BRHS Transition Care Program
Client Information

Essential information to help you in your transition from hospital to home

BRHS Bairnsdale Regional Health Service

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This booklet provides important information about Transitional Care Program This is a Program at Bairnsdale Regional Health Service which explains what you can expect when you are receiving care.

It explains your rights and responsibilities and the obligations of your Transition of Care Service.

A formal agreement between yourself and Bairnsdale Regional Health Service will be entered into when you decide to participate in the Transition Care Program.

When you sign this agreement you authorise Bairnsdale Regional Health Service to provide your personal details and information about your health and the care you receive under the Program to your medical practitioner, relevant service providers, nominated persons including family or carers, and Commonwealth and State Departments of Health.

Information about you will not be disclosed to any other person or organisation without your permission.

Information is also required to be provided to the Commonwealth Department of Health and Ageing and the Victorian Department of Health. This information is required for funding and evaluation purposes.

The information in this brochure has been adapted from the Transition of Care Program Information Booklet developed by Orbost Regional health Service. It is intended as a guide to one of the services provided by BRHS and is correct at the time of publishing.

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Bairnsdale Regional Health Service is located on the traditional land of the Gunaikurnai people.

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What is TCP?

The Transition Care Program (TCP) provides care and restorative services for a short-term period for older people who have been in hospital. By offering low-level therapy and support it allows older people to continue their recovery while appropriate long-term care is arranged.

To receive TCP you will need to be assessed and approved by the Aged Care Assessment Service while you are in hospital. TCP is a joint Victorian-Commonwealth Government program established under the Aged Care Act 1997.

Where will I receive TCP?

TCP will be provided in a rehabilitation ward in an acute hospital setting.

How long can I stay on the program?

TCP will start as soon as you are discharged from your hospital admission. How long you stay on the program will depend on your own care needs and goals. Most people will stay on the program for six to eight weeks. The maximum is 12 weeks. Within this time your Care Co-ordinator will work with you to arrange suitable long-term support.

What are the care and services available under the TCP?

The type of care you receive will depend on what you need and where you receive TCP.

Services that may be arranged include:

Services provided during TCP admission

- Case management
- Nursing
- Meal assistance
- Bathing and showering
- Social activities or diversional therapy
- Low-level therapy such as physiotherapy
- Continence aids

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Services available on discharge

- Domestic home care
- Equipment
- In-home respite
- Other support services as required

It is unlikely you will require all of the services listed above. Hospital and TCP staff will discuss with you what you need and what you can be provided with from the available funding.

The full range of specific care and services that can be provided are listed in the national TCP guidelines. If you would like a copy please ask your Care Co-ordinator.

What types of services are not included?

If you require general medical services such as pathology or radiology services, or an appointment with your GP, then TCP staff can help you with your appointments however you will need to pay for these services in the usual way.

Pharmacy medicines are also not included as part of TCP and you will be required to pay for these separately. Your Care Co-ordinator will tell you how this will be arranged.

What is case management?

Case management is an important part of TCP. A Care Co-ordinator will help you (and your carer or family) from the time you start on the program to when you finish. Along the way your Care Co-ordinator will help you set goals for what you want to achieve. Case management involves:

- Initial and ongoing assessment of your care needs
- Co-ordinating and monitoring your care plan with you
- Liaising with service providers to keep them advised of changes required in your care plan
- Ensuring you have the opportunity to participate in decisions affecting your care
- Providing information and education
- Acting as an advocate or supporter on your behalf if required
- Providing emotional support to you and your carer
- Developing a discharge plan in consultation with you to ensure the support and

services you need when you are discharged are in place.

What will I need to pay?

TCP receives funding from the Victorian and Australian governments; however you are also asked to pay a fee to contribute to the cost of your care.

How much is the fee?

The maximum fee is determined by the Australian Government and is calculated as follows:

· **Residential clients** - daily rate of 84% of current single aged pension

If through financial hardship you are unable to pay the fee as calculated above, please discuss this with your Care Co-ordinator. If applying for a fee reduction, you may be asked to show proof of your income and financial situation.

How are the fees collected?

Your Care Co-ordinator will provide you with information about how to pay your fees. Usually you will be sent an invoice once you are receiving TCP. If you are unable to pay your fees on time, please discuss this with your Care Co-ordinator.

What if my care needs change?

