CPO Respiratory Short Stay (from Hospital to ARRC)

(Does not include patients requiring IV treatment)

The CPO Respiratory Short Stay service is an extension to the CPO Restore in ARRC Short Stay (up to 8 nights) admission to an Aged Related Residential Care (ARRC) facility.

The pathway is for people with a respiratory illness, who have been admitted to HBDHB, and require convalescence prior to returning home. Input can be delivered from the HBDHB Respiratory Team whilst the patient is in the ARRC. These people are not expected to need input from the engAGE MDT. Estimated date of discharge and discharge plan is to be identified at time of admission.

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***

Criteria:

All users of this services are to be assessed prior to discharge from the HBDHB as being medically stable and well enough to benefit from an admission to ARRC.

- *A person with an acute respiratory illness or acute exacerbation of a chronic respiratory condition e.g. COPD, being discharged from the HBDHB, is unable to manage safely at home and expected to be able to be discharged from the ARRC to their own home within 8 days.*
- *Patient is identified as medically stable but not functionally independent for discharge home.*
- *Person can be managed safely in an ARRC Facility.*
- *Person and whānau consent.*
- *GP/NP/RN visits to the ARRC will be funded by CPO, therefore CPO documentation is required.*
- *Person medical issue(s) being expected to improve within the expected period allocated.*

Exclusions:

- *Patients who require residential care to provide respite to the carer who lives with them (carer fatigue/ carer unavailable for a period). Patients who are highly dependent on a live-in carer should be referred to NASC HB for assessment of eligibility for a respite allowance. Those with a respite allowance can make arrangements with an ARRC facility directly.*
- *Patients who require ARRC Facility admission for mental health issues.*
- *End of life palliative.*
- *Patients expected to require longer than 8 days and need MDT in-put should be referred to the Intermediate Care service through Gerontology CNS.*

Short Stay – Admission from Hospital to ARRC (Transition to Home)

- Admission to this service will be by liaison between the Respiratory Clinical Nurse Specialist (CNS) and the GP/ NP (or delegate).
- GPs/ NPs will always have involvement in the plan to admit a patient to this service, choose the ARRC facility and advise when the transfer can take place.
- The GP/ NP will also have the option of transferring care of the patient to another GP/NP at the same practice if they are unable to take clinical responsibility for the patient at the time (e.g. GP/NP going on leave).
- Estimated date of discharge will be set at the time of admission

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

GP/ NP/ Practice Nurse Visits to ARRC Facility

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

Process for Short Stay ARRC– Admission to ARRC from Hospital for Respiratory Patients

1. The Respiratory CNS identify and assesses the patient as medically stable and the patient meets the criteria for Respiratory Short Stay ARRC.

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

3. The Respiratory CNS contacts 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. If accepted, an agreement is made on which facility the patient can be transferred to (see below list for contracted facilities) and when the transfer can take place.

4. If the GP/NP (or delegate) declines to accept clinical responsibility for the patient, the patient remains in hospital

5. The Respiratory CNS will arrange the patient's transfer to the ARRC facility

6. The GP/ NP/ RN completes the CPO referral using the advanced form on MedTech/ My Practice or the paper form and submits the form to Health Hawkes Bay. This is required for payment for GP/ NP/ RN visits to the ARRC facility.

7. 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

8. A plan for discharge is made at the time of admission

9. If the patient requires more than 8 days in the ARRC Facility, the GP/ NP/ practice nurse must contact Clinical Programme Coordinator, Health Hawkes Bay via e-mail or 06 871 5653. If not advised, the patient may be liable for any additional ARRC Facility charges.

Contracted ARRC Facilities

**** Please note that only the facilities in the left hand column have a contract to provide Intermediate Care. 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.**

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.

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

Contact Details

Respiratory CNS	Sue Ward Phone: 027 7059191 e-mail: Susanne.Ward@hawkesbaydhb.govt.nz Kate Te Pou Phone: 027 5631985 e-mail: Kate.tepou@hbdhb.govt.nz
For CPO/ Short Stay queries	Sonya Harwood, Clinical Programme Coordinator, Health Hawkes Bay e-mail: sonya@healthhb.co.nz, Phone DDI: 871 5653

Glossary

Short Stay	This service provides short term (up to 8 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-weight 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) using the NASC referral form in PMS. Print and send via email to NASC.HB@hbdhb.govt.nz . 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 support. 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.Please send referral to NASC.HB@hbdhb.govt.nz.