

**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 | | |
|  | | |
| *Please attach, as a separate PDF, the most recent interRAI ‘Assessment Comments’ which identifies the change to hospital level of care*. | | |
|  | | |
| 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:

|  |  |
| --- | --- |
| 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.

|  |  |  |
| --- | --- | --- |
| 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](mailto:CommissioningNorthernRegionOffice@TeWhatuOra.govt.nz)

**Te Manawa Taki (Midland)**

[serviceimprovement.temanawataki@tewhatuora.govt.nz](mailto:serviceimprovement.temanawataki@tewhatuora.govt.nz)

**Te Ikaroa (Central)**

[serviceimprovement.central@tewhatuora.govt.nz](mailto:serviceimprovement.central@tewhatuora.govt.nz)

**Te Waipounamu (South Island)**

[twp-audit.admin@tewhatuora.govt.nz](mailto:twp-audit.admin@tewhatuora.govt.nz)

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