Aged Residential Care Manager's Manual

South Island – Te Waipounamu

Health New Zealand
Te Whatu Ora

CONTENTS

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1. INTRODUCTION

Welcome to Health New Zealand | Te Whatu Ora. You are receiving this Manual because you are a new Facility Manager or Clinical Manager leading one of the 200+ aged care facilities within the South Island | Te Waipounamu.

We are here to support you and work in collaboration to better care for the vulnerable residents and their whānau who have chosen your facility. This Manual is designed as a reference guide with information relevant to the area in which your facility is located.

While generically, the Age Related Residential Care (ARRC) agreement is a nationally contracted agreement, the resources and support in each region can vary. This document provides an overview of a broad range of areas staff working in leadership positions within an aged residential care (ARC) facility may need to know to support seamless care and transitions for older people going into or leaving a service.

Te Waipounamu | the South Island has a Planning Funding and Oucomes Older Persons Team that oversees the Older Persons programme for its region. This team was previously known as Ageing Well. The Older Persons Team looks at services regionally, across the population and focuses on keeping people well, at their best potential, preventing impairment (where this is possible) and ensuring all parts of the community work together to achieve better care.

The activity that helps us collectively achieve this includes:

- The Health and Disability standards.
- Regular audits/outcomes.
- Ongoing workforce education and investment.
- Learning in a shared environment.
- Working collaboratively to create pathways to achieve optimal outcomes.

The Older Persons Team is responsible for commissioning new and existing services, legislative and performance monitoring of Providers, including ARC; this also includes other organisations such as Home and Community Support Services (HCSS), Community Day Activity Programmes, Dementia Support, Hospice Providers and other Older Persons services. The Older Persons Teams liaise closely with the Older Persons Needs Assessment and Service Coordination (NASC) services.

For monitoring to occur, the Older Persons Team receives information on the following:

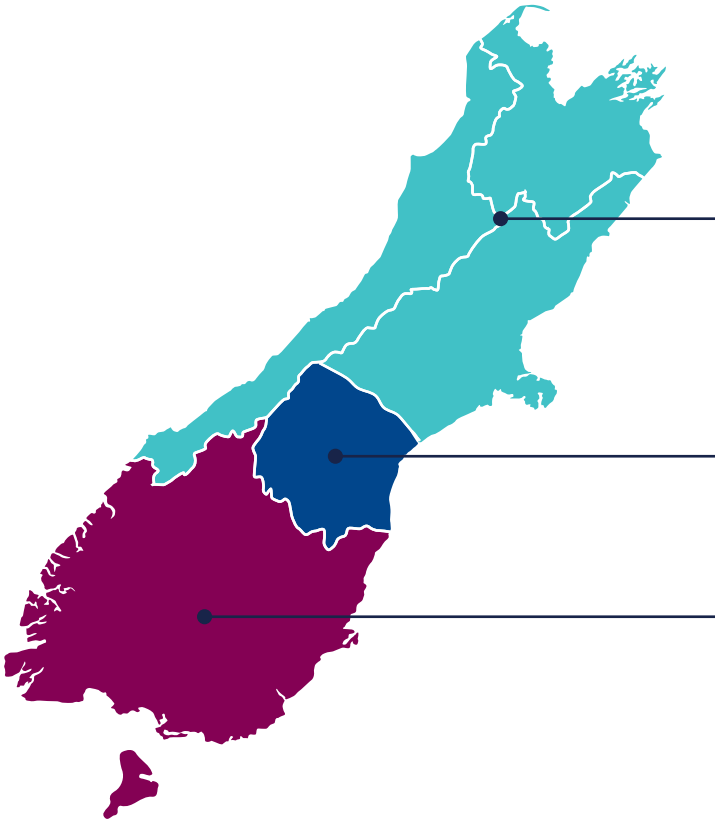
- Kantar Quarterly Bed Survey (data on numbers of residents).
- Audits.
- Quarterly reporting (performance monitoring returns).
- ARC claims data.
- Change of Facility and Clinical Manager notifications.
- Adverse event (SAC) reporting and Section 31 Notifications.
- Complaints from residents, their families or members of the public.
- interRAI compliance reporting.

The Older Persons Team are responsible for both monitoring compliance and supporting excellence in service delivery.

Additionally, there is a Clinical Advisor role within the team who is available to support Aged Residential Care with service development, the resolution of complex issues, complaints and best practice advice. The Older Persons Team may recommend input from the Clinical Advisor as appropriate.

We hope you find the information outlined in this document useful. Please contact the Older Persons Team if you have any questions about the content of this manual.

Key Contacts for ARC



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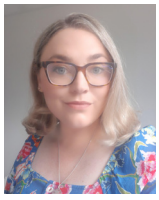


Charlie Maslin
Service Development Advisor

2. SUPPORTING CARE IN THE COMMUNITY

We aim to keep older people living in their own homes for as long as possible when it is safe to do so, and this is supported by the person, and their family/whānau network. Therefore, ensuring a range of community and at home support options is available is a priority. This includes access to general practice services, meals on wheels, home and community support options, and information.

People living in residential care villages or owner-occupied residential apartments (ORA) can access community home and support services unless it is specified in the Admission Agreement that services must be purchased from the specified ARC facility.

Residential care for older people is usually the last option sought after other strategies to support the person at home have been exhausted. Once an older person is deemed eligible for aged residential care, the Needs Assessor will inform them of the level of care they require and facilities with vacancies at that level of care. The older person and their family choose which facility to enter.

It is important that providers understand that aged residential care does not have to be a permanent and final residential home for older people. For some, returning to the community, living with a family member or independently can occur. Where this is the case, aged care providers must notify NASC and gain clarity on best placement for the older person.

Similarly, when a person enters a particular level of care, it is important that they realise that their needs, and corresponding level of care is likely to change over time. They can only remain at your facility whilst you can provide the level of care that meets their needs. **It is imperative that new admissions understand that their stay with you is only for as long as you can meet their level of care needs.**

Southern district:
We have branded this information as "Home as My First Choice" which can be found here.

Referral Pathway to ARC

When it is identified that an older person needs support, a referral is sent to the following service in each district:

District	Contact Details
Nelson Marlborough	**The Community Care Coordination Team** 0800 244 300 needs.assessment@nmdhb.govt.nz
Nelson and Marlborough have two separate NASC Teams which cover Mental Health, EOL, LTC, and HOP. There is an MSD NASC in this Team that covers DSS clients across both areas. Referrals should be made using this form. For a change of level of care, the Form available in the InterRAI should be used.	
West Coast	**The Complex Clinical Care Network (CCCN)** 03 768 0481 cccn@wcdhb.health.nz
West Coast has one NASC with a base in Greymouth and Westport, which covers Mental Health, EOL, LT-CHC and HOP. They are known as the Complex Clinical Care Network (CCCN). Referrals should be made using this form.	

