FOR REFERRING PROFESSIONALS

Dayspring Gardens Referral Pack

Referring a patient to a small assisted-living home in Northriding, Randburg — admission, care scope, step-down and respite stays.

- dayspringgardens.co.za

Contents

Referring a patient to a small assisted-living home in Northriding, Randburg — admission, care scope, step-down and respite stays.

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Referring a Patient to Dayspring Gardens

How to refer a patient to Dayspring Gardens, a small assisted living home in Northriding, Randburg: who we suit, what to send, and how the assessment works.

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SECTION 01

Referring a Patient to Dayspring Gardens

Dayspring Gardens is a small assisted-living home at 209 Bellairs Drive, Northriding, Randburg, offering long-term assisted living and short-term respite or convalescent stays, with 24-hour support, home-cooked meals and a visiting physician. It broadly suits older adults who need daily support — personal care, medication oversight, meals, mobility assistance — in a small residential setting rather than a clinical one. To refer a patient, phone **+27 63 583 2543** or email info@dayspringgardens.co.za with the patient's broad care picture; a care assessment follows, and the family is welcome to visit at any stage.

> **An assisted-living home provides daily personal support — help with bathing, dressing, meals, medication and mobility — in a residential setting with round-the-clock staff presence, for older adults who no longer manage safely alone but do not need continuous nursing care.**

If the patient in front of you fits that description, a referral here is straightforward. If you are unsure, phone anyway — borderline presentations are assessed individually, and you will get a plain answer either way.

The referral path

The path is deliberately short:

1. **Contact.** Phone +27 63 583 2543 or email info@dayspringgardens.co.za with the patient's broad care picture — current needs, mobility, medication, and whether the placement is long-term or a short stay.
2. **Care assessment.** Dayspring assesses the patient's needs against its care scope. Timing and format are confirmed directly when you call.
3. **Family visit and placement.** Families are welcomed for a visit at any stage — most find that seeing the home, its shared lounges and gardens, answers questions no phone call can.

There is no referral form to hunt down and no gatekeeping layer. You speak to the home directly, and the same conversation covers both placement types: long-term residence, or a short-term respite or convalescent stay with a defined end date. If the placement type is still undecided — as it often is straight after a hospital admission — say so; a short stay is frequently the sensible first step, and the longer-term question can be answered once the patient is settled and observed.

What helps a referral move quickly

The assessment can only move as fast as the picture you provide. The most useful items, in rough order of value:

- **Current care needs and mobility** — what the patient needs help with daily, and their transfer and walking status.
- **Medication list** — current prescriptions, ideally with dosing times.
- **Relevant history** — diagnoses and recent events that bear on daily care.
- **Discharge summary** — if the patient is coming from hospital.
- **Family contact** — the family member or proxy who will be part of the decision.

None of these need to be polished. A GP's two-paragraph email with a medication list attached is a perfectly good referral.

What Dayspring Gardens is not

Honest scope keeps patients safe, so it bears stating plainly: Dayspring Gardens is not a hospital, and it is not a frail-care facility or a specialised dementia unit. Patients who need intensive nursing, advanced dementia care with wandering or behavioural risk, or complex clinical management are better served in settings built for those needs — see options beyond assisted living for how that landscape works in South Africa.

That is right-care matching, not rejection. Where a patient sits outside Dayspring's scope, the home will say so plainly and point you onward. For the detail of who thrives here and where the boundaries sit, see admission criteria and care scope.

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Post-hospital and respite referrals

Two referral types deserve their own guides. If you are a discharge planner or case manager with a date looming, the discharge planner's guide leads with the operational detail — documents, timing, transfer checklist. If your care plan has a temporary gap — a carer hospitalised, a frail-care bed awaited — short respite stays are covered in respite for care-plan gaps.

Referrals and enquiries

- **Phone:** +27 63 583 2543
- **Email:** info@dayspringgardens.co.za
- **Online:** the enquiry form

Prefer it printable? Download the professional referral pack (PDF) — the essentials of these four guides in one document. For anything patient-specific, phone: the individual case is always the fastest conversation.

