**CPO – GPs Restore in ARRC Specific Services**

1. **Short Stay Care Services**

This Restore in Aged Related Residential Care (ARRC) - Short Stay Care Service covers three pathways:

1. GP Short Stay;
2. Non-Weight Bearing Stay;
3. Convalescence Flexi Stay.
	1. **GP Short Stay**
* for Services Users aged 65 years of age and older, or 50 to 64 years with age related needs that require very little or no therapy input but are unable to manage at home temporarily (up to eight nights) with referral and input from only their General Practitioner (GP) / Nurse Practitioner (NP) (or delegate);
* the lead referrer is the Service User’s GP/NP (or delegate) and only rest home level of care is available. Admission is for up to eight bed nights, with no prior approval/consultation;
* the Service User’s GP/NP (or delegate) is responsible for locating appropriate bed availability with a contracted ARRC facility and ensuring the Service User enters the ARRC facility with the appropriate medication for their stay.
* The provider can approve additional bed nights over 8 nights up to 14 bed nights per individual GP Short Stay for valid clinical reasons
	1. **Non-Weight bearing Stay**
* for Service Users aged 18 years of age or older who are appropriate for an aged related residential setting with orthopaedic injuries that preclude them from going home, with referral and input from Clinical Nurse Specialist (CNS) Orthopaedics in conjunction with orthopaedic consultant and their GP/NP (or delegate);
* the lead referrer is the Hawke’s Bay District Health Board (HBDHB) CNS Orthopaedics who will determine the appropriate level of care (rest home or hospital), whom will provide clinical input during the stay.
* the HBDHB CNS Orthopaedics is responsible for locating appropriate bed availability with a contracted ARRC facility.
	1. **Convalescence Flexi Stay**
* for Service Users aged 18 years of age or older who are appropriate for an aged related residential setting that 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 or hospital), whom will provide clinical input during the stay;
* the lead referrer is responsible for locating appropriate bed availability with a contracted ARRC facility.
	1. **General Practice Funding for Short Stay**
* CPO funded visits can be provided by either the patients GP/NP (or delegate), Pharmacy Prescriber (employed by the practice) and/or Registered Nurse while the patient is in the ARRC under CPO
* A phone consultation between the patients GP/NP (or delegate), Pharmacy Prescriber (employed by the practice) and the ARRC facility Registered Nurse if appropriate can be funded while the patient is in the ARRC under CPO

These Services are 24 hour, seven day a week service within a contracted facility. The need of the user is usually medical. Input from the engage community team is not available for these services.

1. **Intermediate Care Stay Service**

Intermediate Care stays will be provided when the Service User, HBDHB Geriatrician and/or CNS Gerontology and their GP/NP (or delegate) have agreed the need of residential intermediate care service to allow engAGE interdisciplinary team assessment and re-ablement treatment for up to six weeks.

Service Users will have been assessed by their GP/NP (or delegate) and Geriatrician and/or CNS Gerontology as eligible due to an acute illness or functional decline from which they are expected to recover, and currently are not ill enough to be in hospital but not well enough to cope at home, such as people:

* Aged 65 years of age or older, or
* Aged 50 to 64 with age related needs, and
* Reside within HBDHB region.

The Provider shall supply the following (together referred to herein as the “Services”) in accordance with the specifications set out:

* ensure the Service User and where relevant their main carer and their support network are involved in the decision to enter into these services and the selection of the ARRC facility;
* provide services to CPO GP’s Restore in ARRC Service Users who meet the criteria;
* maintain full clinical responsibility for managing the treatment and ongoing care while the Service User is in ARRC facility under CPO;
* complete the CPO form and provide the ARRC facility with the valid unique CPO reference number.
* will, prior to or on admission, identify the timeframe, identified goals and the specific support required from the ARRC Facility.