Table continued over the page

District	Contact Details
Canterbury	**The Adult Community Referral Centre (ACRC)** 03 337 7765 communityreferralcentre@cdhb.health.nz
Canterbury: Entry to the community services is through the Adult Community referral Centre (ACRC) with referrals triaged to the relevant team and discipline. Interdisciplinary Teams review and manage the response to clients requiring more than one discipline's input. **Community Services Referral form in HCS** » Community Nursing eg. wound care, palliative care etc. » Home Based Support Services. » Specialist Nursing eg. stoma care, specialist continence and dialysis care. » Community Assessment and Rehabilitation eg CREST, OPH, OPMH, ACTS. » Falls Prevention Programme. » Change of level of care - *please also add recent medical review details and blood screen/MSU results, relevant EPoA documents, and ensure the InterRAI has been updated.* Canterbury have separate NASC for the various client groups for example Health of Older People, LTS-CHC NASC, Mental Health Older Persons, Palliative NASC. Ashburton also have a NASC.	
South Canterbury	**The Integrated Community Assessment Treatment Team (ICATT)** 03 687 2109 ext 8314 icatt@scdhb.health.nz
South Canterbury has a central point for all community referrals; these are sent to the integrated Community Assessment Treatment Team (iCATT). iCATT screens the referral, and if the older person meets the criteria for services, refers clients to the appropriate service. If the person has been screened and identified that they will require supports, they will be seen by the local Needs Assessment Service Coordination (NASC) service for an interRAI Home Care Assessment or referred onto the HCSS provider for a contact assessment. South Canterbury has one NASC which covers Mental Health, End of Life (EOL), Long Term Chronic Health Conditions (LT-CHC) and general Health of Older People (HOP) based at Talbot Community Health Hubb in Timaru. The HCSS and NASC provider will explore a range of funded and non-funded supports to keep people at home.	
Southern	**Care Coordination Centre (CCC)** 0800 627 236 carecoordinationcentre@southerndhb.govt.nz
CCC screens the referral, and if the older person meets the criteria for services, refers noncomplex clients to an HCSS (Home and Community Support Services) agency for an interRAI (comprehensive clinical assessment tool) Contact Assessment and supports, or complex clients to the local Needs Assessment Service Coordination (NASC) service for an interRAI Home Care Assessment. The NASC will then explore a range of funded and non-funded supports to keep people at home. While the Care Coordination Centre covers Southern, there are separate NASCs in Dunedin, Waitaki, Central Otago (covering Queenstown/Lakes), Gore, and Invercargill.	

Other Community Needs Assessment and Coordination Services

Long Term Services Chronic Health Conditions (LTS-CHC):
Provides needs assessment and service coordination for children and adults under 65 with complex chronic medical needs.

Ministry of Social Development (MSD):
Provides needs assessment and service coordination for people under 65 with a physical, sensory or intellectual disability.

District	MSD NASC Providers
Nelson Marlborough	DSS NASC which is contracted through HNS Nelson Marlborough and sits within the NASC team
West Coast	Separate DSS NASC – Lifelinks
Canterbury	Separate DSS NASC – Lifelinks
South Canterbury	Separate DSS NASC – Lifelinks
Southern	Separate DSS NASC, Kia Roha | Your Way

Home and Community Support Services (HCSS)

Te Waipounamu works within an Alliance of providers. Access, HealthcareNZ, Nurse Maude and Royal District Nursing Service provide a Restorative Model of Care to older people who require support in the community.

Home Support services are not means-tested, but they are also not unlimited. We are guided by the National Framework for Home and Community Support Services.

3. ENTRY INTO AN AGED RESIDENTIAL CARE (ARC) FACILITY

3.1 New Admissions

This manual provides information regarding Health NZ funded residents only. Please contact MSD or ACC for questions related to residents under those contracts.

- **Confirm funding stream.** Funding streams may be: ARRC, Long Term Support for Chronic Health Conditions (LTS-CHC), End of Life, Mental Health, ACC – transitional care, Respite, Carer Support, or Privately Funded. When whānau/potential residents/ needs assessors/hospital staff contact you regarding a potential new resident, it is imperative that you **confirm the funding stream with the local Older Persons NASC Service.** The NASC is the ultimate source of truth regarding funding streams, which can often be confusing for families, potential residents and even hospital or hospice staff.
- Today, older people have many options to be supported in their later years, ranging from Health NZ funded supports to supports provided, often privately, in a Retirement Villages or Care Homes. For Health NZ supports at home or subsidised care in a Care Home, a NASC interRAI assessment is required. **For those receiving supports privately funded, we strongly recommend clients get a NASC interRAI assessment once they require support:** see here. This is important so that they will be eligible for any Health NZ subsidies or top-ups as they need to access higher levels of care. This also provides a benchmark against which to determine future needs and enables ongoing interRAI to be carried out. Staff should all be clear as to which of these residents is receiving an assessed level of care and which are purchasing 'services'.
- Confirm eligibility and level of care with Older Persons NASC Services and that you have the appropriate contract in place.
- Do not accept admissions from other areas until the interNASC transfer has been confirmed by your local Older Persons NASC Services Team.
- Check interRAI (Momentum) for background information that will help with seamless transition to care and preferred contacts including if the person has a current General Practitioner.
- Check to see if there is an Enduring Power of Attorney (EPOA) in place. If there is no EPOA in place, it is strongly recommended that you request this to be arranged prior to, or shortly after, admission.
- Confirm if the Resident will apply for the Residential Care Subsidy (RCS) or will pay the Maximum Contribution privately. If applying for the RCS, follow up that this application has been submitted within a maximum of 90 days from admission. The Older Persons Team can backdate eligibility for subsidies when there are outstanding circumstances that have meant the application hasn't been able to be made in a timely manner. Information about the RCS is found at Residential Care Subsidy - Work and Income or you can email msd_rcs@msd.govt.nz or phone 0800 999 727.
- Where residents are privately paying for their care, please ensure they are aware of when they might become eligible for a residential care subsidy.
- Always ensure that superannuation payments are redirected to the ARC Facility from the day of admission.
- Ensure the resident/resident's nominated representative has signed an **Admission Agreement.** Clause D13.3 of the Age-Related Residential Care Services Agreement outlines the information that must be included in the Admission Agreement, including any additional costs the resident/ nominee has agreed to pay.
- Note that the Resident Admission Agreement should be signed as soon as is reasonably practicable, but no later than ten working days after the resident is admitted.

3.2 Age-Related Residential Care Services Agreement (ARRC)

This is a national agreement between Health NZ and aged residential care providers for the delivery of age-related residential care services.

It covers care provided in residential settings at the following levels:

- Rest home care.
- Secure dementia care (historically referred to as D3 or D4).
- Geriatric hospital care (continuing care).

The contract ensures a consistent national standard of services for residents in long-term care facilities. It is important that residents, their friends, and whānau understand which services are included under this agreement.

Psychogeriatric services (historically referred to as D6) are covered under a separate, but closely aligned, agreement known as the Age-Related Residential Hospital Specialised Services Agreement.

Key clauses to be aware of

(Please refer to the ARRC Agreement for the exact wording.)

Absences from the Facility – Clause A7

Outlines your responsibilities when residents are absent from the facility. Please note that leave days exclude the day the resident left and returned.