SECTION

02

Admission Criteria and Care Scope

Admission criteria and care scope at Dayspring Gardens: the profile that thrives in assisted living, needs that sit beyond it, and when to phone about a case.

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SECTION 02

Admission Criteria and Care Scope

Dayspring Gardens admits older adults who are largely independent but need reliable daily assistance — the classic assisted-living profile. It is a small residential home in Northriding, Randburg, not a frail-care facility or a specialised dementia unit. For any specific clinical requirement — wound care, oxygen, catheters, hoists, dementia stage — phone **+27 63 583 2543** and discuss the individual patient: borderline presentations are assessed one by one, and you will get a plain answer.

This page exists because the question professionals most need answered is the one care homes are often vaguest about: *who, exactly, can you look after?*

> **Assisted living covers daily personal support — bathing, dressing, meals, medication oversight and mobility assistance — with 24-hour staff presence. It does not extend to continuous skilled nursing, which in South Africa sits with frail care and specialised units.**

The profile that thrives

The resident who does well at Dayspring Gardens is an older adult who:

- manages much of daily life but needs **dependable daily assistance** — bathing, dressing, medication oversight, meals, help moving about;
- is safe in a **supervised residential setting** rather than needing clinical monitoring;
- benefits from **company and routine** — shared meals, shared lounges and gardens, familiar faces — as much as from the practical support.

Many referrals fit this picture exactly: the patient who is no longer safe alone at home, but for whom frail care would be too much care, too soon. The same profile applies to short-term admissions — respite and convalescent residents need to sit within the same daily-support scope as long-term residents, just for a defined period.

The care model

What the home provides, stated as fact:

- **24-hour support** — staff present around the clock.
- **A visiting physician** — medical oversight comes to the resident.
- **Home-cooked meals** — prepared on site, daily.
- **Deliberately low resident numbers** — a small home where every resident is known, with shared lounges and gardens rather than corridors.

For how this compares with other settings on the South African spectrum, see SA care levels explained.

Needs that generally sit beyond an assisted-living home

Across South Africa, assisted living has a recognised outer edge. Needs that generally warrant frail care or a specialised unit rather than an assisted-living home include:

- **Intensive or skilled nursing** — continuous clinical care rather than daily support.
- **Advanced dementia with wandering or behavioural risk** — where a secured, purpose-designed memory-care environment is the safe setting.
- **Full immobility requiring hoists** — where transfers need equipment and trained lifting teams.
- **Complex clinical care** — ventilation, unstable conditions, or treatment regimes that belong under nursing supervision.

Where exactly Dayspring Gardens draws its own lines within that general scope — particular wound-care needs, oxygen, catheters — is a phone conversation, not a table on a website, because it turns on the individual patient. For the settings that serve higher-acuity needs, see options beyond assisted living.

Borderline cases: phone and discuss

Most referrals are not textbook. A patient may be mobile but forgetful, clinically stable but recently discharged, largely independent but with one need that sits near the edge of scope. Do not screen these patients out on your side — phone **+27 63 583 2543** and describe the case. Borderline presentations are assessed individually, on the person's actual needs rather than a diagnosis label, and the care assessment exists precisely to answer the cases this page cannot.

And the commitment that matters most to a referring professional: where Dayspring Gardens cannot meet a patient's needs, it will say so plainly and point you onward. A placement that fits protects the patient, the family, and your judgement; declining a mismatch is part of the same duty of care, not a rejection of the person. When scope fits, the referral path is short.

> **Do not screen these patients out on your side — phone +27 63 583 2543 and describe the case.**

Referrals and enquiries

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- **Online:** the enquiry form

Download the professional referral pack (PDF) — the essentials of these guides in one printable document. For any question about a specific patient's fit, phone — it is the quickest route to a definite answer.

