PENINSULA HEALTH

Transition Care Program At Home

Orientation Guide for clients and families.

GENERAL INFORMATION

The Transition Care Program (TCP) provides care and restorative services for up to 12 weeks for older people who have been in hospital. By offering low level therapy and support it allows people to continue their recovery out of the hospital system, while their appropriate long term care plan is determined.

The Peninsula Health Transition Care Program works with Seniors Community Care for the provision of services at home.

There are 2 teams of staff working with you; Seniors Community Care provides the daily care needs such as showering/dressing and domestic assistance.

The Transition Care Team consists of a Social Worker/Case Manager, Physiotherapist, Occupational Therapist, Allied Health Assistant, Dietitian, and Speech Therapist. We will work with you and your family to determine the most appropriate long term care in the community. Your main contact person is your case manager.

Please be mindful that Allied Health professionals, in addition to Seniors carers will be visiting you regularly at home whilst on TCP.

TCP is not a rehabilitation program and is not able to offer the same level of therapy as your previous hospital setting.

Case Manager – Ongoing assessment, planning, facilitation and advocacy for options and services to meet clients holistic needs through communication and available resources.

Physiotherapist – Initial assessment and recommendation of home exercise program.

Occupational Therapist – Ongoing assessment of assistance needed for personal care tasks, along with domestic and community tasks if appropriate. Recommendation of appropriate aides and equipment to increase your independence and safety with daily tasks.

Allied Health Assistant – works in conjunction with OT and Physio to facilitate ongoing therapy goals.

Dietitian – Completes nutrition assessments as required and will review dietary requirements.

Speech Therapist – Assess as required for speech/swallowing difficulties.

The TCP team meets on a weekly basis to monitor and review your progress and make recommendations for your care needs and options for the future. A family meeting can be arranged with you, your family and the team if you wish to discuss the care needs and options in further detail.

MEDICATION

TCP strongly encourage Webster Packs for medication management. Webster Packs and medications are supplied by your pharmacist.

Webster Packs can be delivered. Please consult with your local pharmacy.

Your GP will prescribe you with scripts as required.

GP (LOCAL DOCTOR)

It is recommended you book an appointment with your local GP within one week post discharge from hospital.

Your GP can review medications, and manage your ongoing medical needs.

With your permission, a letter will be sent to your GP, advising of your admission and discharge from TCP.

SENIORS

Seniors Community Care provides a range of quality care services to meet the needs of those who wish to remain living independently in their own home.

An individual care plan will be developed between yourself and the Case Manager, according to your needs.

This will be reviewed as required. Please speak with your Case Manager regarding any changes you would like to make to the care plan.
Through TCP, Seniors are able to provide the following services:

- Personal Care
- Home Help
- Shopping assistance – escorted or unescorted
- Manor Meals
- RN/Wound management/Medication management
- Transport
- In home respite
- Meal Preparation

COMMUNICATION BOOK

A communication book will be supplied by TCP for use by Seniors carers, TCP staff and yourself and family as required. Your Case Manager will regularly read any comments/questions.

WE VALUE YOUR FEEDBACK

We welcome your feedback about your experience on the Transition Care Program. Please let us know about your concerns, suggestions or compliments regarding any of the services provided.