For absences exceeding the contractual limits, please follow the guidance below:

District	Form	Send to
Nelson Marlborough	Please click here	twp.bed.extensions@tewhatuora.govt.nz
West Coast	Please click here	twp.bed.extensions@tewhatuora.govt.nz
Canterbury	Please click here	twp.bed.extensions@tewhatuora.govt.nz
South Canterbury	Please click here	tfoster@scdhb.health.nz
Southern	Please click here	Local Older Persons NASC Service

Premium Rooms – Clause A13

Details the rules regarding Premium Rooms. Please also refer to the Accommodation premium rules for further guidance.

Annual Review – Clause A21

Allows for an annual National review of the ARRC Agreements between Health NZ and providers. Any agreed variations are incorporated into the contract, with new funding rates typically effective from 1 July each year.

With funding uplifts, the Maximum Contribution also changes. We will send you letters for your residents to inform them of changes to the Maximum Contribution.

For residents where Work and Income has determined a private contribution less than the Maximum Contribution, that amount does not change with a change to the Maximum Contribution. Work on a new Funding Model for ARC is ongoing.

Assignments and Transfers – Clause A30

You must notify Health NZ at least 30 days before any intended transfer or disposal of your facility using this form. You must advise any proposed purchaser that the ARRC Agreement will only transfer to a new owner if Health NZ consents.

Equipment – Clause D15.3

Requires facilities to provide appropriate equipment to meet residents' needs, including bariatric equipment where necessary. If non-standard equipment is required, consult your contracted Physiotherapist or Occupational Therapist. In some cases, Health NZ may cost-share bariatric equipment. Read more here.

Allied Health Services – Clause D16.5v

You must provide the treatment programme prescribed by a Medical Practitioner or Nurse Practitioner to assist the Resident to develop and maintain functional ability. This may include such goal and outcome-oriented treatment as physiotherapy, respiratory therapy, occupational therapy, speech therapy, dietetics and podiatry.

Staffing – Clause D17

Clause D17 outlines the minimum requirements for staffing. Sufficient staffing must be provided to ensure your ability to meet resident needs. The following documents may be helpful with staff planning:

- The '2019-20 Aged residential care industry profile' includes the average number of hours per resident per day being used across the industry at each level of care. This document is available for your reference in order to test your staffing hours against the most recently published national average.
- 'Mandated nursing staff to resident ratios in aged care: Summary of evidence', published by the NZNO in 2017. Recommended international minimum staffing ratios in aged care are outlined and used as a reference point to assess how Aotearoa New Zealand measures up.
- 'Indicators for Safe Aged-care and Dementia-care for Consumers', published by the Ministry of Health - Manatū Hauora in 2005. This document has been withdrawn, however many ARC providers still utilise this guidance.

High-Cost Wound Care – Clause D18.3

Outlines the circumstances under which you may apply for additional funding to cover extraordinary wound dressings. See section 6.3 for more information.

Transport and NEAT Funding – Clause D20.2

You are required to provide transport, including specialised transport required for clinical reasons, to and from the services noted in clause D20.1 (a) – (h).

Clause D20.4 requires you to use your best endeavours to ensure any resident who needs to be accompanied to an appointment is accompanied by a relative/friend but if this is not possible you must provide staff to accompany the resident.

There is some additional funding available for some Non-Emergency Ambulance Transfers, (NEAT) funding. Further information and claim forms can be found here.

It is important that providers are familiar with all terms and conditions contained in the ARRC Agreement.

3.3 Other Funding Streams: LTS-CHC, End of Life, Respite and Carer Support, ACC, Mental Health

While most of your residents will be funded under the ARRC Agreement, you may also hold the following contracts with Health NZ:

- Age-Related Respite (short term care, generally to relieve carer stress).
- Long Term Support for Chronic Health Conditions (LTS-CHC) (adults under 65 with chronic health conditions such as MS or stroke).
- End of Life (EOL) (people assessed (at any age) to be in the last days of life, funded for up to 42 days).
- Individual funding agreements (any resident with needs that sit outside standard contracts).

A resident who is subject to the Mental Health Compulsory Assessment and Treatment Act will be funded without need to apply for a subsidy but will need an alternate funding arrangement once they are no longer subject to the Act.

As noted in Section 3.1 it is imperative that you confirm the Funding Stream with the Older Persons NASC Service.

ACC Transitional Care

This pathway is defined as interim care for clients who are discharged from hospital and require a transitional period of targeted rehabilitation within a residential care support service for a short period of time. After this period, the client will either return to hospital or be discharged home. NB: ARC providers may need to apply to ACC for a Residential Support Services Contract.

Clients on this pathway will continue to receive support from the local HSS Non Acute Rehabilitaion Pathway (NARP), Community Rehabilitation or Early Supported Discharge (ESD) service while in an ARC facility. (eg: allied health inputs during patient stay in ARC facility) based on the case mix community profiling tool which identifies the level of rehabilitation required.

Transitional Care differs from Interim Care (IC) where patients who are unsafe to transfer home, transfer to an ARC facility for convalescing, and/or receive NARP in an ARC facility.

See the links below for further information:

- Interim care
- Short term care
- Long term residential care
- ACC NARP Operational Guidelines (page 30)

Carer Support

While Carer Support is not a 'Contract' with Health NZ, it is funded by Health NZ. It provides reimbursement to Primary Caregivers for some of the costs associated with engaging a support person or provider to care for individuals with age-related needs, mental health conditions, long-term medical conditions, or disabilities. This allows the primary carer to take a break.

It may be used to help cover the cost of services such as day programmes, day care, or respite care in an ARC facility. In all cases, the funding agreement is between the Primary Caregiver and the service provider. Any additional costs must be agreed upon separately.

Further information about Carer Support is available online. If a Primary Caregiver is using Carer Support to fund care in your facility, you should confirm the amount being covered by Carer Support and clearly communicate any additional charges to the resident and their whānau.

3.4 Residential Care Payments Information

- Invoices for residential care are sent to southernpayments@health.govt.nz.
- Information can be found in: Residential Payments: a guide for administrators of residential facilities
- More information about Residential Care Comments Sheets can be found here and an excel template can be found here.

PPS Comments Sheets are due to Sector Operations (southernpayments@health.govt.nz) by midnight on the date due. If the Comments Sheet is not submitted by the correct date and payments are urgently required, please contact your Older Persons Team, who can request an out-of-cycle payment.

3.5 When to inform your local NASC/CNS

You must inform your local NASC/CNS when:

- A resident dies or intends to move out of your facility.
- A resident's needs change, for example:
  - Their behavior puts other residents or staff at risk (this requires a s31 Notification to HealthCERT and the Older Persons team).
  - They 'wander' from the facility or exit unsupervised from a secure placement (this requires a s31 Notification to HealthCERT and the Older Persons team).
  - Their needs change, requiring a higher or lower level of care. In these cases, NASC can support a service coordination function or support reassessment to a change of level of care (see Section 4.4).
- A resident is absent from the facility for a number of days that trigger an Extension Request (see Absences from Facility in Section 3.2 previously).