SECTION

03

A Discharge Planner's Guide to Dayspring Gardens

For hospital discharge planners: how to arrange step-down or respite placement at Dayspring Gardens, what documents to send, and a pre-transfer checklist.

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SECTION 03

A Discharge Planner's Guide to Dayspring Gardens

If you have a discharge date looming and need a step-down, convalescent or respite bed for an older patient, phone **+27 63 583 2543** with the discharge summary, medication list, mobility and transfer status, and a summary of care needs. Availability and the care assessment are confirmed directly on that call — Dayspring Gardens is a small assisted-living home in Northriding, Randburg, and you deal with the home itself, not an admissions department.

> **Step-down (convalescent) care is a short, supported residential stay between hospital discharge and home — full daily care, medication oversight and 24-hour presence while a patient regains strength, without the clinical intensity of a hospital or rehabilitation unit.**

What the setting is — and is not

Dayspring Gardens is a small residential home: 24-hour support, home-cooked meals, a visiting physician, deliberately low resident numbers, shared lounges and gardens. For a patient who is medically stable but not yet strong enough for home, it offers what a ward cannot — rest, decent food, company, and someone present through the night — and what a rushed home discharge cannot: safety.

It is a recovery environment, not a rehabilitation unit. Patients who need intensive rehabilitation — daily physiotherapy blocks, specialised post-stroke programmes — should complete that phase first, or the referring team should arrange visiting therapists during the stay. Patients needing continuous skilled nursing or complex clinical care sit beyond assisted-living scope altogether; the boundaries are set out plainly in admission criteria and care scope. If the fit is uncertain, phone and describe the patient — borderline cases are assessed individually, and you will get a straight answer.

What to have ready when you phone

The assessment moves at the speed of the information available:

- **Discharge summary** — or its key contents if it is still being finalised.
- **Medication list** — current prescriptions and dosing.
- **Mobility and transfer status** — walking aids, assistance required, falls risk.
- **Care needs** — what the patient needs help with daily, and anything clinical (confirm specifics like wound care or oxygen by phone; these are assessed case by case).
- **Family contact** — the relative or proxy involved in the decision.

Two paragraphs and a medication list are enough to start the conversation.

On timing: Dayspring Gardens is a small home with deliberately low resident numbers, so availability is a live question rather than a standing promise — which is exactly why the phone call comes first. What you can rely on is that the answer will be direct: whether a bed is open, what the assessment needs, and whether the patient's needs fit, stated plainly on the call rather than after a committee cycle. If Dayspring cannot take the patient, you will know quickly enough to pursue the next option without losing days.

Pre-transfer checklist

Once a placement is agreed, a clean handover prevents the avoidable first-48-hours problems:

- **Documents travel with the patient** — discharge summary, referral letters, recent results the visiting physician should see.
- **Medication in its original packaging** — with the prescription or script for continuity.
- **Family contact confirmed** — who the home phones, and who phones the home.
- **Follow-up appointments listed** — dates, locations, and who is arranging transport.
- **The human details** — hearing aids, glasses, dentures, and the name the patient likes to be called. Small items, disproportionate impact.

Families under pressure

Discharge deadlines land hardest on families, who are often making a significant decision in days. They are welcome to visit Dayspring Gardens at any stage — even at short notice — and you can point them to the family-facing hospital discharge checklist, which walks through the same transition from their side. A short convalescent stay also gives a family breathing room: the longer-term question can be decided calmly once the patient is safe, rather than from a hospital corridor.

Referrals and enquiries

- **Phone:** +27 63 583 2543
- **Email:** info@dayspringgardens.co.za
- **Online:** the enquiry form

Download the professional referral pack (PDF) — the essentials of these guides in one printable document. When the discharge date is close, phone first — everything else can follow by email.

> **Discharge deadlines land hardest on families, who are often making a significant decision in days.**

SECTION

04

Respite Stays for Care-Plan Gaps

How short respite stays at Dayspring Gardens cover care-plan gaps — carer illness, frail-care waiting lists, trial stays — and what makes referrals succeed.

