care to achieve optimal client and population outcomes

Definition of The 4 Proficiency Levels

LEVEL	RESPONSIBILITY (Degree of supervision and accountability)	AUTONOMY (Degree of decision-making)	COMPLEXITY (Degree of difficulty of situation and tasks)	KNOWLEDGE AND ABILITIES (Required to support work as described under Responsibility, Autonomy and Complexity)
4	Accountable for significant area of work, strategy or overall direction	Empowered to chart direction and practices within and outside of work (including professional field/ community), to achieve/ exceed work results	Highly Complex	• Synthesise knowledge issues in a field of work and the interface between different fields, and create new forms of knowledge • Employ advanced skills, to solve critical problems and formulate new structures, and/or to redefine existing knowledge or professional practice • Demonstrate exemplary ability to innovate, and formulate ideas and structures
3	Accountable for achieving assigned objectives, decisions made by self and others	Provide leadership to achieve desired work results; manage resources, set milestones and drive work	Complex	• Evaluate factual and advanced conceptual knowledge within a field of work, involving a critical understanding of theories and principles • Select and apply an advanced range of cognitive and technical skills, demonstrating mastery and innovation, to devise solutions to solve complex and unpredictable problems in a specialised field of work • Manage and drive complex work activities
2	Work under broad direction May hold some accountability for performance of others, in addition to self	Use discretion in identifying and responding to issues, work with others and contribute to work performance	Non-routine (may not have precedence)	• Select and apply a range of cognitive and technical skills to solve non-routine/abstract problems • Apply relevant procedural and conceptual knowledge, and skills to perform differentiated work activities and manage changes • Able to collaborate with others to identify value-adding opportunities
1	Work with some supervision Accountable for tasks assigned	Use limited discretion in resolving issues or enquiries. Requires occasional to frequent guidance	Routine (has precedence)	• Understand and apply factual and procedural knowledge in a field of work • Apply basic skills to carry out defined tasks • Identify opportunities for minor adjustments to work tasks

Each PC document includes the following:

- **Competency Domain**
- **Competency Sub-Domain**
- **Competency Element**
- **Definition of Competency Element**
- **Proficiency Level Description of Competency Element**
- **Knowledge**
- **Abilities**
- **Sources of information**

The 12 PCs developed for the CNCF are shown in the following pages:

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	**D1.1** Clinical Care Management	**E1** Client Assessment and Care Planning	Perform biopsychosocial and environment assessment of clients in order to develop an individualised care plan using a person-centred care approach

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Assist in the biopsychosocial assessment of clients to contribute in the formulation of individualised care plans	Formulate individualised care plans by conducting biopsychosocial and environment assessment	Formulate individualised care plans by conducting biopsychosocial and environment assessment of clients with complex care needs	Develop and review protocols for assessment; review outcomes and revise care plans appropriately
Knowledge	• Principles of community nursing • Concepts of person-centred care • Basic knowledge of biopsychosocial assessment • Biopsychosocial indicators and assessment tools • Care needs across the lifespan • Approaches to strength-based assessment • Basic knowledge of social determinants • Basic understanding of cultural diversities • Basic understanding of the role of family, caregiver and/or significant other • Care plan components • Principles of clinical reasoning • Types of services provided and resources available at the various care settings	• Principles of community nursing • Concepts of person-centred care • Knowledge of biopsychosocial assessment • Types of biopsychosocial assessment • Types and presentation of care crisis • Comprehensive care needs across the lifespan • Approaches to strength-based assessment • Knowledge of social determinants • Understanding of cultural diversities • Understanding of the influence of family, caregiver and/or significant other on clients' health • Care planning process • Principles of clinical reasoning • Framework for Advance Care Planning • Interdisciplinary team roles and responsibilities • Knowledge of community resources • Knowledge of support infrastructure, and policies for vulnerable clients	• Principles of community nursing • Concepts of person-centred care • Knowledge of biopsychosocial assessment • Types and presentation of care crisis • Approaches to strength-based assessment • Knowledge of social determinants • Understanding of cultural diversities • Understanding of the influence of family, caregiver and/or significant other on clients' health • Interdisciplinary care planning process • Principles of clinical reasoning • Interdisciplinary team roles and responsibilities • Knowledge of community resources • Knowledge of support infrastructure, policies and relevant agencies for vulnerable clients	• Principles of community nursing • Concepts of person-centred care • Principles of clinical reasoning • Approaches to strength-based assessment • Knowledge of social determinants • Understanding of cultural diversities • Understanding of the influence of family, caregiver and/or significant other on clients' health • Management strategies for care crisis • Key elements of clinical care protocols • Emerging community nursing trends and best practices • Diagnosis and management of common medical conditions • Interdisciplinary team roles and responsibilities • Knowledge of community resources • Knowledge of support infrastructure, policies and relevant agencies for vulnerable clients

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Utilise appropriate assessment tools and techniques to assist in the biopsychosocial assessment of clients • Recognise each client's unique needs, strengths and preferences to ensure individualised care planning • Identify and report abnormalities • Document relevant information of clients in appropriate formats and/or systems • Provide accurate and relevant information to assist in the formulation of care plans in collaboration with other members of the team	• Conduct biopsychosocial and environment assessment to determine needs and level of care for clients • Establish goals that identify clients' health outcomes • Formulate individualised care plans in collaboration with clients, families and/or caregivers • Identify early signs of care crisis and suggest solutions or escalate as per the situation • Collaborate and plan support strategies for vulnerable clients • Communicate the essential components of the care plan with clients, families and/or caregivers • Facilitate the Advance Care Planning discussion with clients, families and/or caregivers • Participate in discussions with the interdisciplinary team to ensure care plans are appropriately implemented • Recommend timely and appropriate referrals where necessary	• Recommend the use of appropriate assessment tools based on clients' clinical presentation • Evaluate appropriateness of goals for clients' health outcomes • Formulate individualised care plans for clients with complex care needs in collaboration with clients, families and/or caregivers • Anticipate care crisis and develop appropriate solutions or strategies to manage escalated situations • Collaborate with relevant inter-sectoral agencies to manage vulnerable clients • Explain the essential components of the care plan to clients, families and/or caregivers for complex care cases • Facilitate discussions with the interdisciplinary teams to ensure care plans are appropriately implemented	• Perform comprehensive advanced health assessment (e.g. history taking, physical examinations), diagnostic reasoning and make differential diagnosis* • Prioritise care goals and develop clients' management plans • Manage clients with care crisis in collaboration with the interdisciplinary team • Provide consultation to the interdisciplinary team based on area of specialty • Conduct family conferences and discuss care plans with clients, families and/or caregivers • Serve as a consultant and review individualised care plans for complex cases • Develop clinical care protocols for client assessments based on best practices

Sources of Information

1. Community Health Nurses of Canada. (2010). Home Health Nursing Competencies (Version 1.0, pp. 1-16). Toronto.
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3. Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H., & Lu, M. (2017). How to practice person-centred care: A conceptual framework. Health Expectations, 1-12. doi:10.1111/hex.12640
4. World Health Organization. (2010). A framework for community health nursing education (pp. 1-47). India: World Health Organization, Regional Office for South-East Asia
5. Royal College of Nursing. (2018). Advanced Level Nursing Practice Section 2: Advanced level nursing practice competencies. Retrieved from: https://www.rcn.org.uk/professional-development/publications/PUB-006896

*Ability only relevant to APNs

NOTE: *For APN roles, special/privileged abilities and specific knowledge have been marked with an asterisk "*" and placed under Proficiency Level 4 across the framework. Thus, if a community nurse is an SSN and APN, s/he would refer to the Competency Level assigned to the SSN role in addition to the items marked with an asterisk "*" under Proficiency Level 4.

