FEES:

Client contributions of up to 17.5% of the daily rate of a single pension may be negotiated with the Transitional Care service provider. In some circumstances – fees may be waivered. No client will be excluded from the program based on inability to pay.

DISCHARGE:

On discharge from Transitional Care, referrals can be made to other community services if required and a discharge summary will be sent to your GP.

CONTACT DETAILS:

Blacktown TACP: (02)9881 7187

Aged Care Assessment Team (ACAT): (02) 9881 8288

CONFIDENTIALITY AND ADVOCACY

All information concerning your care is confidential. A health record will be created and information may be shared amongst other health professionals to optimise your care. You are entitled to an advocate if you wish.

A free and confidential Health Care Interpreter Service is available.
Auslan Interpreters are also available.

AFTER HOURS

If you require medical assistance after hours contact your G.P.

In the case of an emergency please contact 000 or attend your nearest Emergency Department.

WSLHD TACP: May 2015

NSW GOVERNMENT Health
Western Sydney Local Health District

BLACKTOWN TRANSITIONAL AGED CARE PROGRAM (TACP)

Covers clients living in the Blacktown Local Government Area

(02) 9881 7187

To maximise quality of life and independence

INFORMATION FOR CLIENTS/ CARERS AND THEIR SIGNIFICANT OTHERS

What is Transitional Care?

The Transitional Aged Care program (TACP) aims to provide a short-term therapy based service (up to 12 weeks plus an extension in certain circumstances) to clients in their own home and community environments immediately following a hospital admission.

Aim:

The aim of the Transitional Aged Care Program is to work with the client and their carer/family towards regaining and improving function to maximise independence. An multidisciplinary team will provide your individual care needs.

STAFFING may include:

Physiotherapists
Occupational Therapists
Social Workers
Community Care Aides
Geriatricians
Secretary

Your G.P is an integral part of your care, so TACP staff will continue to liaise with them as needed.

Who is eligible?

You need to be an older person and

- In hospital, nearing the end of your hospital stay
- Be able to benefit from a program that will help improve your recovery and restore independence as much as possible
- Have been assessed by the Aged Care Assessment Team (ACAT) as being eligible
- Wish to be part of the Transitional Care

Client Must Also:

- Have sustained a recent injury, illness or surgery that has reduced their ability to cope at previous level of function.
- Have the potential for improvement back to or above their previous level of function.
- Be medically stable at time of discharge from hospital.
- Be able to walk independently (with or without aid) if they live alone or need only minimal assistance with mobility by a live in carer.
- Be willing to participate in a **therapy-focused program** both

During hospital admission:

- Potential Transitional Care clients are identified by hospital staff.
- Transitional Care is discussed with the patient.
- Referral to Transitional Care will occur if appropriate
- Your ACAT assessment will take place in hospital
- A Transitional Care team member will visit you to complete an agreement and discuss your care needs.

After discharge from hospital:

- During the first week the client, (carer, family) and Transitional care staff develop an individual therapy program and service plan that works towards achieving both therapeutic and client identified goals.
- Type and frequency of therapy and services will depend on client needs, e.g. physiotherapy, occupational therapy, social work, personal care, assistance with domestic tasks, shopping, transport, and leisure pursuits.
- Eligible clients will also be strongly encouraged to attend group therapy with other clients on the program at