

Our team of nurses, Occupational Therapists, Physiotherapists, Social Worker, Dietician, Speech Pathologist and Allied Health Assistants support you to identify and achieve your goals after your hospital stay.

We operate a weekday service from 8am to 4.30pm. Weekend services are limited to those clients where it is clinically required.

If you were receiving support through another aged care provider prior to your hospital admission, these services can be placed on hold for the duration of the Transition Care Program.

Our program has six beds at Gordonvale Hospital to assist you if you require home modifications to be completed, are awaiting carer support or just need additional support prior to going home.

Transition Care Program does not provide in home or community based respite.

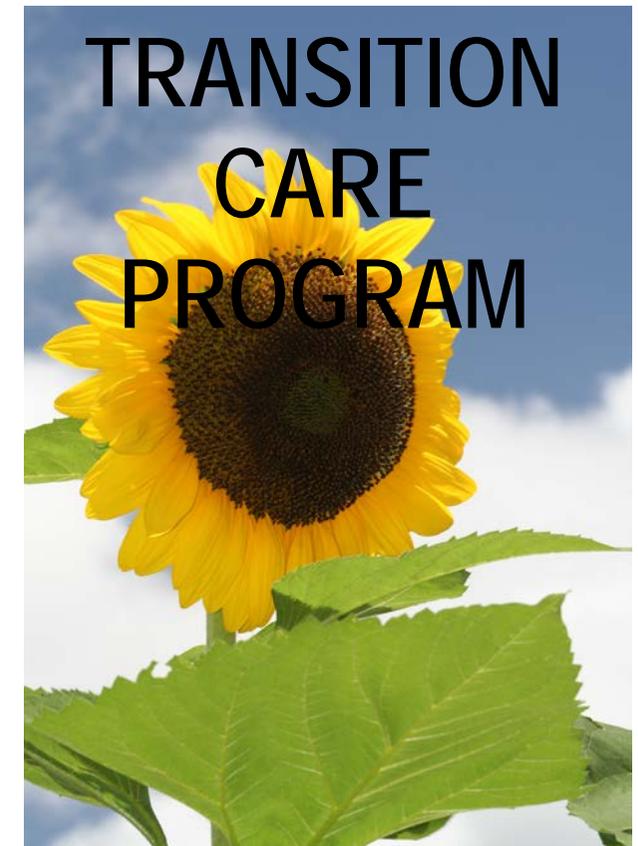
Services are provided at the discretion of the Transition Care Program team. Best efforts are made to adhere to these provisions however the Transition Care Team reserves the right to deviate from these provisions when required.



CONTACT DETAILS

Transition Care Program

PO Box 851,
Cairns North 4870
Phone 4226 4563
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The Transition Care Program provides time-limited, goal oriented support to optimise your transition from hospital and to stay at home

Case Management

We will provide all clients with a case manager to coordinate your package of care. Your case manager will provide an initial home visit, support to identify your goals, liaise with your GP and other services/supporters and will provide you with a summary of achievements at end of the program.

Nursing

Nursing staff review your medication with you and can provide medication assistance as determined by your nurse between 8:30-3:30pm on weekdays. We supply continence aids initially in accordance with the hospital discharge plan where there was no prior approval through Continence Aids Payment Scheme or Medical Aids Subsidy Scheme. Wound management can also be provided up to twice a week.

Allied Health

You will be assessed by our team and your needs and goals will determine which Allied Health team members will support you during the program. At the start of the program, Allied Health staff may each visit you up to once a week. Ongoing visits will be based on your needs and goals. Our Allied Health Assistants may work with you to achieve your goals up to three times per week during the program.

Dietician

Our Dietician can complete an assessment of your dietary needs. Supplements and education can be provided to support you to achieve your goals during the program. Short-term support with Meals on Wheels can also be coordinated by our team if required.

Domestic Assistance

Our team can provide up to 60-90 minutes of house cleaning/laundry/shopping assistance each fortnight where no alternative support is available.

Personal care

We can support you to increase your independence when showering, drying and dressing up to three times a week.

Podiatry

An in-home podiatry services can be provided as clinically indicated.

Transport

If no other alternative is available, we can provide you with transport home from hospital and to medical appointments related to your hospital admission. Transport services are limited to the hours between 9:00am and 3:00pm on weekdays.

Equipment

An Occupational Therapist will assess your needs and equipment essential for your discharge home can be provided for the duration of the Transition Care Program. Some equipment can not be provided i.e. hospital beds, oxygen concentrators.

Medical Alarm

Clients are provided with a medical alarm for the duration of the program which they can use 24 hours per day seven days a week in case of emergency.