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	**D1.1** Clinical Care Management	**E2** Management of Individuals with Health Conditions	Implement holistic evidence-based nursing interventions to manage clients' heath conditions in consideration of care goals and preferences

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Perform basic nursing interventions to support holistic care management	Perform and evaluate holistic nursing interventions to achieve planned care goals	Plan and manage complex and/or specialised nursing interventions to achieve optimal outcomes for the clients	Review and steer the development of holistic nursing interventions to achieve optimal care outcomes **and/or** Plan and perform advanced nursing interventions and procedures*
Knowledge	• Basic anatomy and physiology of body systems • Signs and symptoms of common health conditions • Knowledge of clients' biopsychosocial needs • Basic nursing management of chronic and acute health conditions • Evidence-based practice of basic nursing care and procedures in community settings • Use of medical equipment, assistive devices and therapeutic products within the scope of practice • Knowledge of vital signs and other clinical measurements relevant to community care settings • Concepts of non-judgemental and dignified care • Basic concepts of quality of life • Care principles for specific client groups • Fundamental cultural factors affecting individual's and family's health behaviours and support systems • Organisational procedures and guidelines for care and documentation • Interdisciplinary team roles and responsibilities	• Pathophysiology of common acute and chronic health conditions • Knowledge of clients' biopsychosocial needs and their implications on health and functions • Atypical signs and symptoms of health conditions • Management of common chronic health conditions • Nursing management of acute conditions • Evidence-based practice of nursing interventions in community settings • Indications and contra-indications of medical equipment, assistive devices and therapeutic products • Interpretation of vital signs and other clinical measurements relevant to community care settings • Organisational guidelines to recognise and report abnormal and/or critical laboratory results • Concepts of non-judgemental and dignified care • Principles of quality of life • Care principles for specific client groups • Fundamental cultural factors affecting individual's and family's health behaviours and support systems • Organisational procedures and guidelines for care and documentation • Interdisciplinary team roles and responsibilities	• Pathophysiology of common acute and chronic health conditions • Knowledge of interactions between biopsychosocial needs and their implications on health and functions • Atypical signs and symptoms of health conditions and their complications • Management of chronic health conditions and their complications • Nursing management of acute conditions • Evidence-based practice of nursing interventions and procedures in community settings • Knowledge of the latest trends in nursing interventions and procedures • Knowledge of the latest trends in medical equipment, assistive devices and therapeutic products • Interpretation of vital signs and other clinical measurements relevant to community care settings • Organisational guidelines to recognise and report abnormal and/or critical laboratory results • Principles of quality of life • Care principles for specific client groups • Fundamental cultural factors affecting individual's and family's health behaviours and support systems • Organisational procedures and guidelines for care and documentation • Interdisciplinary team roles and responsibilities	• Advanced pathophysiology* • Knowledge of interactions between biopsychosocial needs and their implications on health and functions • Management of atypical presentations and their complications • Management of chronic health conditions and their complications • Management of acute conditions • Emerging practices and development of nursing interventions and procedures • Interpretation of vital signs, other clinical measurements and basic clinical tests relevant to community care settings • Organisational guidelines to recognise and report abnormal and/or critical clinical results • Principles of quality of life • Care principles for specific client groups • Fundamental cultural factors affecting individual 's and family's health behaviours and support systems • Organisational, local and international policies, guidelines and regulations related to community nursing interventions • Interdisciplinary team roles and responsibilities

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Perform nursing interventions in accordance with established policies and guidelines, taking into consideration clients' physical, psychosocial and cultural context • Utilise appropriate medical equipment, assistive devices and therapeutic products to perform nursing interventions in accordance with policies, procedures and regulations • Assist clients in undertaking activities of daily living in consideration of their abilities • Communicate information on nursing interventions to clients, families and/or caregivers • Assess, document and report clients' responses to nursing interventions • Recognise and escalate any unexpected and/or abnormal changes in clients' health and social conditions • Support interdisciplinary team discussions to update clients' conditions and follow-up activities	• Perform evidence-based nursing interventions as per individualised care plans, goals and preferences • Deliver culturally competent care • Suggest and utilise medical equipment, assistive devices and therapeutic products in accordance with clients' needs, evidence and resources • Evaluate clients' outcomes against defined care goals and revise care plans in collaboration with the interdisciplinary team and community partners • Communicate the outcomes of nursing interventions to clients, families, caregivers and/or care teams • Assess, document and report clients' responses to nursing interventions • Recognise and escalate unexpected and/or abnormal changes in clients' health and social conditions, and render appropriate initial nursing management	• Plan, perform and document complex and/or specialised nursing interventions, in accordance with established policies and guidelines • Reinforce culturally competent care • Recommend and evaluate the use of medical equipment, assistive devices and therapeutic products • Review care goals and provide recommendations to the interdisciplinary team to optimise clients' outcomes • Evaluate and communicate the outcomes of complex/specialised nursing interventions to clients, families, caregivers and/or care teams • Develop and maintain the documentation standards for nursing interventions and procedures • Recognise and manage changes and complications in clients' health and social conditions, and escalate appropriately • Revise the existing approach to care as per best practices, in collaboration with the interdisciplinary teams and community partners	• Plan, perform and document advanced nursing interventions and procedures as per Collaborative Practice Agreement* • Evaluate effectiveness of interventions and efficiency of care delivery for clients with different health conditions • Recognise, manage and escalate actual/potential changes and complications of clients' health and social conditions • Steer the development of protocols and guidelines related to nursing interventions in collaboration with the interdisciplinary team • Contribute to the development of care pathways or approaches in collaboration with the interdisciplinary team and community partners • Analyse gaps in policies and standards in relation to clinical nursing management and formulate recommendations to address the gaps

Sources of Information

1. World Health Organization. (2016). Integrated care models: an overview (pp. 1-42, Working paper). Denmark: WHO Regional Office for Europe

2. Victorian Government. (2019). Community health integrated program guidelines: Direction for the community health program (pp. 1-44) (State of Victoria, Department of Health and Human Services).

3. NHS Education for Scotland. (n.d.). Framework for Development of Community Staff Nurses. Retrieved from: http://www.effectivepractitioner.nes.scot.nhs.uk/media/229753/community%20staff%20nurses%20doc.pdf

4. Starr, S. S., & Wallace, D. C. (2011). Client Perceptions of Cultural Competence of Community-Based Nurses. Journal of Community Health Nursing, 28(2), 57-69. doi:10.1080/07370016.2011.564057

5. Racher, F. E. (2007). The Evolution of Ethics for Community Practice. Journal of Community Health Nursing, 24(1), 65-76. doi:10.1080/07370010709336586

*Ability only relevant to APNs

NOTE: *For APN roles, special/privileged abilities and specific knowledge have been marked with an asterisk "*" and placed under Proficiency Level 4 across the framework. Thus, if a community nurse is an SSN and APN, s/he would refer to the Competency Level assigned to the SSN role in addition to the items marked with an asterisk "*" under Proficiency Level 4.

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	**D1.1** Clinical Care Management	**E3** Medication Management	Perform and advocate safe use, administration and prescription of medication in accordance with policies, procedures and regulations

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Administer non-parenteral medication to clients and support medication self-management	Perform medication administration and institute measures for medication adherence and/or self-management	Enforce and advocate the standards of safe medication practices, manage clients with complex medication management needs	Steer the development of organisational policies and procedures for medication management and drive safe medication practices **and/or** Prescribe medication and perform medication reconciliation*
Knowledge	• Basic pharmacology • Commonly used and approved abbreviations used in medication prescription • Administration methods of non-parenteral medication • Rights of medication administration • Organisational policies and procedures for medication management • Legal and legislative implications of medication errors and incidents • Innovations to improve medication adherence	• Principles of pharmacology • Commonly used and approved abbreviations used in medication prescription • Administration methods of medication • Rights of medication administration • Factors affecting medication adherence • Organisational policies and procedures for medication management • Handling of controlled and cytotoxic drugs • Disposal of drugs and used sharps in the home/community setting • Legal and legislative implications of medication errors and incidents • Innovations to improve medication adherence	• Principles of pharmacology • Polypharmacy and its management • Management of side-effects of medication specific to clients' conditions • Rights of medication administration • Organisational policies and procedures for medication management • Multi-pronged strategies to promote medication adherence and self-management • Quality assurance framework for medication management • Medication reconciliation process • Strategies to reduce medication errors • Policies and guidelines on medication titration • Handling of controlled and cytotoxic drugs • Disposal of drugs and used sharps in the home/community setting • Interdisciplinary team structures • Legal and legislative implications of medication errors and incidents • Innovations to improve medication adherence	• Advanced pharmacology* • Polypharmacy and its management • Advancements in medication management • Rights of medication administration • Quality assurance framework for medication management • Medication reconciliation process • Collaborative practice agreement on medication prescription* • National and organisational policies and procedures for medication management • Handling of controlled and cytotoxic drugs • Disposal of drugs and used sharps in the home/community setting • Interdisciplinary team structures • Legal and legislative implications of medication errors and incidents

