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

*This form is for rest home providers to notify HealthCERT when managing or intending to manage one hospital-level care resident.*

*Discuss your request with your district health board (DHB) Health of Older Persons portfolio/programme manager before completing this form. Evidence of their support must be submitted with the form.*

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| **1. Premises** |
| Legal entity name |
| Enter legal entity name. |
| Premises name |
| Enter premises name. |
| DHB |
| Enter the DHB the premises is in. |

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

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|  | 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 |

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| **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*. | | |
|  | | |
| 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?

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|  | Rest home |  | Other |
|  | Secure dementia unit | State |  |

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

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| --- | --- | --- | --- |
|  | 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)?

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|  | 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. |
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| 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. |
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| 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 (eg hospice) and access to equipment if necessary (eg 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 the completed form to [certification@moh.govt.nz](mailto:certification@moh.govt.nz), together with:

**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**

**Evidence from the DHB Health of Older Persons portfolio/programme manager in support of this request**

If you have any questions, please contact HealthCERT on 0800 113 813.