4 REQUIREMENTS FOR ALL ARC PROVIDERS

4.1 Auditing

The auditing for aged residential care facilities is largely a partnership between Health NZ and HealthCERT. HealthCERT is the legislation, monitoring and compliance division of the Ministry of Health.

All aged residential care facilities are certified and audited to ensure they:

- Provide safe, appropriate care for their residents.
- Meet the standards set out in the Nga Paerewa Health and Disability Services Standard 8134:2021.
- Meet the contractual requirements set out in the ARRC Agreement.

Facilities are certified to the sector standards (Nga Paerewa Standards), with a Certification Audit every one to four years. New providers are initially certified for one year. After that, certification is generally awarded for two to four years based on the outcome of the Certification Audit. Four-year certifications generally require a clean audit (no findings) and documentation of Continuous Improvements. Unannounced surveillance audits occur within the three months either side of the midway point between certification audits. Clause A15.3b of the ARRC Agreement allows for issues-based audits without prior warning. More information, including on Provisional audits, can be found via the Ministry of Health website and the Designated Auditing Agency Handbook.

The Older Persons Team is notified of all aged residential care audits and asked to give feedback regarding any issues or complaints, follow up from previous audits, etc.

Copies of audits have been available online to the public since 2014. NASC services and Health NZ refer families to look at audits when they are contemplating which aged residential care facility their family member may be interested in.

Te Waipounamu is proud of the number of aged care facilities that have achieved four-year certifications and supports Continuous Improvements in all aged residential care facilities.

4.2 Audit Follow up

A Quality Improvement Advisor (QIA) within the Te Waipounamu Older Persons Team monitors and follows up on findings identified during the audit process.

Once HealthCERT finalises the audit report, the QIA reviews it and consults with the Older Persons Team member to develop a Corrective Action Progress Monitoring Report (PMR). The PMR outlines audit findings, required evidence for corrective actions, and associated timeframes. After approval by the Older Persons Team member, the PMR is sent to the facility.

Facilities must submit the required evidence by the specified due dates.

Evidence can be sent via email to twp-audit.admin@tewhatuora.govt.nz or posted to:

Te Waipounamu Regional Programme Office
Level 4, 32 Oxford Terrace
Christchurch Central

The QIA will continue to follow up until all corrective actions are completed. Once resolved, you will receive a letter confirming that the audit is closed.

4.3 interRAI

About interRAI Long-Term Care Facilities assessments

interRAI is a not-for-profit network of researchers in over 35 countries, dedicated to improving care for people with disabilities or complex health needs. They've developed a set of clinical assessments that help improve the quality of life for older and vulnerable people. In New Zealand the Long-Term Care Facilities (LTCF) assessment was introduced in 2013 and became part of the Aged Related Residential Care (ARRC) agreement in 2015. The Palliative Care (PC) assessment is also available and used in both the community and aged care facilities for those needing end-of-life care.

What the interRAI assessments do:

interRAI assessments do more than highlight problems — they also recognise a person's strengths, needs, and preferences. This ensures:

- Care is tailored to what the person needs.
- The person is involved in their care.
- Their quality of life is supported and can improve.

The LTCF and PC assessments help detect signs of decline and:

- Identify risks early.
- Help plan targeted support.
- Aim to improve health outcomes and stability.

The Home Care (HC), Community Health Assessment (CHA) or PC assessments are acceptable assessments used to determine eligibility into ARRC.

interRAI offers a suite of assessment instruments supporting continuity of care. See the linked guideline for when to complete the LTCF or PC assessments in aged residential care.

interRAI New Zealand website / Resources and Training

The interRAI website has information for assessors, managers, and support staff, including training options and data access. You can also use the Data Visualization tool on the web page in which you can see nominalised data from all regions.

Information about LTCF or PC interRAI training can be found here.

To gain read only access to iAS (interRAI Assessment Software), complete a user access form via the website. It is highly recommended that managers complete 'Understanding and interpreting interRAI assessments' course which is on the website. The information in this course will provide managers with information on how to read resident's assessments and their outputs, including those about to be admitted into the facility. Managers (clinical and non-clinical) and facility administrators can request to complete the 'Administrative Training for Residential Care Facilities' training course which covers managing admissions and discharges and demographic information changes and navigating the software. (This course is not currently on the website). Please refer to Training - interRAI.

Contractual requirements

Contractual requirements regarding interRAI are found in Clause D15 and D16 of the Age-Related Residential Care Agreement. It is recommended that facilities have one interRAI trained staff member for every 15 residents.

Older Persons Teams receive a variety of interRAI compliance reports including:

- The number of people entering aged residential care who have had an interRAI Home Care assessment in the prior six months.
- The number of subsequent assessments completed by aged care facilities within six months following a previous interRAI assessment.

Data is reported to the Older Persons teams which shows those facilities who have achieved 100% completion of resident interRAI and those that have not. The Older Persons Team will follow up with facilities who are not meeting their contractual obligations around assessment for residents to identify barriers. Other reports are available on the interRAI Assessment Software (iAS) under reports and will help you in maintaining your quality service.

Quality improvement

Your facility will receive regular quality indicator data from interRAI services, which can be used for quality improvement initiatives.

Here are two great YouTube videos that highlight how facilities can use interRAI data for Quality Improvement:

» CIHI Data Helps Put Philosophy into Practice (youtube.com)

» CIHI Data Helps Battle Depression (youtube.com)

If you need help or assistance with anything that is interRAI related, please reach out to interRAI Services for support:

Phone: 0800 10 80 44
Email: interrai@tas.health.nz

Subscribe to receive regular updates shared in the interRAI Pānui newsletter.

4.4 Change of Level of Care

You are certified to deliver one or more levels of care to your residents:

» Rest Home (also known as Residential).

» Secure Dementia (also known as D3, D4, Residential or Rest Home Dementia).

» Hospital (also known as Continuing Care).

» Psychogeriatric (also known as D6, Dementia Hospital, Secure Hospital or Specialised Continuing Care).

Residents' needs are likely to change over time. The ARRC Agreement requires you to assess residents within 21 days of admission, every six months and when their needs change. If your professional judgement indicates a resident may require a different level of care (higher or lower), you must refer to your local NASC for a Change of Level of Care (CLOC) review.

You are responsible for discussing with the resident and their family/whānau that due to a significant change in status, a reassessment is being completed and a change in care level is likely to be required.

If the change in status is due to a recent onset of illness, behavioural or mental health concerns you need to ensure the resident has had a medical review or a review by the Nurse Practitioner to see if any issues can be reversed/addressed before referring to the NASC.