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Administer and document non-parenteral medication adhering to organisational policies and procedures • Assist to monitor and report effects and side effects of medication • Report adverse effects of medication in accordance with established policies and procedures • Assist in medication incident management • Educate clients, families and/or caregivers on medication • Monitor clients' medication adherence • Assist in storage and proper disposal of medication and advise clients according to manufacturers' and legislative requirements	• Administer medication and document according to organisational policies and procedures • Handle controlled drugs in accordance with organisational policies and procedures • Monitor clients and report effects and side-effects of medication • Perform immediate intervention to manage adverse effects of medication and escalate appropriately • Raise medication incident reports and recommend preventive measures • Work in partnership with clients, families and/or caregivers to facilitate self-management of medication • Assess clients' medication adherence and recommend strategies to promote medication self-management and adherence • Ensure proper storage and disposal of medication and advise clients according to manufacturers' and legislative requirements • Ensure medication continuity by coordinating replenishment of prescribed medication • Participate in medical reconciliation process • Identify clients who require reviews of their regular medication and recommend accordingly • Supervise the junior nurses to ensure adherence to organisational policies and procedures	• Supervise management of clients with complex medication regimens • Supervise management of clients with challenging issues affecting medication self-management • Ensure compliance of medication management for controlled drugs in accordance with organisational policies and procedures • Analyse incident reports to identify gaps in relation to organisational practices and processes • Investigate and follow up on medication incidents and non-compliance where necessary • Work in collaboration with the interdisciplinary team to facilitate medication self-management • Educate junior nurses on safe handling of medication • Guide clients, families, caregivers and/or nurses to utilise available resources for continuity of medication management • Initiate medication reconciliation process in accordance with organisational guidelines • Conduct audits on medication management • Guide junior nurses and educate clients on medication effects, managing side-effects and escalating adverse effects • Tailor and optimise medication management for clients by reviewing care processes and interventions	• Develop and review organisational policies and procedures for medication management • Keep abreast of latest practices in medication management • Develop strategies to improve quality assurance in safe medication administration • Prescribe medication according to policies and guidelines** • Review key performance indicators in medication management and recommend systemic-level measures • Evaluate the audit results and develop strategies to address gaps around medication management • Supervise the team to provide support on escalated issues around medication management • Oversee the management of controlled drugs

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1. Ministry of Health, Singapore. (2018). The National Medication Reconciliation Guidelines. Retrieved from: https://www.moh.gov.sg/resources-statistics/medication-safety
2. Picton, C., & Granby, T. (2002). Maintaining and developing competencies in nurse prescribing. British Journal of Community Nursing, 7(2), 90-93. doi:10.12968/bjcn.2002.7.2.9207
3. Latter, S., Maben, J., Myall, M., Young, A., & Baileff, A. (2007). Evaluating prescribing competencies and standards used in nurse independent prescribers' prescribing consultations. Journal of Research in Nursing, 12(1), 7-26. doi:10.1177/1744987106073949
4. Royal Pharmaceutical Society. (2016). A Competency Framework for all Prescribers. Retrieved from: https://www.rpharms.com/resources/frameworks/prescribers-competency-framework
5. Ministry of Health. (n.d.). Guidelines for the Implementation of Collaborative Prescribing Services. Retrieved from: https://www.moh.gov.sg/hpp/all-healthcare-professionals/guidelines/GuidelineDetails/collaborative-prescribing

*Ability only relevant to APNs
**Ability only relevantto APNs who have completed the National Collaborative Prescribing Programme (NCPP) and who are credentialed by their institution.

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Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	**D1.2** Engagement and Empowerment	**E4** Client, Family and Caregiver Education and Empowerment	Enable clients, families and/or caregivers to recognise assets and responsibilities to promote self-management of health and well-being

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Support education and training and encourage self-management	Provide education and training to facilitate self-management, and promote shared decision-making	Plan, develop and implement education and training programmes, and enable self-management and self-advocacy	Develop strategies, guidelines and protocols to reinforce self-management and improve health literacy
Knowledge	• Client engagement strategies • Concepts of self-management • Concept of health literacy • Factors that affect or facilitate self-management • Techniques of motivational interviewing • Self-management methods, tools and supporting technology • Basic principles and methods of education and training for clients, families and/or caregivers • Education and training resources and platforms for clients, families and/or caregivers • Organisational procedures and guidelines for documentation	• Client engagement and motivation strategies • Strategies for relationship building • Concepts and models of self-management • Concept of health literacy and relevant assessment tools • Effective strategies facilitating self-management • Principles and methods of education and training for clients, families and/or caregivers • Education and training resources and platforms for clients, families and/or caregivers • Methods to evaluate understanding and learning outcomes • Organisational procedures and guidelines for documentation	• Principles and models of self-management • Strategies for relationship building • Strength-based approach to care • Principles of health literacy and relevant assessment tools • Effective strategies facilitating self-management of specific needs • Principles and methods for education and training for clients, families and/or caregivers • Education and training design for clients, families and/or caregivers • Evaluation of training effectiveness and efficiency • Engagement and motivation strategies • Organisational procedures and guidelines for documentation	• Emerging trends in self-management • Strength-based approach to care • Framework and measurement methods of health literacy • Methods to improve health literacy • Best practices in education and training design and delivery for clients, families and/or caregivers • Relevant stakeholders for education and training of clients, families and/or caregivers • Social network theory

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Establish rapport and trust with clients, families and/or caregivers • Assist in identification of learning needs of clients, families and/or caregivers in consideration of their level of health literacy • Encourage clients, families and/or caregivers to utilise their strengths and capabilities in managing health and well-being • Support education and training of clients, families and/or caregivers on self-management within own scope of practice • Prepare the environment and required resources to facilitate learning for clients, families and/or caregivers • Provide feedback to care team on education and training outcomes for clients, families and/or caregivers • Communicate options to clients, families and/or caregivers to make decisions based on their own care needs • Guide clients, families and/or caregivers to access appropriate community resources • Maintain documentation of education and training activities and outcomes	• Facilitate therapeutic relationships with clients, families and/or caregivers to encourage clients to take ownership of care decisions • Identify the learning needs, potential strengths and capabilities of clients, families and/or caregivers to manage own health and well-being • Identify appropriate resources, methods and tools that cater to the learning needs, readiness and context of clients, families and/or caregivers • Identify opportunities to create learning moments • Provide self-management education and training to the clients, families and/or caregivers to facilitate skills development and behavioural change • Evaluate effectiveness of education and training sessions and address gaps • Recommend care and support options according to the needs and preferences of clients, families and/or caregivers • Identify and utilise strategies to facilitate shared decision-making • Maintain documentation of education and training activities and outcomes	• Maintain therapeutic relationships with clients, families and/or caregivers • Plan, develop and provide education and training programmes to target specific needs or gaps • Facilitate clients', families' and/or caregivers' recognition of potential strengths and capabilities to enhance self-management and self-advocacy • Coach nursing team on utilising the appropriate resources, methods and tools for education and training of clients, families and/or caregivers • Guide nursing team to identify learning moments to optimise learning opportunities and experiences by the clients, families and/or caregivers • Evaluate effectiveness of education and training programmes and recommend strategies for improvement • Facilitate the partnership of community resources with clients, families and/or caregivers for self-management • Motivate clients, families and/or caregivers to actively seek available support options to meet their care needs and facilitate shared decision-making • Develop documentation framework for education and training activities and outcomes	• Develop strategies to reinforce self-management of health and well-being • Identify and collaborate with appropriate stakeholders on the education and training of clients, families and/or caregivers • Drive planning, development and implementation of education and training programmes catering to needs and gaps • Garner resources for education and training of clients, families, caregivers and/or nursing team • Synthesise the latest methods and tools to drive and improve health literacy of clients, families and/or caregivers • Incorporate principles of self-management and shared decision-making into care management guidelines and protocols • Engage and influence community stakeholders to foster a strong network of resources and support options to promote self-management of care

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1. Royal College of Nursing. (2009). Integrated core career and competence framework for registered nurses. Retrieved from: https://www.rcn.org.uk/professional-development/publications/pub-003053
2. Ferrer, L. (2015). Engaging patients, carers and communities for the provision of coordinated/integrated health services: Strategies and tools (pp. 1-66, Working paper). Denmark: WHO Regional Office for Europe
3. Community Health Nurses of Canada. (2010). Home Health Nursing Competencies (Version 1.0, pp. 1-16). Toronto.

