CPO Restore in ARRC: Short Stay

The CPO Restore in ARRC pathway is for medically stable, frail older people who are not well enough to be in their own home, but do not require acute hospital care.

This pathway provides funding to support a length of stay including GP/ NP/ practice nurse funded consultations in Aged Related Residential Care (ARRC).

The Restore in Aged Related Residential Care (ARRC) Short Stay includes:

(a) GP Short Stay (5 nights, with an approved extension of 5 nights)
(b) Non-Weight Bearing Stay (up to 56 nights)
(c) Convalescence Flexi Stay (up to 42 nights)

The GP/NP (or delegate)

- **Must take clinical responsibility for the patient while they are in the ARRC facility under CPO.**
- Complete the CPO referral form and provide the ARRC facility with the valid unique CPO reference number, which is generated through the CPO Advanced referral form eg HB1234

Short Stay Pathways

(a) GP Short Stay

Service Users

- Aged 65 years of age or older or
- Aged 50 to 64 with age related needs and
- Reside in Hawke's Bay DHB region

- require very little or no therapy input but are unable to manage at home temporarily (up to five nights) with referral and input from only their own GP/NP (or delegate);
- the lead referrer is the patient's GP/NP (or delegate) and only rest home level of care is available. Admission is for up to five bed nights, with no prior approval/consultation.
- An extension of 5 nights can be approved by the Clinical Programme Coordinator at HHB, if required
- Locate appropriate bed availability with a contract ARRC facility;
- Ensure service user enters the ARRC facility with the appropriate medication for their stay.

(b) Non-Weight bearing Stay

Service Users

- Aged 18 years of age or older
- Reside in Hawke's Bay DHB region

- for patients who are appropriate for an aged related residential setting with orthopaedic injuries that preclude them from going home, with referral and input

from CNS Orthopaedics in conjunction with orthopaedic consultant and their own GP/NP (or delegate)

- the lead referrer is the HBDHB CNS Orthopaedics who will determine the appropriate level of care (rest home or hospital), whom will provide clinical input during the stay.

(c) Convalescence Flexi Stay

Service Users

- Aged 18 years of age or older or
- Reside in Hawke's Bay DHB region

- require very little or no therapy input but are unable to manage at home short-term with referral from CNS Gerontology in conjunction with their own GP/NP (or delegate), input may be from another CNS;
- The lead referrer is the HBDHB CNS Gerontology whom will determine the appropriate level of care (rest home of hospital), whom will provide clinical input during the stay. The lead referrer is responsible for submitting the Admission notification, and the ARRC facility is responsible for submitting the Discharge Notification

Service Users

All users of these services are to be assessed as being medically stable and well enough to benefit from the Restore in ARRC residential care services. This will include (but is not limited to):

- significant acute changes in medical management that have not been anticipated, with the expected period allocated.
- the user not requiring secondary inpatient services, treatment or investigations.
- the user's medical issue(s) (physical and/or cognitive) being expected to improve within the expected period allocated.

GP/NP/practice nurse visits to ARRC Facility

- CPO funded visits can be provided by either their GP/NP (or delegate) or a Registered Nurse (RN) under the instruction of their GP/NP, while the patient is in the ARRC
- A visit may be replaced by a phone consultation between the patient's GP/NP and the ARRC facility RN, if appropriate.

Exclusions:

The Service is not for patients who are receiving residential care services under other public funding arrangements such as:

(a) Respite & Day Care Service;
(b) Long Term Support— Chronic Health Conditions;
(c) Dementia Care Services;
(d) Palliative Care Services;

CPO Referral process: GP Short Stay

1. GP/NP identify the patient as appropriate for an ARRC Short Stay bed, discusses this option with the patient and gains consent to admit patient to an ARRC facility.

2. The GP/NP completes the CPO referral through the CPO Advanced Form on Medtech and My Practice or paper referral and submits to Health Hawkes Bay. The CPO referral must be received by HHB for the ARRC to be funded.

3. The practice arranges the placement with a contracted ARRC facility (see attached list). Please provide the ARRC facility with the patients CPO number that is derived when the referral on the CPO advanced form is completed eg: HB1234.

4. The Eldernet website can be used to identify which facilities have vacancies and is updated daily (www.eldernet.co.nz)

5. **Funding is available for the patient to stay in the ARRC facility for up to five days.** It is essential to have a discharge plan completed at the time of admission.

6. CPO will fund GP/NP/nurse ARRC visits and GP/NP telephone consultation with ARRC RN. Invoice services through the CPO Advanced Form on Medtech and My Practice or on paper based form.

7. **If more than 5 days in the ARRC facility is required**
    a. The HHB Clinical Programme Coordinator can approve a further 5 days stay in the ARRC for patients, if required
    b. The practice must contact the Clinical Programme Coordinator on 8715653. If not available please leave a message or e-mail sonya@healthhb.co.nz
    c. The patient may be liable for the any additional ARRC facility charges if not advised.

8. If the patient requires a significantly longer stay (more than 10 days) and support from the engAGE MDT to transition to home, the GP/NP practice must contact the Gerontology CNS/ Geriatrician for their area to discuss transfer to Intermediate Care (ICB) service and complete an engAGE referral. If accepted into Intermediate Care, the GP practice must inform the Clinical Programme Coordinator of this change.

9. If the patient requires an assessment of their on-going care needs by NASC Hawkes Bay, please refer directly at the time of admission to the Short Stay bed.

CPO Referral process: Non-Weight Bearing and Convenience Flexi Stay

1. The Clinical Nurse Specialist (CNS) HBDHB identify the patient as appropriate for an ARRC Non- weight bearing and Convenience Flexi Stay.

