CPO Restore in ARRC: Intermediate 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).

This may be at the time of an acute change in function due to a minor illness or injury or deconditioning following an acute hospital stay. It may also be for a period of assessment and reablement for a person who is on the cusp of requiring permanent placement but wishes to remain at home. Older people can be admitted to this service from their own homes or from the acute hospital and receive input from the engAGE MDT service.

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

GP/NP can access Intermediated Stays in ARRC for up to six weeks. Access to Intermediate Care Beds (ICB) occurs as either:

a. Admission from patient's home.
b. Admission from acute hospital (transition to home).

Service Users:

- ***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***

Criteria:

- Medically stable but is not well enough to be at home/ return home from hospital. This may be for ongoing clinical management or for increased supports for a short period of time due to deconditioning.
- Can be managed safely in an ARRC Facility
- Consents and Family/whanau notified
- Person's GP/NP or another GP /NP (i.e. a covering GP from same centre) must accept clinical responsibility for the person. This includes weekly GP/ NP/practice nurse consultations at the facility and attendance at the engAGE MDT meeting.
- Patient consultations at the ARRC facility will be funded by CPO, therefore CPO documentation essential.
- There must be documented goals with the goal to discharge home after a period of support, within an agreed timeframe being essential.

Exclusions:

- If the person requires permanent placement in an ARRC Facility, an assessment must be undertaken on the ward for placement by NASC HB.
- People who could be managed at home with a package of care from NASC HB or ACC should be referred for same and discharged home/ remain at home. Referral for engAGE MDT follow up at home could be considered.
- Medically unstable and/or needing inpatient investigations or inpatient care.
- End of life palliative patients. Pathway for up to two weeks funded residential care is in place through NASC HB.
- Patient awaiting significant housing modifications or permanent placement under the Protection of Personal and Property Rights (PPPR) Act.
- Person requires assistance of two people for transfers and mobility.

  Patients who require rest home admission for mental health issues

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

ICB- Admission from home:

Admission to this service will always be via liaison between the GP/ NP/ RN and Gerontology CNS, Te Whatu Ora-Hawkes Bay.

- The person needs to be admitted to the facility within two working days of the face-to-face assessment with the GP/ NP.
- People admitted to this service will receive in-put from the engAGE MDT who will develop and implement a reablement plan.
- GP/ NP/ RN consultations will be required weekly, or as agreed with the MDT, and visits from the Geriatrician and Gerontology CNS will also occur as indicated.
- GP/ NP/ RN attendance at the weekly engAGE meeting will be essential for these patients. Length of stay will be a maximum of six weeks.
- Estimated date of discharge will be set at the time of admission and reviewed at the engAGE meeting based on the person's progress.
- Permanent admission to ARRC is also an acceptable outcome in cases where this is identified as the most appropriate outcome for the person through discussion with the person, their family/whanau and the MDT (including the GP/ NP/ practice nurse).

Process for ICB- Admission from home:

1. GP/ NP/ RN identify the patient as appropriate for ICB, discusses this option with the patient and gains consent to admit patient to ICB.
2. GP/ NP/ RN contacts the CNS Gerontology, Te Whatu Ora-Hawkes Bay, to discuss the case including goals, estimated length of stay etc.
3. If there is agreement between the GP/ NP/ RN and CNS, the practice arranges the placement with a contracted ARRC facility (see attached list) and sends an engAGE referral to engAGE in ARRC email address: engageinarrc@hbdhb.govt.nz

4. The GP/ NP/ RN complete the CPO referral using the Halcyon Form and submit to Health Hawkes Bay. This is required for payment for visits to the ARRC facility. The ARRC facility will require the CPO number generated to arrange payment for the bed from the HBDHB.
5. Admission paperwork and medication chart are completed by the GP/NP on admission or within five working days of admission.
6. The ARRC facility completes a notification of admission form and forwards to the HBDHB to secure funding for the bed.
7. The GP/NP visits the patient within two working days of their admission to the ICB.
8. A member of the engAGE MDT visits the patient within two working days of admission to the ICB to identify goals and develop the reablement plan with the person.
9. The GP/ NP/ RN visits the patient at the ARRC facility weekly (or as agreed with the MDT) and attends the weekly engAGE MDT to discuss the patient's progress and plan for their discharge home.

ICB- Admission from Hospital (transition to home)

Admission to this service will be by liaison between the GP/NP and the Geriatrician/ CNS Gerontology nurse, Te Whatu Ora-Hawkes Bay. GPs/NPs will always be involved in the plan to admit a patient to this service, the choice of ARRC facility and 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 going on leave). The GP/ NP must visit these patients within two working days of their admission to the ARRC facility.

- People admitted to this service will receive in-put from the engAGE MDT who will develop and implement a reablement plan.
- Weekly GP/ NP/ RN visits to the ARRC facility will be required and visits from the Geriatrician and Gerontology CNS, Te Whatu Ora-Hawkes Bay, will also occur as indicated.
- GP/ NP/ RN nurse attendance at the weekly engAGE meeting will be essential for these patients.
- Length of stay will be a maximum of six weeks with estimated date of discharge set at the time of admission and reviewed at the weekly engAGE meeting based on the person's progress.
- Permanent admission to ARRC is also an acceptable outcome in cases where this is identified as the most appropriate outcome for the person through discussion with the person, their family/whanau and the MDT (including the GP/ NP/ RN).

Process for ICB- Admission from Hospital:

1. Acute hospital MDT identifies patient as appropriate for transfer to ICB. Patient is medically stable but not functionally independent for discharge home and not requiring rehabilitation in AT&R ward.
2. The CNS Gerontology or Geriatrician, Te Whatu Ora-Hawkes Bay, contacts the patient's GP/NP to discuss the case and the possibility for the patient to transfer to an ICB under their care. If the GP declines to accept clinical responsibility for the patient in the ICB, the patient remains in the acute hospital. If the GP accepts clinical responsibility, an

agreement is made on which ARRC facility the patient can be transferred to (see attached list for contracted facilities) and when.

3. The CNS Gerontology / Geriatrician work with the acute hospital MDT to arrange the patient's transfer to the ICB.
4. The GP completes the CPO referral using the Halcyon Form and submit to Health Hawkes Bay and submits to Health Hawkes Bay. This is required for payment for visits to the ARRC facility. The ARRC facility will require the CPO number generated to arrange payment for the bed from the HBDHB.
5. The ARRC facility will complete a notification of admission form and forward to the HBDHB to secure funding for the bed.
6. The GP/NP visits the patient within two working days of their admission to the ICB.
7. A member of the engAGE MDT visits the patient within two working days of admission to the ICB to identify goals and develop the reablement plan with the person.
8. The GP/NP/ practice nurse visit the patient at the ARRC facility weekly and attends the weekly engAGE MDT to discuss the patient's progress and plan for their discharge home.

ARRC Bed Availability

GPs/ 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

GP 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 carer. 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 carer 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-carer's 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.