

**Notification for One Hospital - level Resident in a Rest home service Area (NOHRRA) form**

***This form is to be completed when an aged care providers needs to notify Health New Zealand when managing or intending to manage one hospital-level care resident in a rest home area.***

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| **1. Premises** |
| Legal entity name |
| Enter legal entity name. |
| Premises name |
| Enter premises name. |
| Hospital District area  |
| Enter the hospital name and district the premises is in. |

This facility is certified to provide (tick as applicable):

|  |  |
| --- | --- |
|[ ]  Rest home services (excluding secure dementia care) |[ ]  Residential Disability Services – Physical |
|[ ]  Rest home services (including dementia care) |[ ]  Residential Disability Services – Sensory |
|[ ]  Hospital services – Medical services |[ ]  Residential Disability Services – Intellectual |
|[ ]  Hospital services – Geriatric (psychogeriatric) |[ ]  Residential Disability Services – Psychiatric |
|[ ]  Hospital services – Geriatric (excluding psychogeriatric) |[ ]  Hospital services – Mental Health |
| **2. Resident’s details** |
| Title |  | First name(s) |  | Last name |
| Choose an item. |  | Enter first name(s). |  | Enter last name. |
| Date of birth |  | NHI number |  | Date of admission to the service |
| Enter date of birth. |  | Enter NHI number. |  | Enter a date. |

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| **3. Reason for the arrangement** |
| Reason for the arrangement, details about the premises and services, the resident’s prognosis/circumstances that led to the arrangement |
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| *Please attach, as a separate PDF, the most recent interRAI ‘Assessment Comments’ which identifies the change to hospital level of care*. |
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| Are any other residents at the premises receiving hospital-level care in a rest home service area (bed/room)? | Choose an item. |
| If yes, please provide further details (name of the resident, etc). |  |

What area of the premises does the resident currently reside in?

|  |  |
| --- | --- |
|[ ]  Rest home |[ ]  Other |
|[ ]  Secure dementia unit | State |  |

What area of the premises will the resident be cared for?

|  |  |
| --- | --- |
|[ ]  Rest home |[ ]  Other |
|[ ]  Secure dementia unit | State |  |
| What is the approximate distance from the nurses’ station?*Please attach as a separate PDF a plan of the unit identifying this resident’s bedroom.* |
| Enter distance from nurses’ station. |
| How will you ensure that this resident’s care needs will not impact on other residents? |
| Describe how impact on other residents will be minimised. |

Have discussions about this request taken place with: (tick as applicable)?

|  |  |
| --- | --- |
|[ ]  Resident |[ ]  Clinical Nurse Specialist |
|[ ]  Next of kin and or enduring power of attorney (EPOA) |[ ]  Hospice |
|[ ]  Clinical Nurse Manager and/or Registered Nurse |[ ]  NASC |
|[ ]  Geriatric Nurse Specialist |  |  |

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| --- | --- |
| Has the resident consented? | Choose an item. |
|  |  |
| Has the resident’s enduring power of attorney (EPOA) consented?(required if the resident is not competent and the EPOA has been activated) | Choose an item. |
| Has the family agreed? | Choose an item. |
| Has the resident’s general practitioner (GP) or nurse practitioner (NP) agreed to take responsibility for the hospital level care needs of this resident? | Choose an item. |

Please comment on the 24/7 staffing arrangements, including:

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| --- | --- |
| registered nurse hours | Comment on registered nurse hours. |
|  |  |
| increase in staff numbers to manage the 24/7 transfer, position-change and mobilisation needs of this resident | Comment on staff numbers |
|  |  |
| on-call arrangements | Comment on on-call arrangements. |

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| Please identify the specialist services involved in care of this resident (e.g. hospice) and access to equipment if necessary (e.g. hoist, air mattress) |
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| **4. Declaration to be completed by a Registered Nurse** |

I declare that the information provided is true and correct.

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| --- | --- | --- |
| Name |  | Date |
| Enter your name. |  | Enter date. |
| Designation |
| Enter your designation. |
| Phone number |
| Enter your phone number. |

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| **5. Submitting form** |

Please email this completed form along with the below PDFs to your regional commissioning team (choose the appropriate email address from the below).

[ ]  **PDF of the interRAI ‘Assessment Comments’ which identify the change to hospital level of care and/or any correspondence with NASC service**

[ ]  **PDF of a layout/plan of the unit identifying the resident’s bedroom and its proximity to the nurses’ station/office**

**Northern Region**

CommissioningNorthernRegionOffice@TeWhatuOra.govt.nz

**Te Manawa Taki (Midland)**

serviceimprovement.temanawataki@tewhatuora.govt.nz

**Te Ikaroa (Central)**

serviceimprovement.central@tewhatuora.govt.nz

**Te Waipounamu (South Island)**

 twp-audit.admin@tewhatuora.govt.nz

If you have any questions about this process, please email these through to your regional contact (above).