Transition Care Program

Accepts referrals from all public and private hospitals within the Townsville and North West Health Service Districts and other Transition Care Programs

**AIM**
- To provide short term support and active management to assist older people to transition from hospital to home via therapy based, goal orientated care and services.
- Services are tailored to optimise physical, cognitive and psychosocial functioning to optimise personal capacity for independent living and assist in making appropriate long term care arrangements eg. HACC services, Home Care Packages Level 1, 2, 3, 4 or residential placement.

**ELIGIBILITY**
Aged Care Assessment Team approved for flexible care and:
- Current hospital inpatient
- Medically stable and ready for discharge
- Maximum one assist for mobility and assessed as safe in their discharge environment
- Potential to improve or maintain their physical function
- Capacity to benefit from goal-oriented, time limited and therapy focussed package of care that includes at least, low intensity therapy and nursing support or personal care

**PROCESS**
- Referrals are accepted from all inpatient sources including pre admission clinics and self-referral.
- Potential patients should be identified at least 72 hours prior to discharge, be medically stable and completed their sub acute care episode if required.
- Complete referral form and fax to 4433 4501.
- TCP Assessor will visit within 2 business days to gain patient agreement to participate in the program and undertake an aged care assessment to gain approval for flexible care.
- TCP Assessor will document the ACAT approval in the medical record and notify the ward shift coordinator to confirm discharge date, time and transport arrangements.
- 1000hrs discharge is preferred to enable best continuum of care in the community.
- Clients requiring medication monitoring and/or assistance must have a webster pack.
- Discharge summary, allied health handover reports and discharge medication list must be faxed to the TCP office at least by time of discharge.
- Medical aid equipment loan requires 24 hours to arrange.
- Notify TCP of time patient leaves the hospital.
- If a TCP client is readmitted to hospital for 24 hours or more, they must be discharged from the program.
- Readmitted clients can be accepted back on the program if the ACAT approval is still valid ie up to 28 days from date of approval.
- If a readmitted client is outside the valid period a new referral and ACAT assessment is required if the client would benefit from continuing on the program.
SERVICES

Nursing
- Case management – coordinate care and establish community supports and services
- Wound care
- Continence assessment and management
- Pain management

Allied Health Services
- Physiotherapy
- Occupational Therapy
- Dietetics
- Podiatry
- Social Work

Medical
- GP oversight

Assistance
- Personal care
- Domestic
- Shopping

Safety
- Personal alarm system loan
- Medical aid equipment loan
- Home modifications (client may be required to contribute some costs)

Cost: 17.5% of single pension (community based)
85% of single pension (residential based)

CONTACT US

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