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	**D1.3** Care Transition and Integration	**E5** Care Transition Across Care Continuum	Facilitate and manage the transition of clients across care settings and/or levels of care to ensure coordination and continuity of care

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Support care transition planning and coordination	Facilitate and manage care transition of clients	Establish care transition framework in collaboration with stakeholders	Integrate and streamline care transition systems and resources to enhance client care quality and safety
Knowledge	• Overview of healthcare delivery system with a focus on the community care landscape • Basic concepts of care transition • Community partners and resources in various community settings • Common transitional care needs • Common issues and challenges during care transition • Transitional care plan and its components • Technology enablers for care transition • Overview of healthcare financing schemes and subsidies	• Overview of healthcare delivery system with a focus on the community care landscape • Principles of care transition • Key stakeholders and resources in community care • Essential tools and models in care transition • Evidence-based interventions for care transition • Factors influencing sites, levels and types of care • Technology enablers for care transition • Overview of healthcare financing schemes and subsidies	• Overview of healthcare delivery system with a focus on the community care landscape • Principles of care transition • Key stakeholders and resources in community care • Essential tools and models in care transition • Evidence-based interventions for care transition • Characteristics of clients at risk of care transition failure • Factors influencing sites, levels and types of care • Strategies to enhance transition of care and minimise risk of failure • Technology enablers for care transition • Overview of healthcare financing schemes and subsidies	• Overview of healthcare delivery system with a focus on the community care landscape • Principles of care transition • Key stakeholders and resources in community care • Essential tools and models in care transition • Evidence-based interventions for care transition • Organisational resources for care transition • Evaluation of key performance indicators for care transition • Factors influencing sites, levels and types of care (right-siting of care) • Strategies to enhance transition of care and minimise risk of failure • Technology enablers for care transition • Overview of healthcare financing schemes and subsidies • Potential agencies, government and community resources for collaboration and partnerships

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Assist in identifying the needs and readiness of clients, families and/or caregivers for care transition • Assist in developing care transition plans according to the clients' care needs, goals and preferences • Assist in identifying the clients, families and/or caregivers education and/or training needs for the continuity of care • Assist in providing relevant information needed for continuity of care to enable clients to navigate the care system • Support the coordination of care among different care providers • Assist in the follow up care to ensure care continuity of clients • Perform timely documentation of care transition activities	• Assess needs and readiness of clients, families and/or caregivers for care transition • Assess clients', families' and/or caregivers' education and/or training needs for the continuity of care • Develop care transition plans in collaboration with the interdisciplinary team according to the clients' care needs, goals and preferences • Determine appropriate education and/or training required for continuity of care • Provide relevant care information needed for continuity of care for clients, families and/or caregivers and care providers • Refer clients to appropriate level, site and type of care to meet their care needs • Liaise with the appropriate agency, government and community resource for continuity of care • Conduct follow up care proactively to ensure care continuity for clients • Maintain proper documentation and handover reports of clients' transition care needs	• Identify clients at risk of care transition failure and recommend solutions in collaboration with the interdisciplinary team • Review and evaluate care transition plans for clients at risk of care transition failure • Provide guidance on appropriate level, site and type of care to meet clients' care needs • Oversee care coordination activities for clients at risk of care transition failure • Establish care transition assessment, planning and education framework • Adopt care transition tools, models and interventions appropriate for own setting • Define framework for information transfer needed for continuity of care in collaboration with the interdisciplinary team • Incorporate appropriate technologies into the care transition processes • Build partnerships with appropriate agencies, government and community resources for continuity of care	• Advocate care transition as an organisational priority to enhance client care quality and safety • Establish organisational policies and procedures to address key care transition issues in collaboration with other stakeholders • Integrate and streamline framework and resources to support the interdisciplinary team in care transition • Promote technology-enabled care transition • Forge formal pathways with agencies, government and community resources for continuity of care

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1. World Health Organization. (2016). Transitions of Care: Technical Series on Safer Primary Care (pp. 1-28). Geneva: World Health Organization
2. Alliance for Home Health Quality and Innovation. (2014). Improving Care Transitions Between Hospital and Home Health: A Home Health Model of Care Transitions. Retrieved from: https://www.ahhqi.org/quality-initiatives/care-transitions
3. American Nurses Association. (2012). The Value of Nursing Care Coordination (pp. 1-24, White paper).

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	D1.4 Communication and Collaboration	E6 Communication, Collaboration and Teamwork	Utilise engagement strategies to work together on a common goal towards the health and well-being of clients and the community

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Utilise communication techniques to work with clients, families, caregivers and/or peers	Engage with clients, families and/or caregivers and collaborate with team members and relevant stakeholders	Manage challenging relationships with clients, families, caregivers and collaborate with community partners/ relevant stakeholders	Foster collaboration and synergise services to enhance client care and develop nursing capability
Knowledge	• Therapeutic communication techniques • Effective questioning techniques • Basic concepts of workplace communication • Basic methods of persuasion • Relevant healthcare communication models • Organisational procedures and guidelines for documentation	• Therapeutic communication techniques • Basic counselling techniques • Concepts of workplace communication • Inter-professional collaboration framework • Relevant healthcare communication models • Organisational procedures and guidelines for documentation	• Therapeutic communication techniques • Basic counselling techniques • Inter-professional collaboration framework • Advisory methods and approaches • Conflict resolution methods • Negotiation strategies	• Inter-professional collaboration framework • Negotiation strategies • Organisational culture development strategies • Community resources, stakeholders and network • Collaborative leadership

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Build trust and rapport with clients, families and/or caregivers • Use appropriate communication techniques to elicit information from clients, families and/or caregivers • Use methods of persuasion to promote positive lifestyle choices for clients, families and/or caregivers • Work with team members to determine appropriateness and availability of required services • Record and convey relevant information in a clear and organised manner	• Build trust and rapport with clients, families and/or caregivers and community partners • Conduct discussions with clients, families and/or caregivers to better understand clients' needs • Provide guidance and/or counselling to clients, families and/or caregivers on their care needs and preferences • Collaborate with team members and relevant stakeholders to support individual client's needs and preferences • Adapt and explain the required information to clients, families and/or caregivers • Present relevant information on clients and participate in interdisciplinary discussions • Gather feedback from clients, families and/or caregivers	• Apply engagement strategies to overcome barriers to build and maintain rapport with community partners • Identify alternative counselling strategies for challenging situations • Establish networks and collaborative partnerships with relevant stakeholders to manage clients' needs and preferences • Influence decision-making through discussions with various stakeholders to meet clients' needs and preferences • Facilitate interdisciplinary case discussions • Resolve conflicts within teams and other stakeholders • Manage feedback from clients, families and/or caregivers	• Build a culture of trust and openness within the organisation and with the broader stakeholders • Identify best practices/experts to enhance communication strategies • Identify and garner opportunities for collaboration to broaden and enhance the services delivered to clients • Lead engagements and sustain relationships with a diverse range of stakeholders • Establish communication channels and define organisational policies and protocols • Synergise the services provided by various stakeholders in the best interests of the clients • Analyse feedback trends to identify opportunities, enhance client care and develop nursing capability

Sources of Information

1. Royal College of Nursing. (2009). Integrated core career and competence framework for registered nurses. Retrieved from: https://www.rcn.org.uk/professional-development/publications/pub-003053
2. Ferrer, L. (2015). Engaging patients, carers and communities for the provision of coordinated/integrated health services: Strategies and tools (pp. 1-66, Working paper). Denmark: WHO Regional Office for Europe
3. World Health Organization. (2010). A framework for community health nursing education (pp. 1-47). India: World Health Organization, Regional Office for South-East Asia

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	**D1.5** Safety and Risk Management	**E7** Client and Environment Safety and Risk Management	Identify and mitigate factors affecting clients' care, well-being and safety

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Identify hazards and risks to clients' safety in the environment and care delivery process	Implement appropriate client safety and risk management measures	Develop client safety and risk management plans based on organisational and national policies and guidelines	Establish organisational approach to client safety and risk management
Knowledge	• Client safety protocols and guidelines • Organisational guidelines for client safety • Tools for clinical and environmental risk assessment • Organisational guidelines and procedures for client feedback, documentation and reporting • National pandemic readiness and response plan	• Client safety protocols and guidelines • Organisational guidelines for client safety • Clinical and environmental risk assessment and management principles • Tools for clinical and environmental risk assessment • Tools for incident review and investigation (e.g. Root Cause Analysis) • Organisational guidelines and procedures for client feedback, documentation and reporting • Clinical governance framework • National pandemic readiness and response plan	• Client safety protocols and guidelines • Organisational guidelines for client safety • Clinical and environmental risk assessment and management principles • Risk management approaches and frameworks • Tools for incident review and investigation (e.g. Root Cause Analysis and Failure Mode and Effect Analysis) • Organisational guidelines and procedures for client feedback, documentation and reporting • Clinical governance framework • National pandemic readiness and response plan	• Best practices for client safety and risk management • National and international guidelines for client safety • Clinical and environmental risk assessment and management principles • Tools for incident review and investigation (e.g. Root Cause Analysis and Failure Mode and Effect Analysis) • Risk management approaches and frameworks • Clinical governance framework • National pandemic readiness and response plan

