CPO Restore in ARRC: Short Stay

Purpose

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

The GP/NP (or delegate)

- **Must agree to 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

Short Stay Pathways:

The Restore in Aged Related Residential Care (ARRC) Short Stay covers three pathways:

(a) GP Short Stay
(b) Non-Weight Bearing Stay
(c) Convalescence Flexi Stay

(a) GP Short Stay

- Aged 65 years of age or older or
- Aged 50 to 64 with age related needs and
- Reside in Te Whatu Ora-Hawkes Bay region

- require very little or no therapy input but are unable to manage at home temporarily (up to five days) 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.
- 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

- Aged 18 years of age or older
- Reside in Te Whatu Ora-Hawkes Bay 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, Te Whatu Ora-Hawkes Bay, in conjunction with orthopaedic consultant and their own GP/NP (or delegate)

- the lead referrer is the CNS Orthopaedics, Te Whatu Ora-Hawkes Bay, who will determine the appropriate level of care (rest home or hospital), and will provide clinical input during the stay.

(c) Convalescence Flexi Stay

- Aged 18 years of age or older or
- Reside in Te Whatu Ora-Hawkes Bay region

- require very little or no therapy input but are unable to manage at home short-term with referral from CNS Gerontology, Te Whatu Ora-Hawkes Bay, in conjunction with their own GP/NP (or delegate), input may be from another CNS;
- The lead referrer is the CNS Gerontology, Te Whatu Ora-Hawkes Bay, who will determine the appropriate level of care (rest home or hospital), and will provide clinical input during the stay.

Entry into Pathway:

All patients 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.

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;

Funding:

Referral and Claiming/Outcome is through the **Halcyon Provider Portal > CPO Programmes > Acute Care > Restore In ARRC.** Funding is fee for service.

- CPO funded consultations 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
- As appropriate, a visit may be replaced by a phone consultation between the patient's GP/NP and the ARRC facility RN.

Referral process: GP Short Stay:

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

2. Complete the CPO referral through the Halcyon Provider Portal and submit to Health Hawkes Bay. The CPO referral must be received by Health Hawkes Bay for the Te Whatu Ora to fund the rest home.

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

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

5. The ARRC facility completes a notification of admission form and forwards this to HBDHB to secure funding for the bed.

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

7. If the patient requires more than 5 days in the ARRC facility the GP practice must advise Health Hawkes Bay on 8715653. If not advised, the patient may be liable for the any additional ARRC facility charges.

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, Te Whatu Ora-Hawkes Bay, for their area to discuss transfer to Intermediate Care service and complete an engAGE referral. If accepted into Intermediate Care, the GP practice must inform Health Hawkes Bay 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.

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

1. Clinical Nurse Specialist (CNS), Te Whatu Ora-Hawkes Bay, 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 patients GP/NP (or delegate) agrees to take clinical responsibility for the patients while they are 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 Halcyon form and submits to Health Hawkes Bay. The CPO referral must be received by Health Hawkes Bay for Te Whatu Ora-Hawkes Bay to fund the rest home.

6. General Practice provides the ARRC facility with the patients CPO number that is derived from the referral.

7. CPO will fund GP/NP/nurse ARRC visits and GP/NP telephone consultation with ARRC RN. Invoice services to the patient through the Halcyon form.

ARRC Bed Availability

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:

engAGE in ARRC – Intermediate & 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	

**** 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.**

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.