IN THIS SECTION

SECTION 04

Respite Stays for Care-Plan Gaps

When a care plan develops a gap — the carer is hospitalised, the frail-care bed is weeks away, the home is mid-renovation — a short respite stay at Dayspring Gardens can hold the patient safely until the plan resumes. To arrange one, phone **+27 63 583 2543** or email info@dayspringgardens.co.za with the dates you need to cover and the patient's broad care picture; availability and fit are confirmed directly. Dayspring is a small assisted-living home in Northriding, Randburg, offering short-term respite stays alongside long-term care.

> **A respite stay is a short, fixed-period admission to a care home — with full daily support, meals, medication oversight and 24-hour staff presence — that keeps a patient safely cared for while their usual arrangement is unavailable or under review.**

The gaps a respite stay covers

The referrals that fit this pattern are familiar to any professional coordinating community care:

- **The carer is out of action** — hospitalised, recovering from their own procedure, or travelling.
- **The home environment is temporarily unsuitable** — modifications, repairs, or a move in progress.
- **A frail-care or specialised bed is awaited** — the right placement exists but has a waiting period, provided current needs still sit within assisted-living scope.
- **A family crisis** — the informal arrangement has collapsed and the patient cannot safely wait at home while it is rebuilt.
- **A trial before permanent placement** — the family wants evidence, not brochures, before a long-term decision.
- **Carer burnout intervention** — a planned break prescribed before the caring arrangement fails rather than after.

In each case the clinical logic is the same: an unmanaged gap is where falls, missed medication and rapid decline happen. A respite stay closes the gap.

How a short stay works

A respite resident gets the full daily arrangement, not a reduced version of it: a set period agreed upfront, with home-cooked meals, medication oversight, help with personal care, 24-hour staff presence, and the ordinary life of a small home — shared lounges, gardens, company. The visiting physician provides medical oversight during the stay. Whether a particular patient's needs fit — and what dates are available — is confirmed by phone; the general boundaries are set out in admission criteria and care scope.

What makes referred respite succeed

Short stays succeed on preparation more than duration. Three things consistently separate smooth respite from rocky respite:

- **Clear dates.** A defined start and end, agreed with the home and the family — including an honest conversation upfront if the end date might move (a carer's recovery, a frail-care waiting list).
- **Complete medication and routine notes.** Current medication in original packaging with dosing times, plus the routine detail that lets carers get the first day right: how the patient takes tea, sleep patterns, continence needs, what distresses and what settles them.
- **A warm handover.** A phone conversation between someone who knows the patient — you, the family, the home-care agency — and the home, before arrival. Ten minutes of context prevents a week of trial and error.

The referral path is the same as for long-term placement: phone or email with the care picture, followed by a care assessment.

Respite as an assessment opportunity

A short stay often does double duty. Two weeks of round-the-clock observation by people who support older adults daily will tell you things a consultation cannot: how the patient actually manages bathing and dressing, what medication adherence looks like without prompting, how they eat, sleep and socialise, and whether the care level in your longer-term plan matches the person in front of you. For a patient whose true level of need is contested — family optimistic, hospital pessimistic — a respite stay replaces speculation with observation. Treat the home's feedback at the end of the stay as clinical input for the next decision.

> **The referral path is the same as for long-term placement: phone or email with the care picture, followed by a care assessment.**

Families arranging the same stay from their side can be pointed to the family's respite guide.

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- **Online:** the enquiry form

Download the professional referral pack (PDF) — the essentials of these guides in one printable document. If the gap is imminent, phone — dates and fit are settled fastest in conversation.

Refer a patient or discuss a case

Phone +27 63 583 2543 or write to info@dayspringgardens.co.za with the patient's broad care picture. Where Dayspring isn't the right fit, we will say so plainly and point you onward.

Referral enquiry →