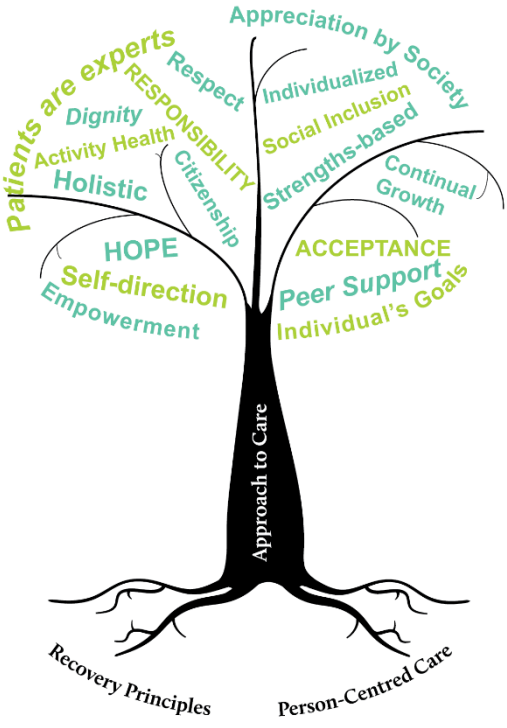
Providence
Transitional Care
Centre

GUIDE

What is Transitional Care?

A guide about transitional care services



Transitional Care

Transitional care is intended to provide the right level of care for patients to support their move (transition) back to the community or to another level of care (i.e. high intensity rehabilitation) who no longer need acute care and/or to avoid an unnecessary hospital admission.

Our goal is to ensure patients are receiving “the right care in the right place,” according to their individual care needs for a better outcome. **Once a patient no longer requires the level of care provided at Providence Transitional Care Centre, the goal is for them to return home or to a community setting**. Planning for discharge starts as soon as a patient arrives, so that required care and services are in place after the hospital stay.

Four clinical services will be offered at PTCC

Restorative Transitional Care:

- Rehabilitative and recreational activities to build strength & stamina, to manage at home or participate in higher intensity rehab.

Cognitive Behavioural Support:

- Behaviorual care to build strategies to manage mild to moderate behavioral, cognitive impairment or wandering.

Short Stay Respite:

- In response to a frail older adult who is deteriorating & caregiver burnout, patients may be admitted for a period of restoration & caregiver relief. We are exploring options to provide scheduled respite stays for families caring for patients long-term in the community to avoid caregiver burnout.

Restorative Convalescent Care:

- Activation care to maintain strength while waiting for another medical service or procedure or transition to Rehabilitation (i.e. patient is currently non-weight bearing who will become a candidate for high intensity rehabilitation).

Where will PTCC Referrals come from?

- Patients may be admitted to PTCC from:
  - **South East regional hospitals** readying for PCH programs, or needing further activation and strengthening to return home, including from the ER
  - Home Care/Primary care in the **community** who may need restorative care to remain in a community setting
  - **PCH** for further activation and strengthening to return home

PTCC Referrals

- Patients will be referred using the PCH Referral form and process.
- The Patient Flow Team will assess patients for all programs, including the Transitional Care Centre
- Processes still in development to support Emergency Department and planned weekend/evening admissions

Admission Eligibility

Admission eligibility will be assessed on a case by case basis, considering the referral information, patient needs and destination, and established conditions and treatments depending on patient acuity and staff skillset on the unit at the time of referral

To be considered for admission patients must be able to:

- Participate in activation (therapy and recreation)

- Potential for restoration

- Potential for transition to a rehabilitation program

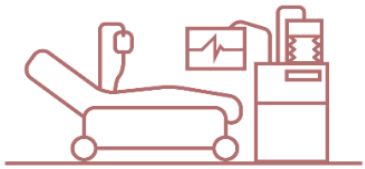
- Have a goal to return home or to the community

- May have cognitive and responsive behaviours and/or wander

The following patients will *not* be considered for admission:

- Those with severe responsive behaviours/sexual disinhibition

- Those who fit the criteria for an acute care admission or admission to programs at PCH



- Those not returning to the community

Delivery of this Program

Care on the two units will involve patients in a high level of activation that mirrors their routines at home by the interprofessional care team. Also included are a number of key support services, with spiritual care, social work, discharge planning and an integrated role for Home Care Coordinators.

On-unit Activation Rooms

Provide a range of equipment for patients to strengthen and increase tolerance to manage activities back at home. Fully equipped patient rooms have been renewed with shared spaces for restorative or recreational therapies. Active restoration will take place days and evenings Monday to Saturday.

Independent Living Suite

This suite is available as patients progress to return home, where **caregivers** will be able to stay with the patient as they ready for discharge with the support of the care team close by.

Options for **respite care** are being developed so that patients and their caregivers can access short-stay support while caregivers recover from a health situation or to have a needed break. Contact us for more information on how to access and book this service.

Meal Times Matter

A mix of congregate dining and tray services will be available for nutrition and social interaction. A kitchenette is equipped with light snacks on each unit.

A **program kitchen** is equipped on Level 2 for practice as patients prepare for home.