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Adhere to client safety guidelines • Guide the support care staff to ensure adherence to client safety guidelines • Recognise signs of abuse and neglect during the care delivery process and escalate appropriately • Identify potential safety hazards and risks in the environment and care delivery process • Assist in mitigating safety hazards and risks in the environment and care delivery process • Support coordination and implementation of activities to promote safe care practices • Assist in the investigation, documentation and reporting of hazards, risks and safety breaches • Adhere to protocols in crisis situations	• Promote adherence to national and organisational client safety guidelines • Recognise signs of abuse and neglect during the care delivery process; intervene and escalate appropriately • Assess safety hazards and risks within the environment and provide inputs to the risk management plans • Implement and reinforce safety and risk management measures to mitigate safety issues in the environment and care delivery process • Initiate and participate in incident reviews to identify causes of safety breaches and measures to prevent recurrence • Maintain appropriate documentation of risk management initiatives and support investigation of hazards, risks and safety breaches • Support interventions and emergency procedures in crisis situations	• Manage care delivery in adherence to client safety guidelines • Guide the care team and work with the interdisciplinary team in managing abuse and neglect incidents • Develop client safety and risk management plans in collaboration with the quality, risk and safety teams • Manage incident reviews to identify causes of safety breaches and develop preventive measures • Disseminate learning points from incidents reviews to prevent recurrence • Lead investigations and provide findings for discussion with stakeholders, as appropriate • Incorporate best practices to improve client and environment safety • Manage interventions and emergency procedures in crisis situations	• Cultivate a safety culture in the organisation • Identify relevant national safety standards for organisation-wide adherence • Establish organisational approach to prevent or minimise potential safety and health hazards for clients in collaboration with appropriate stakeholders • Evaluate effectiveness of risk management plans and recommend adjustments to mitigate risks • Provide guidance for investigation of incidents and discuss with stakeholders, as appropriate • Provide professional opinion and endorse recommendations for systematic improvement • Lead intervention and activation of emergency procedures in crisis situations, in collaboration with appropriate stakeholders

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2. Ward, M., Aumann, O., (co-author.) Di Stefano, G., (co-author.) & Greene, M., (co-author.) & Community Health Nurses Special Interest Group ANF (Vic Branch) (issuing body.) (2013). Practice standards for Victorian community health nurses. [Carlton, Victoria] Community Health Nurses Special Interest Group ANF (Vic Branch)
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Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D2 Population-based Practice	NIL	E8 Population-based Practice	Assess and prioritise health risks, needs and resources to develop, implement and evaluate strategies for optimising health outcomes of population segments

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Support and participate in population-based interventions	Deliver and document population-based interventions	Develop and manage population-based interventions	Define strategic direction and drive population-based strategies
Knowledge	• Basic understanding of population-based practice • Population-based assessment tools (e.g. Quality of Life, Patient-level risk assessment tool) • Population-based interventions and activities • Care team and community partners • Organisational procedures and guidelines for documentation	• Population-based assessment tools (e.g. Quality of Life, Patient-level risk assessment tool) • Concepts and frameworks applied to population-based practice • Population-based interventions and activities • Care team and community partners • Outcome measurement indicators • Organisational procedures and guidelines for documentation	• Healthcare data analytics • Components of population assessment • Population-based assessment tools • Concepts and frameworks applied to population-based practice • Population-based interventions and activities • Outcome measurement indicators • Community resources, stakeholders and network • Resource management	• Healthcare data analytics • Components of population assessment • Population-based assessment tools • Concepts and frameworks applied to population-based practice • Emerging trends and anticipated outcomes of population-based interventions • Outcome measurement indicators • Community resources, stakeholders and networks • Multi-sectoral systems/partnerships that impact population health needs

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Assist in population-based assessment • Support the delivery of population-based interventions • Participate in health promotion and health prevention activities within targeted population groups • Assist in the coordination with care team and community partners to support the delivery of population-based interventions • Assist in the documentation for the interventions and activities	• Use population-based assessment tools to determine relevant interventions required • Deliver population-based interventions • Lead health promotion and health prevention activities within targeted population groups • Coordinate and work with care team and community partners to support the delivery of population-based interventions • Identify and highlight challenges during the delivery of population-based interventions and activities • Provide feedback and suggestions to improve the delivery and outreach of population-based interventions and activities • Maintain accurate documentation of the population-based interventions and activities	• Assess needs and determinants of health of the targeted population groups • Develop the population-based interventions aligned to the strategies • Create a detailed implementation plan including timelines, resources required, processes and outcome indicators • Collaborate across disciplines and community partners to support the implementation of population-based interventions • Implement and manage population-based interventions • Recommend alternative and innovative solutions to the challenges during implementation • Monitor the efficiency and effectiveness of the intervention process • Measure the outcomes of the population-based interventions • Refine the interventions based on evaluation of the outcomes	• Identify and prioritise risks and needs of the population groups • Develop strategies to manage the risks and needs of the population groups, incorporating emerging trends in population-based practice • Provide direction on identifying and planning the population-based interventions aligned to the strategies • Develop partnerships and networks to mobilise community assets and facilitate population-based processes • Drive and oversee the implementation of population-based interventions • Monitor and guide the review of the implementation plan • Evaluate the outcomes to refine population-based strategies • Provide inputs to the development of population-based policies

Sources of Information

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2. Stanhope, M., & Lancaster, J. (2015). Population-Based Public Health Nursing Practice: The Intervention Wheel. In Public Health Nursing (9th ed.).
3. Ferrer, L. (2015). Engaging patients, carers and communities for the provision of coordinated/integrated health services: Strategies and tools (pp. 1-66, Working paper). Denmark: WHO Regional Office for Europe

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D3 Professional Development and Leadership	NIL	E9 Develop and Lead Self	Develop awareness of one's role and abilities, enhance capabilities and manage behaviours and practice to achieve professional and/or organisational goals

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Understand own scope of practice and implement steps for self-development	Reflect on own practice and learning, and identify self-development needs	Reflect on own practice and behaviours, review and prioritise development needs	Enhance own leadership practice and behaviours, and develop strategies in response to the changing healthcare and community landscape
Knowledge	• Code for Nurses and Midwives • Knowledge of ethics in community practice and the escalation process • Concepts of therapeutic relationships and professional boundaries • Clinical judgement and decision-making framework • Nursing career structure and development pathways • Self-evaluation methods • Available resources for self-development • Scope of competencies and qualifications of self • Emerging nursing roles in own practice • Organisational guidelines on personal safety • Data security principles and threats • Personal Data Protection Act (PDPA)	• Code for Nurses and Midwives • Knowledge of ethics in community practice and the escalation process • Concepts of therapeutic relationships and professional boundaries • Clinical judgement and decision-making framework • Nursing career structure and development pathways • Self-evaluation methods • Available resources and opportunities for self-development • Scope of competencies and qualifications of self • National healthcare strategy and directions • Updates in organisational and professional practice standards • Resource management • Data security principles and threats • Personal Data Protection Act (PDPA)	• Professionalism in nursing practice • Comprehensive scope and standards of professional and ethical practice locally and internationally • Leadership development in nursing • Self-performance evaluation methods and tools • National healthcare strategy and directions • Trends and advancements in nursing practice • Resource and manpower management • Analytical, critical and systems thinking • Principles of value-based healthcare delivery model • Data security principles and threats • Personal Data Protection Act (PDPA)	• Professionalism in nursing practice • Comprehensive scope and standards of professional and ethical practice locally and internationally • Leadership development in nursing • Self-performance evaluation methods and tools • National healthcare strategy and directions • Trends and advancements in nursing practice • Advanced systems and strategic thinking • Framework for value-based healthcare delivery • Data security principles and threats • Personal Data Protection Act (PDPA)

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Adhere to relevant national, professional and organisational policies, guidelines and legislations • Recognise and practise within own scope and competencies • Seek assistance promptly on situations and/or issues impinging on professional and clinical practice • Recognise risks and take necessary measures for personal safety • Seek feedback on and reflect on own practice and professional behaviours • Initiate personal development planning for professional growth in consultation with seniors • Seek opportunities and participate in continuous learning and professional development • Apply learning to own practice • Advocate for practice development of own job level • Utilise resources in an effective, efficient and responsible manner in delivery of care	• Promote adherence to relevant national, professional and organisational policies, guidelines and legislations • Reflect on own practice and competencies • Manage situations and/or issues impinging on professional and clinical practice • Adopt proactive approaches to personal safety in accordance with guidelines and protocol • Improve practice and professional behaviours based on feedback and self-reflection • Identify learning needs based on evaluation of own practice • Develop and implement a personal development plan in consultation with seniors • Take ownership of own learning and professional development • Synthesise learning to improve own practice • Advocate practice development for own and junior job levels • Apply analytical thinking and creative problem solving for decision making • Plan and utilise resources in an effective, efficient and responsible manner in delivery of care	• Translate relevant national and professional policies, guidelines and legislations into practice • Reinforce and ensure adherence to relevant national, professional and organisational policies, guidelines and legislations • Reflect on own practice and behaviours to understand the impact on others • Anticipate situations and/or issues impinging on professional and clinical practice and develop preventive solutions • Initiate the development of organisational personal safety guidelines • Enhance own practice and change behaviours based on feedback, self-reflection to facilitate team's performance • Prioritise development needs based on team and organisational requirements • Review personal development plan and make suitable adjustments • Identify trends and advancements in nursing to advocate practice development for the team • Apply systems thinking for problem-solving and decision-making • Develop and implement processes aligned to value-based healthcare delivery model	• Engage stakeholders to influence the development and enhancement of relevant national, professional and organisational policies, guidelines and legislations • Reflect on own practice and behaviours to understand the impact on organisation and stakeholders • Develop strategies to enhance the professional and clinical practice in response to the changing healthcare landscape • Review and endorse the organisational personal safety guidelines • Enhance leadership practice and behaviours based on feedback, self-reflection and relevant performance indicators • Set direction on adoption of trends and advancements in nursing practice • Apply strategic thinking for problem-solving and decision-making • Develop the organisational strategies to drive value-based healthcare delivery

