Transition care after hospital

Summary

- If you are about to be discharged from hospital but feel that you may need extra help, the Transition Care or Home and Community Care Programs offer assistance.
- Talk to your hospital healthcare team about arranging any services you need on discharge. An Aged Care Assessment Services assessment may be needed.
- The Transition Care Program includes a range of allied health services such as dietary advice, physiotherapy, social work, nursing support, social activities and personal care.
- Your healthcare team will help you to organise any mobility aids and equipment you may need before you leave hospital.
- Your GP will develop a discharge plan for when you leave hospital, which will include details about your ongoing treatment and medication.
- Contact your GP or NURSE-ON-CALL (1300 60 60 24) if you feel you need to check anything with a healthcare professional.

If you are about to be discharged from hospital but feel that you may need extra support for a while, the Home and Community Care (HACC) Program or the Transition Care Program (TCP) could be good options for you.

Accessing home support services

The kind of support you are eligible for will depend on your age and health.

The HACC Program provides basic support and maintenance services while the TCP provides short-term care through tailored support services for older people after they leave hospital. This allows older people to continue their recovery out of hospital while appropriate long-term care is arranged.

When you are about to be discharged from hospital, your healthcare team at hospital will arrange any support programs you need. They can also provide you with information about care services if you want to organise extra support once you return home.

Home and Community Care (HACC) Program

If you think you might benefit from getting some help in the home or from allied health services, talk to your doctor about how you can get local support services through the HACC Program.

You do not need a Aged Care Assessment Services (ACAS) assessment to receive HACC services as the organisations that provide these services conduct their own assessments to work out if you are eligible and how much it will cost.

To get an assessment for HACC services, contact your local council or ask your doctor for a referral.

Services available through HACC include:

- housework
- home maintenance
- transport
- personal care
- nursing
- respite care
- social activities
- allied health services.
For more information see the **Home and Community Care** fact sheet.

**Transition Care Program**

The TCP provides a higher level of support than HACC and requires approval by the ACAS while you are still in hospital.

The ACAS assessor (a doctor, nurse, social worker, physiotherapist or occupational therapist) will visit you in hospital to ask you about how you are managing day-to-day and about your overall health situation. At the visit, the assessors will give you information about the types of services that are available. Whether you are eligible for the TCP will depend on your individual needs, not on your ability to pay.

You can receive the TCP in a bed-based care setting (such as in a nursing home) or in your own home, depending on the type of care you need. Some people may even use the TCP in both settings during their time on the program.

Transition care services include:

- case management
- allied health services such as physiotherapy, dietetics, podiatry and social work
- nursing support
- personal care.

For more information:

- talk to your discharge planner or hospital social worker
- visit the **My Aged Care** website.

**Aids and equipment**

Before you go home from hospital, your healthcare team will work closely with you to find out what aids and equipment you may need when you go home. It’s a good idea to tell your healthcare team if you have any concerns about going back home, as they may be able to address these concerns.

Your healthcare team can help you get certain aids and equipment to help with your day-to-day life, for example, a walking frame or shower seat. They can help you decide what you’ll need, and also give you information about who to contact should you need any extra aids or equipment once you’re home.

Once you get your aids and equipment, your healthcare team will also check in with you regularly to see if the aids and equipment are meeting your needs or whether they need to make any adjustments or changes. Find more information on the **Home aids and equipment** fact sheet.

**Support networks**

Recovery at home can be a slow and lonely experience if you do not have family or friends close by. However, there is a wide range of support networks available for people leaving hospital, ranging from social and peer support (such as online and in-person support groups) through to organisations offering support around particular health conditions (such as the **Cancer Council Victoria** and **beyondblue**).

Ask your healthcare professional or local doctor about support groups in your area, or search our **Health Services Directory**.

**Discharge plan**

Your doctor will develop a discharge plan for when you leave hospital. This plan will cover:

- your expected date of discharge
- your living arrangements (if you live alone, if someone can be there to help, what services you currently receive and if you have caring commitments of your own, such as an elderly partner)
- any possible restrictions on your activities such as lifting or driving a car
- your expected recovery and how long it will take
- any extra services you might need at home, such as wound care
- any aids and equipment you will need to help you to recover and regain your independence.

Your discharge plan will also be sent to your local doctor. Share this plan with any new healthcare professionals you see during your recovery. If things are not working out

If things are not working out
If you are feeling unwell once you get home or you are not recovering as expected, check your hospital discharge plan to make sure you are following the instructions.

Contact your doctor or NURSE-ON-CALL (1300 60 60 24) if you feel you need to check anything with a healthcare professional.

Sometimes the road to recovery can be long and the path ahead unclear. If you find you are struggling with your recovery emotionally, speak with your doctor, social worker, counsellor or community health centre. Your physical recovery will be most effective if you are mentally well.

Where to get help
- Your GP (doctor)
- Aged Care Assessment Services
- Commonwealth Respite and Carelink Centre on 1800 052 222
- Local council (HACC Program)
- Your local community health centre or district nursing service (HACC Program)
- Your migrant resource centre or ethnic or Koori organisation (HACC Program)
- Carers Victoria, call 1800 242 636
- Seniors Information Victoria, call 1300 135090
- Aged Care Complaints Scheme, call 1800 550 552

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