See the table below for how to make the referral to NASC:

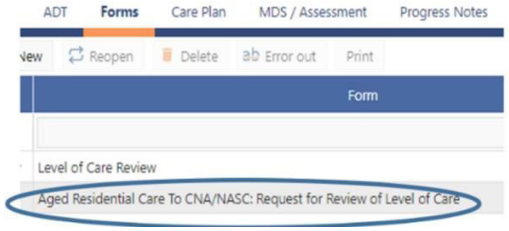
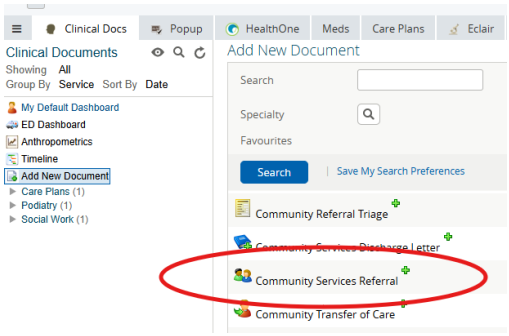
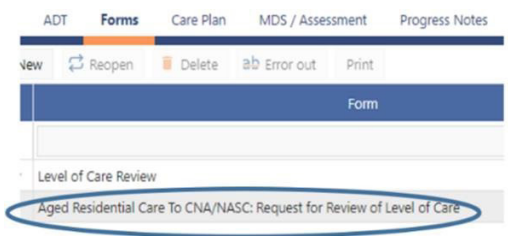
District	Process	Form
Nelson Marlborough	Complete the 'Aged residential care to CNA/NASC form' (in interRAI). This short form summarises the change in status for the client. Then send an email to the address listed at the bottom of the form, advising it has been completed. There is no need to print or email the actual form. A referral will be opened from your email.	

Table continued over the page

District	Process	Form
West Coast	Refer via the CCCN Referral Form and ensure the InterRAI has been updated.	Please click here
Canterbury	Refer via ACRC and include the following: *recent medical review details and blood screen/MSU results, relevant EPA documents, and ensure the InterRAI has been updated.*	Health Connect South Referral Form 
South Canterbury	Complete and send iCATT referral form for change in level of care indicating it is a referral to NASC. If resident requires dementia or psychogeriatric care, refer to the OPMH team (you can use the same iCATT form). NASC will be in touch when care needs level is completed, and outcome known.	Please click here
Southern	Complete the 'Aged residential care to CNA/NASC form' (in interRAI). This short form summarises the change in status for the client. Then send an email to the address listed at the bottom of the form, advising it has been completed. There is no need to print or email the actual form. A referral will be opened from your email.	

The Clinical Needs Assessor will determine the required level of care and discuss with the resident and their family/whānau if their current facility offers that new level of care, or if they will need to transfer to a new facility. If a new facility is required, this will generally occur over the next week. A longer time may be negotiated, keeping the resident's safety paramount.

In extraordinary circumstances, consult with your Older Persons Team member about the possibility of additional temporary funding.

If you are a Rest Home only facility, you may continue to care for one Hospital level resident if the conditions of a NOHRRA (see section 4.5 next) below are met.

4.5 Requirements for Certified Providers

You must be familiar with the requirements under the Health and Disability Services (Safety) Act 2001. Please ensure you take the time to familiarise yourself with the Ministry of Health website.

This includes:

- Annual service provider declaration: certified providers are required to submit an annual declaration in any calendar year in which an audit related to certification does not occur.
- Notifying of a change of clinical or facility manager: all certified aged residential care providers must notify Health CERT when they have a change in facility or clinical manager.
- Notifying an incident under section 31 (see section 4.6 following).
- Reconfiguration services or building new premises.
- Reporting on an ACC notification of harm.

Please copy all notifications to the Older Persons Team.

4.6 Notification for one hospital-level resident to be cared for in a rest home service area

This process enables a facility to provide Hospital Level of Care in a Rest Home service area for one resident when a rest home resident suddenly requires end of life care, a rest home resident has a change in level of care to hospital-level of care and is awaiting transfer, or a long term rest home resident requires hospital level of care and transfer to another part of the facility or another facility compromises continuity of care.

The process requires a discussion with Older Persons Team who need to be satisfied that the arrangement is safe, the provider can provide the hospital level of needs for that resident, and the provision of this care will not have a significant impact on the other residents.

There is a NOHRRA form that needs to be completed and sent to the Older Persons Team and this needs to be updated on a 3 monthly basis.

Email completed forms to:
twp-audit.admin@tewhatuora.govt.nz

Canterbury:
Please discuss with the GNS assigned to your facility in the first instance.

4.7 Section 31 Notifications

Under section 31(5) of the Health and Disability Services (Safety) Act 2001, certified providers must promptly notify the Director-General of Health of the following:

- **Any health and safety risk to residents** or a situation that puts (or could potentially put) the health and safety of people at risk.
- **Any police investigation** into any aspects of the service.
- **Any death reported to the Coroner** of a person to whom you have provided services or that occurred in any premises in which services are provided.
- **All changes in name, address, or telephone number** of the person who should be contacted about the service/s.
- **Any new fixed location** at which the services are being provided.
- **Any change in the membership of the governing body**, partners or trustees of the service provider.

Please ensure you take the time to familiarise yourself with the full details of section 31 of the Act. For more information on making a notification, visit the Ministry of Health website.

RN Shortages

Please note that a Section 31 notification is required if you do not have enough RN staffing (or staffing) on site to meet your contractual obligations.

Pressure Injuries

Effective 1 July 2024, reporting of pressure injuries in aged residential care is via the Te Tāhū Hauora Health Quality and Safety Commission (Te Tāhū Hauora) adverse events reporting process. This change aims to simplify reporting and ensure consistent data collection. The Health Quality & Safety Commission has more information on the adverse events reporting process.

As noted in Section 4.1 Auditing, you are also required to comply with the Ngā Paerewa Health and disability services standard NZS 8134:2021.

Please copy all Section 31 Notifications and Adverse Event Reports to the Older Persons Team.

4.8 Health Quality and Safety Commission | Te Tāhū Hauora

Te Tāhū Hauora works with clinicians, providers, consumers and whānau to improve health and disability support services. They support the aged residential care (ARC) sector through strong stakeholder relationships to build a culture of continuous learning and development and ultimately improve residents' experience of care. There are great resources available, including the widely acclaimed Frailty Care Guides, the Care Guide for Healthcare assistants, and the Cultural Considerations video series for health professionals caring for kaumātua.

Te Tāhū Hauora hosts the National Adverse Events Reporting Policy, as required in Criteria 2.2.5 of the Ngā Paerewa Health and disability services standard.

The revised Te Tāhū Hauora 'Healing learning and improving from harm; national adverse events policy 2023' came into effect on 1 July 2023. The policy provides a national framework for health and disability providers to continually improve the quality and safety of services.

It provides a consistent way to learn and improve through recognising and reviewing harm. Under Ngā Paerewa Health and disability services standard 2021, ARC providers are required to review and report all SAC 1 and 2 events of harm to Te Tāhū Hauora, this includes fractures and pressure injuries that meet the definition of SAC 1 and 2 events. The User Guide is a useful document.

If your organisation needs a submissions portal login or more information on the submissions process, please email adverse.events@hqsc.govt.nz.

For more information on learning from harm education, please email: learningfromharm@hqsc.govt.nz.

A helpful document summarising reporting requirements for ARC in Te Waipounamu can be found here.

4.9 HealthCERT Bulletin

HealthCERT publishes a quarterly newsletter that provides the Sector with updates, research and information to help answer commonly asked questions.

Current and back issues of the HealthCERT Bulletin are available here.

4.10 Contractual Reporting Requirements

Quarterly Bed Survey

Your ARRC Agreement requires you to complete this quarterly email survey.

