

# Community Outreach Team

## West Bedford Transitional Health



# Community Outreach Team

## What is the Community Outreach Team?

The Community Outreach Team are health care providers who will work closely with you and your support persons as you leave West Bedford Transitional Health. We work with people who live in the Halifax (HRM) and West Hants regional municipalities.



## **What does the Community Outreach Team do?**

- We make home visits, help you access services, equipment, and technology that you need, and help you with problems as soon as we can.
- We work with a network of health care and community service providers to create your care plan. These include:
  - › Primary care
  - › Home support and nursing services
  - › The Canadian Red Cross
  - › Alzheimer Society of Canada
  - › Caregivers Nova Scotia
  - › Community Health Teams
  - › Food programs (like Meals on Wheels)
- We look at more than just your medical needs to treat you as a whole person and understand what you will need to live successfully at home.
- With your consent, we will share any important information about your health with your support persons or your primary health care provider (family doctor or nurse practitioner).

- We will support you after your discharge from West Bedford Transitional Health. We look forward to working with you and making sure you get the support you need at home.

## **My Community Outreach Team:**

**Name:** \_\_\_\_\_

**Role:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Role:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Role:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

## **Do you have feedback for our team?**

We would love to hear from you! Please send your questions, comments, or concerns to:

- › Email: [Lynda.Culley@nshealth.ca](mailto:Lynda.Culley@nshealth.ca)

## Dennis' Story

After Dennis' stay at West Bedford Transitional Health, the Community Outreach Team helped Dennis build up both his confidence and his skills.

The Team made sure Dennis' home was accessible and provided emotional and practical support while he made the change from rehabilitation to daily life.

Dennis was impressed by how much the team cared and how they kept in touch with him after he had left the hospital.

*“Keeping the communication open with the patient who’s not physically present in the building means an awful lot”.*

– Dennis



## Getting you home safely checklist

- ☐ I have reviewed and understand my care instructions.
- ☐ My support persons or caregiver have reviewed and understand my care instructions.
- ☐ I know who is picking me up and how I am getting home from the hospital.
- ☐ I have my house key or can access my home.
- ☐ I know what medications I will be taking, what they are for, and what side effects I may have.
- ☐ I know the date, time, and location of my follow-up appointments.
- ☐ I know what activities I will need help with and have made plans to get help with them.
- ☐ I know what equipment and medical supplies I will need.
- ☐ I know what symptoms to look for, and when I should see my primary health care provider or go to the Emergency Department.
- ☐ I know which Community Outreach Team member to call if I need help at home.

On the next page, write down any questions you may have about your discharge plan or your care once you are home. Make sure you tell us about any concerns before you go home.

# Notes:

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This pamphlet is for educational purposes only. It is not intended to replace the advice or professional judgment of a health care provider. The information may not apply to all situations. If you have any questions, please ask your health care provider.

Find all patient education resources here:  
[www.nshealth.ca/patient-education-resources](http://www.nshealth.ca/patient-education-resources)

Connect with a registered nurse in Nova Scotia any time:  
Call 811 or visit: <https://811.novascotia.ca>

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To be reviewed December 2028 or sooner, if needed.  
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