Sources of Information

1. Ward, M., Aumann, O., (co-author.) Di Stefano, G., (co-author.) & Greene, M., (co-author.) & Community Health Nurses Special Interest Group ANF (Vic Branch) (issuing body.) (2013). Practice standards for Victorian community health nurses. [Carlton, Victoria] Community Health Nurses Special Interest Group ANF (Vic Branch)
2. The Nursing Council of Hong Kong. (2012). Core-Competencies for Registered Nurses (General). Retrieved from: https://www.nchk.org.hk/en/core_competencies_and_reference_guides/registered_nurses_general/index.html
3. Royal College of Nursing. (2009). Integrated core career and competence framework for registered nurses. Retrieved from: https://www.rcn.org.uk/professional-development/publications/pub-003053

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D3 Professional Development and Leadership	NIL	E10 Develop and Lead Others	Drive change, foster a collaborative culture, cultivate dynamic and competent care teams and networks to shape the community care landscape

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Support a learning, collaborative and inclusive culture and maintain positive working relationships	Coach peers and junior care team members to promote professional development and embrace a dynamic, collaborative and inclusive team culture	Lead department and/or teams to achieve established objectives efficiently and provide clinical leadership	Lead the organisation by developing long-term strategy, goals and drive strategies to improve key performance areas
Knowledge	• Techniques for teamwork and collaboration • Goal setting theory • Effective communication techniques • Understanding of the expectations of the care team • Change management techniques • Organisational guidelines on safety • Basic concepts of conflict management	• Culture building techniques • Staff engagement and motivation techniques • Goal setting process • Team performance indicators • Effective communication techniques • Training design concepts • Resource utilisation • Basic concepts of conflict resolution • Clinical supervision process • Organisational guidelines on safety • Performance appraisal requirements • Basic concepts of conflict management • Relevant professional code of conduct, practice and standards	• Leadership principles • Staff engagement and motivation techniques • Strategies to build culture • Diversity and inclusion practices • Goal setting process • Performance indicators for team and department • Training design methodology • Budget management • Conflict resolution methods • Clinical supervision guidelines • Organisational guidelines on safety • Performance appraisal process • Relevant professional code of conduct, practice and standards • Succession planning framework	• Leadership principles and approaches • Best practices in cultivating organisational culture • Staff engagement and motivation techniques • Strategic and systems thinking • Diversity and inclusion • Organisational mission and vision • Evaluation tools and measures for organisational performance • Risk factors to business continuity • Latest trends in technology and skills for nursing • Training design methodology • Advanced resource allocation methods and tools • Approaches to conflict management • Succession planning framework • Performance appraisal framework • Concepts and theories of succession planning • Relevant professional or industry codes of conduct, practice and standards

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Guide junior care team members on care practices and initiate co-learning with peers for the development of the care team • Support a learning, collaborative and inclusive culture and maintain positive working relationships • Communicate expectations to junior care team members and seek clarity on own goals • Monitor performance of junior care team members and provide feedback • Embrace a collaborative and dynamic team culture • Provide input on new areas of education and training programmes • Help junior care team members handle difficult situations as appropriate • Guide nursing students and volunteers to meet their learning objectives	• Coach peers and junior care team members to promote professional development • Demonstrate positive approach to embrace change • Discuss expectations and monitor team's progress to recommend measures for optimising performance • Guide the care team to take action aligned to the organisational changes • Assist in the development of education and training programmes • Provide clinical supervision to enhance capabilities of the care team • Mediate between team members in conflict situations and act in a fair and decisive manner to resolve conflicts • Precept nursing students on their learning needs using various training techniques • Communicate organisational expectations on safety and professionalism • Assist in performance appraisals by providing feedback on junior nurses	• Mentor junior nurses to aid their professional development and build resilience • Promote a collaborative and dynamic work culture • Set realistic departmental goals based on discussions with team members to ensure buy-in • Establish team members' performance indicators and measures for productivity and outcomes of services • Recommend appropriate strategies to improve individual and departmental performance • Coach others to develop opinions and accept changes • Review and design education and training programmes as well as clinical supervision guidelines based on current best practices, skills and technology • Provide clinical leadership, including establishing parameters of services and clinical standards • Lead discussions or counselling for complex conflict situations across teams • Delegate professional practices and aspects of care to team according to their competencies and scope of practice • Reinforce guidelines on safety and professionalism • Provide guidance and leadership in multi-disciplinary and/or cross-department teams to create effective working relationships • Participate in performance appraisals and assist in identifying candidates for further development • Assess performance of junior nurses and develop individual training and development roadmaps in a collaborative manner	• Foster a collaborative culture and develop dynamic and competent care teams • Develop long-term objectives and strategies based on the organisational vision • Translate organisational goals into tangible targets for the organisation • Review organisational performance and implement strategies to improve key performance areas • Mentor others on complex change management and coping strategies • Identify and mitigate risks to the organisation's reputation and business continuity • Oversee the management of business model and operations, along with the levers that can be adjusted to impact various organisational metrics • Promote and maintain the professional role of the nurse by upholding core values of the profession • Manage disagreements and conflicts within and outside the organisation in a logical and composed manner and propose resolutions for a win-win situation • Define organisational guidelines on safety and professionalism • Lead groups, partners and/or communities in identifying a vision, values and principles for community health initiatives • Drive decision-making in performance appraisals to identify candidates for further development • Develop succession planning philosophy in consultation with other stakeholders and facilitate development of identified candidates • Ensure the continuity of leadership in the organisation by nurturing potential leaders

Sources of Information

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2. Kantanen, K., Kaunonen, M., Helminen, M., & Suominen, T. (2017). Leadership and management competencies of head nurses and directors of nursing in Finnish social and health care. Journal of Research in Nursing, 22(3), 228-244. doi:10.1177/1744987117702692
3. Royal College of Nursing. (2009). Integrated core career and competence framework for registered nurses. Retrieved from: https://www.rcn.org.uk/professional-development/publications/pub-003053

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D4 Improvement, Innovation and Research	NIL	E11 Innovation and Quality Improvement	Develop and implement new and improved technologies, services, delivery methods and processes to drive value-based care in the community

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Participate and provide feedback for the development and implementation of innovation and quality improvement projects	Recommend initiatives and implement innovation and quality improvement projects	Design innovation and quality improvement projects and facilitate implementation and integration into practice	Drive innovation and quality improvement strategies for value-based care
Knowledge	• Concepts of innovation and quality improvement • Presentation techniques • Approach to critical thinking • Concepts of change management • Basic knowledge and application of technologies and delivery methods • Roles and responsibilities related to implementation of new or improved services • Organisational standards and guidelines for technologies, services and tools	• Concepts of innovation and quality improvement • Tools and methods of quality improvement • Report writing framework • Presentation techniques • Approach to critical thinking • Framework for change management • Quality indicators for the community healthcare sector • Success measures of innovation and quality improvement projects • Challenges and barriers to innovation and quality improvement initiatives • Knowledge and application of technologies and delivery methods • Approaches to enhance adoption of new technologies • Roles and responsibilities related to implementation of new or improved services • Organisational standards and guidelines for technologies, services and tools	• Best practices of community care systems, technologies, services, delivery methods and processes • Principles of innovation and quality improvement • Tools and methods of quality improvement • Approach to analytical and critical thinking • Quality indicators for the community healthcare sector • Change management strategies • Feasibility assessment for innovation and quality improvement projects • Quality Assurance Framework • Organisational quality standards • Clinical audit processes • Strategies to enhance adoption of new technologies • Roles and responsibilities of community partners and other stakeholders related to the implementation of new or improved services • National and organisational standards, guidelines and legislation on technologies and tools	• Trends impacting community care systems, technologies, services, delivery methods and processes • Systems thinking • Approach to analytical and critical thinking • Quality indicators for the community healthcare sector • Change management strategies • National and international frameworks and platforms for innovation and quality improvement • Feasibility assessment for innovation and quality improvement projects • Clinical audit processes • Framework for value-based healthcare delivery • National and international quality standards