You will receive this shortly after each quarter ends from the email address: invite@veriansurveys.nz.

If you need to update or confirm your email address, please contact arcbedsurvey@tewhatuora.govt.nz.

Performance Monitoring Reports

Other Health NZ Agreements (Respite, LTS-CHC, End of Life, Mental Health) require quarterly Performance Monitoring reports.

4.11 Assisted Dying

Assisted dying became legal in New Zealand in 2021. All health professionals need to understand their legal and professional obligations to respond appropriately if a person raises assisted dying with them as part of their everyday roles.

More information is available here.

It is important that every ARC determines whether it will permit Assisted Dying on its premises. This should be reflected in your information for residents.

5 COMPLAINTS MANAGEMENT

Complaints are a valuable opportunity to improve service quality and reflect on current practices.

We support a culture where:

- Consumers and staff are empowered to report events without fear of retribution.
- Events that are reported are investigated with a focus on determining the underlying system failures and not blaming or punishing individuals.
- Providers ensure a just culture prevails, so individuals are not held accountable for system failures.

Managers play a critical role in ensuring complaints are handled constructively, transparently, and in alignment with regulatory expectations.

Most complaints about aged residential care received by Health NZ relate to:

- Inadequate communication or unclear expectations between staff and families.
- Failure to collaborate and consult with residents and families when making decisions.
- Misunderstandings around payments or premium service charges.
- Equipment shortages or concerns about clinical care.

Completion of Shared Goals of Care can promote shared understanding, informed consent, and person-centered care, which may reduce the likelihood of complaints arising.

Process for residents/whānau to make complaints about aged residential care.

The Ministry of Health has a process for residents and whānau to follow when making a complaint. It is freely available on their website alongside resources to navigate the aged residential care complaints process. HealthCERT and auditors are advised of all complaints.

If in doubt, treat every complaint as if it might go to the Health and Disability Commissioner's office. Act quickly and document carefully.

6 PROGRAMMES DELIVERED TO SUPPORT AGED RESIDENTIAL CARE

6.1 Palliative care

- Palliative Care is an approach that supports people with a life-limiting condition and their whānau.
- Palliative care aims to identify and improve issues that are threatening a person's quality of life.
- Palliative care uses a holistic process ensuring spiritual, psychological, physical or whānau related aspects are assessed.

Why is palliative care important in aged residential care (ARC) facilities?

Aged residential care is the most common setting for death and dying among people over 65 in New Zealand. As such, a palliative care approach is essential in these facilities.

This approach involves:

- Embracing the principles of palliative care.
- Fostering a positive, open attitude toward death and dying among all staff.
- Respecting the treatment and care preferences of residents and their families/whānau.
- Supporting bereaved families.

In New Zealand most palliative care is provided by generalist provider such as GP's practice nurses, district nurses and the staff in Aged Care facilities. Most of your palliative residents will be covered by the ARRC agreement. Occasionally, a resident will come to you funded specifically for end of life care, under an End of Life Care contract (as per section 3.3).

For residents within ARC who need specialist palliative care support, referral should be made to a specialist palliative care service.

Referral may be appropriate if:

- The resident's condition/complexity was unable to be adequately supported by the facility team and or the GP.
- The resident has complex or distressing emotional or behavioural difficulties related to the illness.
- Facility staff require additional support/education/training to support a resident with palliative care needs.
- Whānau have questions or need additional support, reassurance, or assistance during a crisis period.
- Whānau need help to find appropriate counselling or psychological support.

Specialist Palliative Care Support

District	Process
Marlborough	Hospice Marlborough provides specialised palliative care to eight aged residential care facilities in Marlborough. The Hospice Marlborough ARC service is available to residents, families and staff to promote and support good palliative care. The service includes medical, nursing, social work and family support, with access to a 24-hour on-call service for advice and support. Hospice Marlborough also provides education on palliative care, including Hospice NZ programmes, to all eight sites. **Please refer using the following form:** Palcare Referral Form

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District	Process
Nelson	Nelson Tasman Hospice provides specialist palliative care services. Health professionals can refer patients when the complexity of the illness is such that specialist palliative care is needed to achieve control of symptoms and where social, psychological and spiritual support would assist the patient and family/whānau. Information about referral can be found here. **You can make a referral using the following form:** Palcare Referral Form 03 546 3950 hospice.marlborough@mht.org.nz
West Coast	**Greymouth and Hokitika** Two palliative CNS's are available Monday to Friday during business hours. **Please refer via HCS or contact as follows:** » **Sandra Hartwig** 027 224 4056 sandra.hartwig@wcdhb.health.nz » **Nicky Featherstone** 027 605 6362 nicky.featherstone@wcdhb.health.nz Any requirements for clinical review out of those times would need to be either after hours GP service or Emergency Department. **Westport** Two palliative CNS's are available Monday to Friday during business hours. **Please refer via HCS or contact as follows:** » **Alison Lobb** 022 0109 128 alison.lobb@wcdhb.health.nz » **Lindsey Gardner** 027 605 6361 lindsey.gardiner@wcdhb.health.nz
Canterbury	Specialist palliative care services are provided by the Nurse Maude Palliative Aged residential care Service (PARC). The Nurse Maude PARC service is part of the Specialist Palliative Care Service. The service comprises a team of Clinical Nurse Specialists who work in partnership with all ARC Facilities across Canterbury to ensure palliative care support is available to residents and their whānau. The focus of the PARC Team is on education and specialist support of the Facility staff to assist with palliative care provision. This may include symptom management advice, help with Advance Care Planning/Shared Goals of Care, assisting with whānau meetings and consultation with the wider Nurse Maude Hospice Palliative Care Service. To refer to the PARC service, contact Nurse Maude Hospice on 03 375 4274 and ask for the service manager.

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District	Process
South Canterbury	HNZ has a palliative care team consisting of a Specialist Palliative Medical Officer, clinical nurse specialists and social worker. Palliative care can be given at home, in hospital, in an aged care facility or at a hospice. The palliative care team works alongside general practice team, hospital services, district nursing, aged care facilities, Hospice South Canterbury, community agencies, whānau, friends and spiritual advisors. Referral to the service is via iCATT, each ARC facility has a designated Palliative Clinical Nurse Specialist who is responsible for supporting your team as and when required. Palliative CNS can be contacted via 03 687 2100. District Nursing assess new palliative patients, providing ongoing support, liaising with the Hospice, providing referrals to other health professionals, setting up with equipment in the home, setting up of syringe drivers for symptom management and end of life care, support for patients in rural and outlying areas. **South Canterbury Hospice:** South Canterbury Hospice provides specialist palliative care to people of all ages within the region of South Canterbury from the Waitaki to the Rangitata river. Quality care is provided for people, their families and whānau who are affected by cancer and non-cancer life limiting illnesses. Medical and nursing care is provided to manage complex symptoms and pain. Our service extends to education, training and advice to residential care facilities in this region. Hospice Services and programmes include: Inpatient unit: seven beds for specialist palliative care; Family support services: loss and grief counsellor, chaplain, and a bereavement support team.
Southern	Otago Community Hospice and Hospice Southland provide specialised palliative care to Otago and Southland respectively. Queenstown is covered by Hospice Southland. Both Otago and Southland Hospices provide a Clinical Nurse Specialist/Nurse Practitioner service to support palliative care in aged residential care. The Hospice ARC service is available to all of these residents, families and staff to promote and support good palliative care. **To refer, use the:** » Otago Hospice Residential Care Team Referral Form » Hospice Southland Referral Form

Palliative Care Education

Hospice regularly offers courses and education for health professionals supporting those with palliative care need. This is provided either at the Hospice or on the ARC site if possible. Education sessions can often be tailored to the needs of each facility in regard to topic, length of session, location and audience.