2. The CNS discusses this option with the patient and gains consent to admit patient to an ARRC facility.

3. The CNS will contact the patients GP/NP and the patients GP/NP (or delegate) agrees to take clinical responsibility for the patients while in the ARRC under the Restore in ARRC programme.

4. The CNS arranges the placement of the patient with a contracted ARRC facility.

5. General Practice completes the CPO referral through the CPO Advanced Form on Medtech and My Practice or paper referral and submits to Health Hawkes Bay. The CPO referral must be received by Health Hawkes Bay for the ARRC to be funded.

6. General Practice provides the ARRC facility with the patients CPO number that is derived when the referral on the advanced form is completed eg: HB1234

7. CPO will fund GP/NP/nurse ARRC visits and GP/NP telephone consultation with ARRC RN. Invoice services through the CPO Advanced Form on Medtech and My Practice or on paper based form.

Finding an Available Bed

GPs/ NP/Practice Nurses can use the Elder Net Website (www.eldernet.co.nz) to identify which facilities have vacant beds. Follow the "Residential Care Vacancies" Quick Link at the bottom of the home page. This list is updated daily.

Contracted ARRC Facilities

**** Please note that only the facilities in the left hand column have a contract to provide Intermediate Care (ICB). If a person is in a Short Stay bed but goes on to require Intermediate Care and they are not in a facility that has a contract to provide this, they will need to move to one of the facilities in the left hand column for their Intermediate Care stay. If it is anticipated that a person may need Intermediate Care, they should only be placed in a facility from the left hand column.**

engAGE in ARRC – Intermediate(ICB) & Short Stays	engAGE in ARRC – Short Stays ONLY **
Atawhai Care	Bardowie Retirement Complex
Brittany House	Bryant House
Duart Care	Eversley Care
Glengarry Rest Home & Hospital	Gladys Mary Rest Home
Gracelands Care	Greendale Residential Care
Mary Doyle Trust Life Care	Otatara Heights Residential Care
Mt Herbert House	Roseanne Retirement
Princess Alexandra Retirement Village	Voguehaven Rest Home
Radius Hampton Court	Waverley House Rest Home
Summerset in the Bay	Woburn Rest Home
Summerset in the Vines	
Taradale Masonic Residential Home	
Waiapu House Rest Home	

Glossary

Short Stay	This service provides short term (up to 5 days) admission to an ARRC facility for frail older people with an acute minor illness or injury from which they are expected to recover and return to their own home. Accessed directly by GP/ Practice Nurse. No input from engAGE MDT. Not to be used as respite.
Non-weighting Bearing	For patients who are appropriate for an aged related residential setting with orthopaedic injuries that preclude them from going home. Assessed by HBDHB CNS Orthopaedics. No input from engAGE MDT. Not to be used as respite.
Convalescence Flexi Stay	For patients who are appropriate for an aged related residential setting. Assessed by HBDHB CNS Gerontology as being appropriate. No input from engAGE MDT. Not to be used as respite.
Intermediate Stay	Intermediate Care Bed (ICB) services provide short term placement, up to 6 weeks, in an ARRC facility for medically stable frail older people who are not well enough to be at home, but do not require acute hospital care. Accessed via discussion with CNS Gerontology. engAGE MDT involved to support reablement.
Respite Care	**'Respite' is a break for a full time care giver.** This is allocated via NASC assessment, for people with long term high support needs. The client does not need to have agency supports to be eligible for respite. Respite can be in an ARC setting (at any level of care); or it can be in the persons home – this type or respite is called 'Carer Support'; where the full time care giver arranges for a relief carer to come in and take over for a period of time (can be hours at a time; or days). Carer Support is not funded at an hourly rate; it is a 'contribution' towards the relief-carers time. To access respite, refer to NASC for clients/ carers in this situation (refer the client, not the carer, but mention the carer stress). Under some emergency circumstances, 'emergency respite' can be considered for clients who might not be known to NASC – please phone the NASC to discuss – 06 834 1871 (referrals) or 870 7485 (reception).
End of Life	There is no formal palliative or end of life funding for residential care; however for new clients NASC can offer a more flexible approach to supports. NASC aim to be particularly responsive and sensitive to palliative clients (especially those at end of life) – please ensure this information is included in the referral so we are aware of the additional needs of the client. Any questions phone the NASC referral team on 06 834 1871.

Contact Details

Referrals to Gerontology CNS	Email: cnsgerontology@hbdhb.govt.nz
Te Mata Peak Practice, Havelock North Medical Centre, Hastings Health Centre, Medical and Injury	Kerri Peachey, Gerontology CNS, 027 5073122
The Doctors Hastings, Totara Health Nelson Street and Flaxmere, Hauora Heretaunga, Clive Medical, Mahora Medical Centre, Hawkes Bay Wellness Centre, The Doctors Greenmeadows, Tamatea Medical Centre. Maraenui Medical Centre.	Paul Scofield, Gerontology CNS, Phone: 027 2002574
Taradale Medical Centre, Greendale Medical Centre, Carlyle Medical Centre, Shakespeare Road Medical Centre. The Doctors Napier and Westshore, Central Medical, Dr Robert Harris, Marewa Surgery.	Carrie Chandler, Gerontology CNS, Phone: 027 3276187
For CPO/ Restore in ARRC queries	Sonya Harwood, Clinical Programme Coordinator; Health Hawkes Bay, Phone: 027 2454015
General enquiries- EngAGE	engAGE Team Leader Sarah Shanahan, Phone: 0273233193 e-mail: Sarah.Shanahan@hbdhb.govt.nz
engAGE MDT	Contact MDT for the person's GP Contact details of key worker to be provided in reablement plan