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Collect clients' feedback and provide input on potential areas for improvement • Participate in innovation and quality improvement activities • Undertake interventions to support implementation of innovation and quality improvement projects • Assist in pilot testing and prototyping to determine effectiveness of new technology • Support clients, families and/or caregivers in adopting new technologies, services and delivery methods • Participate in quality assurance activities	• Identify and analyse potential areas for improvement • Seek feedback from clients, community partners and other stakeholders to support innovation and quality improvement activities • Implement innovation and quality improvement activities • Conduct pilot testing and prototyping for new technology • Assist in evaluation of innovation and quality improvement interventions • Identify clients, families and/or caregivers for adoption of new technologies, services and delivery methods • Assist in spreading of innovation and quality improvement interventions within department and/or across organisation • Support team members for appropriate application of new technologies, services and delivery methods • Support quality audits to maintain and improve standards of care	• Explore internal and external practices for improvement and innovation opportunities • Review and prioritise potential areas for improvement • Design innovation and quality improvement initiatives in collaboration with relevant stakeholders • Lead innovation and quality improvement projects • Analyse pilot testing and prototyping results • Evaluate the feasibility and effectiveness of innovation and quality improvement interventions • Assess feasibility of new technologies, services and delivery methods to own setting/client population • Spread innovation and quality improvement interventions across the organisation/department • Promote active adoption of new technologies, services and delivery methods • Develop quality assurance frameworks for technology, services and delivery methods • Conduct and evaluate quality audits to maintain and improve standards of care • Provide feedback on feasibility and effectiveness of new technology to stakeholders	• Analyse trends to distil ideas and opportunities for improvement and innovation • Set direction for innovation and quality improvement efforts in alignment with organisational objectives • Synergise relevant stakeholders to drive value-based design for innovation and quality improvement initiatives • Seek and allocate resources for innovation and quality improvement initiatives • Determine feasibility of new technologies, services, delivery methods and processes • Develop strategies to spread innovation and quality improvement interventions through various platforms • Drive adoption of new technologies, services and delivery methods across community partners • Develop strategies for sustainability and accessibility of technologies, services and delivery methods • Guide the development of quality assurance frameworks and provide inputs based on best practices • Benchmark quality audit results to identify improvement requirements

Sources of Information

1. Hong Kong College of Nursing and Health Care Management. (2015). Competency Framework for Advanced Practice Nurse. Retrieved from: http://www.hkcnhcm.org/index.php/about/competence-framework
2. Royal College of Nursing. (2009). Integrated core career and competence framework for registered nurses. Retrieved from: https://www.rcn.org.uk/professional-development/publications/pub-003053

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D4 Improvement, Innovation and Research	NIL	E12 Evidence-based Practice and Research	Integrate best practices and research evidence in the delivery of care to achieve optimal client `and population outcomes

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Adhere to evidence-based practice guidelines to deliver care	Appraise available evidences and participate in research activities	Lead research project and implement evidence-based practice in the organisation	Set research direction and drive evidence-based practice within the organisation
Knowledge	• Evidence-based practice guidelines and protocols • Basic concepts of evidence-based practice • Basic research ethics	• Evidence-based practice guidelines and protocols • Concepts of evidence-based practice • Research ethics • Research methodology and process • Research guidelines and regulations • Basic statistics for research • Data visualisation	• National and international evidence-based practice guidelines and protocols • Concepts of evidence-based practice • Research ethics • Research methodology and process • Research guidelines and regulations • Statistics for research • Data visualisation	• National and international evidence-based practice guidelines and protocols • Concepts of evidence-based practice • Research guidelines and regulations • Influencing strategies and tactics • Networking strategies
Abilities	• Apply evidence-based practice guidelines in the delivery of care • Encourage peers to apply evidence-based practice guidelines in the delivery of care • Participate in research and evidence-based practice projects	• Identify gaps and research problems in delivery of care based on issues escalated • Search, consolidate and appraise relevant evidences for validity and applicability • Initiate and participate in research activities to generate evidence • Communicate findings of research and impact on delivery of care • Support the integration and promotion of research evidences in delivery of care • Collect feedback for evaluation of evidence-based practice and share results with relevant stakeholders	• Evaluate the relevance and feasibility of proposed research topic to own setting • Introduce relevant sources of evidence and guide the appraisal • Lead research activities in collaboration with relevant stakeholders • Disseminate research findings and implications on delivery of care to relevant stakeholders • Integrate and promote evidence-based practice in delivery of care • Evaluate evidence-based practice outcomes and recommend practice change	• Set research direction and identify priority areas for evidence-based practice • Influence relevant stakeholders to provide access to relevant sources of evidence • Garner support of relevant stakeholders for research activities • Network with other institutions and/or government agencies to corroborate research results • Build a culture of evidence-based practice for delivery of care • Drive practice change in collaboration with relevant stakeholders to obtain optimal client and population outcomes

Sources of information

1. Ward, M., Aumann, O., (co-author.) Di Stefano, G., (co-author.) & Greene, M., (co-author.) & Community Health Nurses Special Interest Group ANF (Vic Branch) (issuing body.) (2013). Practice standards for Victorian community health nurses. [Carlton, Victoria] Community Health Nurses Special Interest Group ANF (Vic Branch)
2. Hong Kong College of Nursing and Health Care Management. (2015). Competency Framework for Advanced Practice Nurse. Retrieved from: http://www.hkcnhcm.org/index.php/about/competence-framework
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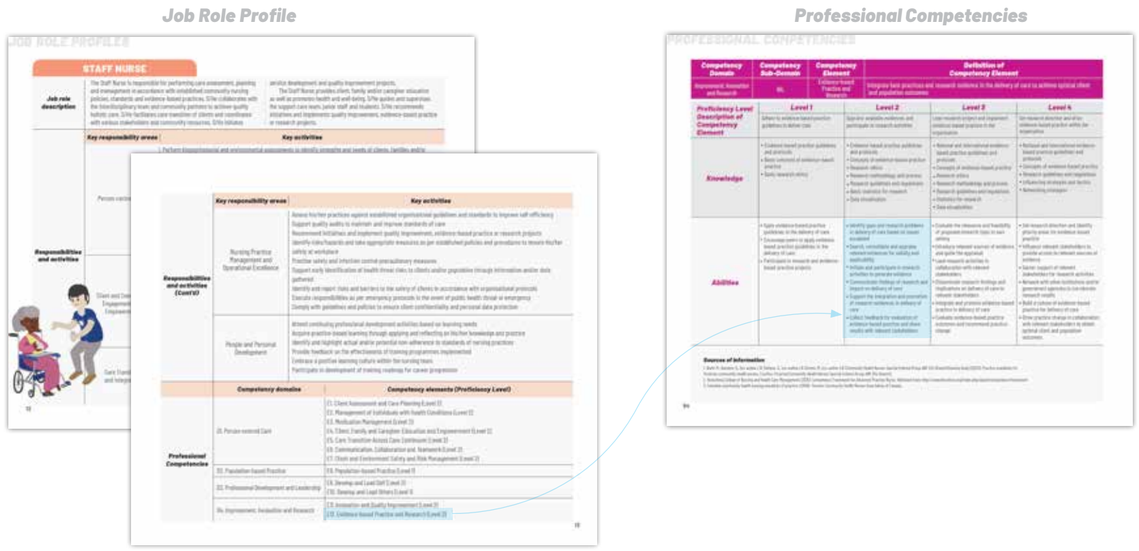
USING THE FRAMEWORK

Linking the Job Role Profiles and Professional Competencies

Job Role Profiles (JRPs) and Professional Competencies (PCs) are linked as illustrated below. In the last section of the JRP document, a list of PCs is stated at the required proficiency levels. The proficiency level indicates the level of knowledge and abilities the incumbent needs to exhibit for a specific PC. Referring to the illustration below, the Staff Nurse has Evidence-based Practice competency tagged at Level 2. This means that the Staff Nurse is required to understand or possess knowledge of the items listed, including the capability to perform the abilities stated at Level 2 of the competency.