Hospice NZ provides the Palliative Care Lecture Series; an educational opportunity designed for healthcare professionals with an interest in palliative care. You can access these lectures by attending at registered sites around the country, or by registering online.

You can view the programme and register for the lectures here.

6.2 Advance Care Planning, Serious Illness Conversation Guide and Shared Goals of Care

Advance Care Planning (ACP) helps people prepare for current and future decisions about their medical treatment and place of care. Advance care planning is an ongoing process.

In response to requests from the aged residential care sector, Health Quality and Safety Commission have developed a Shared Goals of Care Form. It builds on the hospital shared goals of care work and the Frailty care guides | Ngā aratohu maimoa hauwarea.

The Shared Goals of Care form is available for all aged residential care facilities. It should be used with the shared goals of care factsheets for nurses and Allied Health workers and clinicians responsible for decision-making. The Serious Conversation Guide supports discussions about Shared Goals of Care. Information for residents and whānau can be found here.

One way to share the Shared Goals of Care information from ARC is by using the digital plan on Health Connect South, this makes it accessible to St John, ED, Acute Hospital and visiting health professionals. See here for more information.

When shared goals provide the basis for clinical treatment plans, the risk of a resident receiving unwanted or unwarranted treatments if their condition deteriorates, is reduced. Further information can be found here.

ACP Training and Serious Illness Conversation Guide Training to Support Shared Goals of Care Implementation

Training is available at no cost to ARC staff to support implementation of Shared Goals of Care. These sessions focus on the communications skills required for a partnership approach to establishing shared goals of care.

Serious Illness Conversation Guide training sessions are generally 3 hours and can be arranged for a group of ARC staff onsite. This training is recommended for any registered nursing staff who are facilitating admissions to the facility.

In addition, **Level 1A Advanced Care Planning** Training sessions are one day.

Please contact:

District	Serious Illness Conversation Guide Training	Advance Care Planning Training
Nelson/Tasman	acp@nbph.org.nz **Training:** Workshops — Nelson Bays Primary Health	
Marlborough	acp@marlboroughpho.org.nz	
West Coast	Not currently available	
Canterbury	03 364 4198 acp@cdhb.health.nz	03 364 4198 acp@cdhb.health.nz
South Canterbury	03 687 2100 ext 3774 sstevenson@scdhb.health.nz	**Paula Hogg –** **Clinical Lead for Social Work Team** **Timaru Hospital** 027 388 7349 phogg@scdhb.health.nz
Southern	helen.sawyer@southerndhb.govt.nz	**WellSouth:** https://training.wellsouth.nz/upcoming-events-2/cat-67-advance-care-planning/

6.3 Specialist Wound Care

Health New Zealand provides specialist wound care and vascular advice for aged residential care for the following:

- Any wound that has failed to progress in the expected time frame.
- Complex issue where specialist wound or vascular advice is required.
- Compression hosiery, if referral has been discussed and agreed with the patient.
- Note GP/NP can also activate wound or vascular referrals via ERMS.

District	Form	Contact details
Nelson/Marlborough	Please click here	The referral form can be followed up by contacting the local District Nursing service.
West Coast	Please click here	For the Wound and Vascular Services on the West Coast, following GP review please contact the District Nurses who operate Monday to Friday during business hours. **Greymouth:** 03 769 7400 ext 2721 greydn@wcdhb.health.nz **Hokitika:** 03 755 8044 or 027 244 8136 **Westport - District Nursing via Buller Health:** 03 788 9277
Canterbury	Canterbury Health Pathways outlines separate referral processes for Canterbury and Ashburton Specialist Wound Management Nursing Services here.	**To access Specialist Wound Care Management Services from Nurse Maude:** » Log in to Canterbury Community HealthPathways via: https://canterbury.communityhealthpathways.org/ **Username:** aged **Password:** residential » Search 'Specialised Wound Care Management Nursing' » Prepare the required information - drop down box - 'If referring from aged residential care, a completed Specialist Wound Care Service Aged Residential Care Pre-Assessment Form' ARC complete this. » Send the request - Adult Community Referral Centre Referral Form - tick the box for 'Specialist Wound Service' » Complete the two forms and email both forms to communityreferralcentre@cdhb.health.nz
South Canterbury	Please click here	**Wound and Vascular Services** zmatchett@scdhb.health.nz

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District	Form	Contact details
Otago	Please click here	**Wound Care Service** emil.schmidt@southerndhb.govt.nz lisa.schmidt@southerndhb.govt.nz **Vascular Service** rebecca.aburn@southerndhb.govt.nz
Southland	Please click here	**Wound Care Service – Monday to Friday** **Mandy Pagan – CNS Wound** 027 807 0132 mandy.pagan@southerndhb.govt.nz **Shannan Miller – RN Wound** 027 274 5570 shannan.miller@southerndhb.govt.nz **Vascular Service – Monday to Thursday** Terra works with the Dunedin Vascular Team and Diabetic Foot Clinic **Terra Wilson – Vascular CNS** 027 213 5547 terra.wilson@southerndhb.govt.nz

Provision of High Cost Dressing Supplies

The ARRC and ARHSS agreements allow for claiming directly from Health NZ for high cost wound products. In 2013, a cost sharing arrangement was introduced and forms clause D18.3b of the respective agreements.

Find the application here.

ACC will also fund some treatment costs related to either accidental or treatment related injuries.

Additional information is available here.

6.4 Other Hospital Specialist Services available to Aged Residential Care

Gerontology Nurse Specialists (Canterbury only)

The Canterbury Gerontology Nurse Specialists (GNS) work proactively to promote excellence in ARC by working closely with Facility staff, providing:

- Clinical support in all aspects of care for residents with complex needs.
- Evidence based guidance, advice, liaison and navigation of health care pathways.
- Professional development through education and clinical coaching.

These nurses are available Monday to Friday and can be contacted via the Adult Community Referral Centre (ACRC) on 03 3377 765.

Older Persons Mental Health Services

Many ARC residents may have some level of cognitive impairment, and like the general population may experience psychiatric illness. Some may exhibit behavioural and psychological symptoms of dementia. You are responsible for the training and education of your staff to support your residents' needs.

If there are heightened or ongoing concerns about diagnosis or management, your primary care provider should be the first point of contact. Referrals can be made to request specialist assessment and treatment advice.