It is expected that your care needs will change while you are receiving TCP. As your health improves you may need less or different services. Your Care Co-ordinator will keep in contact with you and review your services regularly.

If your care and service needs increase significantly, your Care Co-ordinator will discuss with you whether TCP can provide the care you need. They will also consult with the people involved in your care to work out how TCP can best assist you. This may include changing from TCP in a residential setting to TCP in an aged care setting.

If TCP is no longer able to provide adequate care to support you, your Care Co-ordinator will work with you to make alternative arrangements at which time TCP will finish. These arrangements will be confirmed in writing.

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What happens if I need to return to hospital during TCP?

If you are only going to be in hospital for a day or overnight, then you can return to TCP when you are discharged from hospital.

If you require a longer hospital stay then your TCP will end.

If you would like or need to return to TCP then the hospital will check whether there is a place available and if you need to be re-assessed by the Aged Care Assessment Service.

What quality of service can I expect?

To ensure you receive care of a high standard, TCP has a Quality Improvement Framework and Monitoring System. The system covers such things as quality of care, staff, support , your rights and complaints.

You can expect that TCP will:

- be based on an assessment of your needs with input from you and the health professionals involved in your care
- involve you in all the decision making about your care
- document your care in a written care plan and provide you with a copy
- be focused on achieving your goals
- be provided in a timely, flexible and responsive manner
- be provided by experienced, skilled staff
- be provided in a safe, home-like environment (where TCP is provided in an aged care setting).

What are my rights and responsibilities?

We all have rights no matter where we live or how much assistance we need.

When you are receiving TCP you have the right to:

- be treated as an individual, to be treated with dignity and shown respect
- support in decision making processes and someone to speak on your behalf, if you require it
- information to assist you to make decisions about your care
- expect that your needs and those of your carer will be treated as most important when your care plan is being organised

- be part of any planning and decision making that affects you and your chosen lifestyle, including:
    - the development of your care plan
    - talking freely and in confidence with your Care Co-ordinator about any aspect of your care requirements
    - an interpreter and culturally appropriate services.

Who will be provided with information about me?

When you are receiving TCP, information is required to be shared with your medical practitioner, other health professionals and relevant service providers. This is so your care plan will best meet your needs.

What if I have a concern or a complaint?

All people using health and aged care services have the right to make a complaint and take the steps to sort out any problems.

If you have a complaint or concern you have the right to:

- raise it without fear of retribution
- have the matter resolved in the shortest possible time
- have an advocate of your choice, if you wish
- appeal to senior levels of management.

TCP works to ensure that problems and concerns are dealt with promptly and confidentially. If you have a problem, issue or concern, you are encouraged to discuss this with your Care Co-ordinator. Often problems can be quickly resolved before becoming a major issue.

If you have a complaint

All TCP services have a complaints resolution system to provide a process for addressing your complaint, or those made on your behalf. Your Care Co-ordinator will give you a brochure that provides information about the system and how to make a complaint.

Where possible, it is always best to talk to your Care Co-ordinator about your complaint. However you may decide that your complaint should be raised with the Nurse Unit Manager. In both cases your complaint will be dealt with promptly following the complaints resolution system.

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If you are unable to raise your complaint with your TCP service, or you are dissatisfied with the outcome of your complaint, you may wish to raise your complaint with an external organisation.

In Victoria, the Health Services Commissioner is responsible for receiving and resolving complaints about health service providers. The Commissioner is also responsible for receiving and resolving complaints about TCP.

You can contact the **Office of Health Services Commissioner on 1800 136 066.**

As TCP is a Commonwealth funded aged care service, you also have the right to access the **Aged Care Complaints Scheme on 1800 550 552** if you believe your complaint has not been resolved by the Health Services Commissioner.

If you require information, assistance or someone to speak on your behalf, you can contact the **Aged Care Advocacy Program on 1800 700 600**. This is a free and confidential service for people receiving aged care services.

If you have feedback

You will be sent a client satisfaction form at the end of your program. This form gives you an opportunity to tell us about your experience of TCP. You are also welcome to complete the BRHS feedback form available at the hospital or, online at www.brhs.com.au at any time.

We welcome your suggestions on how we could improve the service for you and future clients.

Contact Information

For further information of the Transition Care Program please contact Bairnsdale Regional Health Service on **03 5150 3333.**

TCP Office Hours are **Monday to Friday 8.30am - 4.30pm.**