Fig 1: Illustration of Linkage Between Job Role Profiles and Professional Competencies



A Training Roadmap has been developed to serve as a repository of Continuous Education and Training (CET) programmes for the sector. Each programme is mapped to proficiency levels within the PCs and can be used as reference for the development of community nurses. This will be described in a separate document.

Glossary

As the framework draws from international resources, this glossary is developed to contextualise the key terms to the Singapore setting. It also contains the sources from which the definitions are derived.

Terms	Definition
Assets	Assets can be described as the collective resources which individuals and communities have to protect them against negative health outcomes and promote health status. (Glasgow Centre for Population Health_concept paper)(e.g. financial/tangible assets, individual capabilities and traits, family and social support network etc.) *Source: Glasgow Centre for Population Health. (2012). Putting asset based approaches into practice: Identification, mobilisation and measurement of assets (pp. 1-24, Briefing paper).* *Retrieved from: https://www.gcph.co.uk/publications/362_concepts_series_10-putting_asset_based_approaches_into_practice*
Clinical measurements	Indexes, rating scales and other expressions that are used to describe or measure symptoms, physical signs and other clinical phenomena. *Source: Laboratory of Psychosomatics and Clinimetrics, Department of Psychology, University of Bologna, Bologna, Italy. (2012). Clinimetrics: The science of clinical measurements. [Abstract]. 66(1):11-5. doi: 10.1111/j.1742-1241.2011.02825.x.*
Complex care needs	Care needs that are dynamically intertwined, require intensive healthcare services coordinated across multiple providers as well as a wide range of social supports to maintain the client's health and functioning. Clients with complex care needs require a person-centred approach of care delivery that is coordinated, interdisciplinary, evidence-based and centred on the needs, goals, and circumstances of the individual. *Source: What is Complex Care? (n.d.).* *Retrieved from: https://www.nationalcomplex.care/our-work/what-is-complex-care/*
Culturally competent care	Nursing care which incorporates cultural sensitivity, knowledge, and skills. *Source: Kim-Godwin, Y. S., Clarke, P. N., & Barton, L. (2001). A model for the delivery of culturally competent community care. Journal of Advanced Nursing, 35(6), 918-925. doi:10.1046/j.1365-2648.2001.01929.x*
Holistic nursing care	Developing a relationship with patients in which the nurse honours and promotes consideration of the wholeness of persons, authentic presence, and facilitation of healing, while incorporating the physical, emotional, spiritual, social, and psychological aspects of the patient's existence in supporting, guiding, and assisting patients in gaining self-knowledge and in co-creating a plan of care. *Source: Kinchen, E. (2014). Development of a Quantitative Measure of Holistic Nursing Care. Journal of Holistic Nursing, 33(3), 238-246. doi:10.1177/0898010114563312*
Interdisciplinary care team	*An interdisciplinary care team consists of practitioners from different health professions, who have a shared patient population and common patient care goals, and have responsibility for complementary tasks. The team is actively interdependent, with an established means of ongoing communication among team members to ensure that various aspects of patients' healthcare needs are integrated, aligned, addressed, and met in a time-efficient manner.* *Source: Academic Geriatric Resource Center, & Reynolds, D. W. (n.d.). Interdisciplinary Team Care Facilitator Guide. University of California Los Angeles, David Geffen School of Medicine.* *Retrieved from: https://www.pogoe.org/productid/21709*
Medication reconciliation	Medication reconciliation is a structured and explicit process of creating the most accurate list possible of all medications a patient is taking, with the goal to ensure accurate and complete medication information transfer during transitions of care. This is usually preceded by the medication review process. *Source: Ministry of Health, Singapore. (2018). The National Medication Reconciliation Guidelines.* *Retrieved from: https://www.moh.gov.sg/resources-statistics/medication-safety*
Medication review	Medication review may be defined as a systematic, critical evaluation of a patient's medications with the objective of reaching an agreement with the patient about treatment, optimising the impact of medications, minimising the number of medication-related problems and reducing waste. *Source: Ministry of Health, Singapore. (2018). The National Medication Reconciliation Guidelines.* *Retrieved from: https://www.moh.gov.sg/resources-statistics/medication-safety*

Terms	Definition
Person-centred care (PCC)	PCC is a holistic (bio-psychosocial-spiritual) approach to delivering care that is respectful and individualised, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual who is receiving the care. Being person-centred means: • Affording people dignity, respect and compassion • Offering coordinated care, support or treatment • Offering personalised care, support or treatment • Being enabling *Source: Morgan, S., & Yoder, L. H. (2012). A Concept Analysis of Person-Centered Care. Journal of Holistic Nursing American Holistic Nurses Association, 30(1), 1-10. doi:10.1177/0898010111412189* *Source: The Health Foundation. (2016, December 16). What is person-centred care* *Retrieved from: http://personcentredcare.health.org.uk/overview-of-person-centred-care/what-person-centred-care*
Quality of life	An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. *Source: World Health Organization. (2014, March 11). WHOQOL: Measuring Quality of Life.* *Retrieved from: https://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/*
Self-management	Actions that individuals and carers take for themselves, their children, their families and others to stay fit and maintain good physical and mental health, meet social and psychological needs, prevent illness or accidents, care for minor ailments and long-term conditions, and maintain health and well-being after an acute illness or discharge from hospital. *Source: Ferrer, L. (2015). Engaging patients, carers and communities for the provision of coordinated/integrated health services: Strategies and tools (pp. 1-66, Working paper). Denmark: WHO Regional Office for Europe*
Value-based care delivery	A framework for restructuring health care systems with the overarching goal of value for patients. Value-based care is a healthcare delivery model which seeks to improve quality and outcomes for patients while rationalising the costs required to provide the desired quality care and outcomes for patients/clients. Value-based care focuses on care coordination that ensures patients/clients are given the right care by the right provider at the right time. The fundamental goal of healthcare is maximising value for patients/clients. $\text{Value} = \frac{\text{The set of outcomes that matter for the condition}}{\text{The total costs of delivering these outcomes over the full care cycle}}$ *Sources: Institute For Strategy & Competitiveness. (n.d.).* *Retrieved from: https://www.isc.hbs.edu/health-care/vbhcd/Pages/default.aspx* *Porter, M. E. (2016). Value-Based Health Care Delivery: Implications for Singapore (pp. 1-42, Publication).* *What is value-based healthcare? (2019, April 17).* *Retrieved from: https://catalyst.nejm.org/what-is-value-based-healthcare/* *National University Health System. (n.d.). Value Driven Quality Care - NUHS: National University Health System.* *Retrieved from: https://www.nuhs.edu.sg/For-Patients-Visitors/Pages/Value-Driven-Quality-Care.aspx* *Institute for Healthcare Improvement. (n.d.). Quality, Cost, and Value.* *Retrieved from: http://www.ihi.org/Topics/QualityCostValue*
Vulnerable clients	A person who suffers from physical or mental infirmity, disability or incapacity, and is incapable of protecting him/herself from harm. *Source: Ministry of Social and Family Development. (n.d.). Protection for Vulnerable Adults. Retrieved from: https://www.msf.gov.sg/policies/Helping-the-Needy-and-Vulnerable/Pages/Protection-for-Vulnerable-Adults.aspx*

Acknowledgements

COMMUNITY NURSING COMPETENCY FRAMEWORK (CNCF) DEVELOPMENT WORKGROUP MEMBERS

Advisor:
Ms Tan Soh Chin
Chief Nursing Officer,
Office of the Director of Medical Services,
Ministry of Health

Chairperson:
Ms Paulin Koh
Deputy Group Chief Nurse, SingHealth
Chief Nurse, Changi General Hospital

Vice-Chairperson:
Ms Chen Yee Chui
Chief Nurse,
National Healthcare Group Polyclinics

Members:

Ms Gillian Beins
Director of Nursing, St Joseph's Home

Ms Stephanie Yeap
Director of Nursing, Outram Community Hospital

Ms Chan Mei Mei
Director of Nursing, Home Nursing Foundation

Ms Fong Yoke Hiong
Assistant Director of Nursing, Tsao Foundation

APN Tay Yee Kian
Assistant Director of Nursing, National University Hospital

APN Zhang Di
Assistant Director of Nursing, Changi General Hospital &
SingHealth Office of Regional Health

Ms Laura Tham
Nurse Clinician, Khoo Teck Puat Hospital

APN Chen Wei Ting
Senior Nurse Clinician, Tan Tock Seng Hospital

Ms Goh Helen
Senior Manager, Office of the Director of Medical Services,
Ministry of Health

Secretariat:

Dr Dong Lijuan
Assistant Director of Nursing, National Healthcare Group Polyclinics

APN Gan Pei Ying
Nurse Clinician, Changi General Hospital

Ms Ng Qi Wen
Senior Staff Nurse, National University Hospital

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