District	Send referral to	Contact details
Nelson Marlborough	Older Person's Mental Health	**For general enquiries:** 03 539 3920 **Case management (complex included)** Medical Referral required (from GP, NP or geriatrician) ReferralsOlderPersonsMentalHealth@nmdhb.govt.nz **Liaison Support** Referral required (from GP, NP, geriatrician, or ARC manager) **Nelson:** sheree.lavender@nmdhb.govt.nz **Marlborough:** elyse.sibley@nmdhb.govt.nz
West Coast	Older Person's Health, Complex Clinical Care Network	03 768 0481 cccn@wcdhb.health.nz
Canterbury	Adult Community Referral Centre (ACRC)	03 337 7765 communityreferralcentre@cdhb.health.nz Or contact the Gerontology Nurse Specialist assigned to your facility: **Natalie Mcguffie** 027 836 0825 Natalie.Mcguffie@cdhb.health.nz **Sue Holland** 027 488 5952 Sue.Holland@cdhb.health.nz **Rachel Leary** 021 543 593 Rachel.Leary@cdhb.health.nz **For specialised hospital care residents (psycho geriatric) contact Helen O'Connor, Dementia Clinical Nurse Specialist:** 021 987 602 Helen.O'Connor2@cdhb.health.nz
South Canterbury	iCATT	03 687 2109 ext 8314 icatt@scdhb.health.nz **General enquiries:** 0800 277 997 OPMHS – Kensington Centre, Older Persons Specialty Nurse, Mark Eastup

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District	Send referral to	Contact details
Southern		**Otago:** Please contact your known MHSOP Nurse Practitioner (Angela, Jenni or Matt) **Southland:** Referral through the Mental Health SPOE team mentalhealth.spoe@southerndhb.govt.nz discussion with MHSOP nurse attending the MDT

Walking in Another's Shoes

The Walking in Another's Shoes training programme inspires and enables aged-care staff/kaiawhina to strengthen their person-centred approach to dementia care and to responsive behaviours.

This free Health NZ programme has been playing a major role in upskilling care staff in the Te Waipounamu for over a decade.

To find out more or to request places on the Walking in Another's Shoes course, contact:

District	Contact Details
Nelson Marlborough	Not available at this time
West Coast	**Giselle Hamilton** giselle.hamilton@wcdhb.health.nz
Canterbury	**Sharyn Creighton** Sharyn.creighton@cdhb.health.nz or the Older Persons Team
South Canterbury	Not available at this time
Southern	**Paula Hogan** 027 458 5845 paula.hogan@southerndhb.govt.nz

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Infection Prevention and Control Support and Advice:

District	Send referral to	Contact details
Nelson Marlborough	Awanui Labs Nelson Marlborough – Microbiologist	Can provide IPC telephone support – **Dr Aaron Keene** during business hours or a/h on-call Microbiologist – Awanui Labs 03 359 0900
	Public Health Service – for notification of communicable diseases including gastro outbreaks	**Clinical Microbiologist:** (via Health NZ – Te Whatu Ora Teleops) 03 546 1800 NM-NPHS-OnCallHPO@TeWhatuOra.govt.nz **Notification Form:** aged-residential-care-outbreak-notification-form.docx

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District	Send referral to	Contact details
West Coast	IPC CNS	**Can provide some IPC telephone and in-person support** **Julie Ritchie** 027 807 2670 **Sarah Tito** 022 017 6477 ipcnursing@cdhb.health.nz
	Public Health Service for notification of communicable diseases including gastro outbreaks	**WC Public Health Service** 03 768 1160 **Notification Form:** aged-residential-care-outbreak-notification-form.docx
Canterbury	IPC CNS	**Can provide IPC telephone support and offer virtual education sessions** **Ethan Walker** 021 228 9046 **Rebecca Henderson** 021 229 5496 ipcnursing@cdhb.health.nz
	Public Health Service for notification of communicable diseases including gastro outbreaks	**National Public Health Service –** 03 364 1777 **Notification Form:** aged-residential-care-outbreak-notification-form.docx
South Canterbury	IPC CNS	**Angie Foster** 03 687 2255 afoster@scdhb.health.nz
	Public Health Service for notification of communicable diseases including gastro outbreaks	**National Public Health Service** 03 687 2600 **Notification Form:** aged-residential-care-outbreak-notification-form.docx
Southern	IPC CNS	**For advice, guidance, training and education:** ipcarc@southerndhb.govt.nz
	Public Health Service for notification of communicable diseases including gastro outbreaks	**National Public Health Service** 0800 668 439 SO-NPHS-NotifyMOH@tewhatuora.govt.nz

6.5 Infection Prevention and Control

Vaccination

Vaccination is the most effective tool we have to prevent the transmission of infectious diseases and lessen the effects. Please ensure that your residents and staff have every opportunity to get vaccinated. We advise that you keep a spreadsheet of your residents' current vaccinations, including COVID-19, that alerts you when the next booster is due. Influenza vaccination is a key strategy in reducing the impact of the disease in older people as it does in healthy adults. Find more information and resources here. Vaccination of staff is an important measure to control the impact of influenza on residents and is also vital protection to the staff themselves and their families. A template is available to help track resident vaccination status.

A poster has been developed by the Medical Officer of Health, with some information about vaccine effectiveness over time.

Outbreak Notification

ARCs are required to notify their local public health services of notifiable disease outbreaks eg. Gastroenteritis, influenza-like illness, COVID-19 etc. You can find contact details for your local public health service here.

A reminder that all Outbreaks require a Section 31 Notification.

COVID-19 Notification

COVID-19 positive results for residents must also be notified promptly using an online COVID-19 RAT Result Questionnaire. Staff will notify using Provider View. Two documents are available to guide this process: firstly, step-by-step instructions on how to gain access to Provider View for the first time and secondly, how to use the COVID-19 RAT Result Questionnaire.

For future requests or support please email FHIRsupport@TeWhatuOra.govt.nz.

Health New Zealand Guidance:

- Information and guidance on COVID-19 for aged care providers.
- COVID-19 (Part of the Communicable Disease Control Manual). This includes guidance for COVID-19 testing in Aged residential care (ARC) facilities.
- Managing healthcare workers' return to work post-infection or exposure to acute respiratory illness, including COVID-19.

Some ARC organisations implement pre-employment occupational health screening. As an example, see the Occupational Health Screening Form that Health NZ Southern uses for all new staff. Please note this is not used as part of our employment decisions. This is purely for your information, as you might want to consider something similar.

ARC Admissions Screening Tool

Some ARC organisations screen for infection risk when residents are admitted. As an example, see the Te Whatu Ora Southern Aged Residential Care Admission Screening Tool. This is purely for your information, as you might want to consider something similar.

6.6 Resident Transfer to Hospital – Supporting Transition of Care

To transfer a resident from an ARC to hospital or emergency department:

- Complete a Yellow Envelope with EVERY transfer to hospital.
- Complete an ARC Transfer to Hospital Form with EVERY transfer to hospital.

Staff from Health NZ or Rural Hospitals and the aged residential care sector co-designed the 'Yellow Envelope' for patients and residents transferring from an aged residential care facility to hospital and back. The envelope has a check-list of resident information on either side, with one side being dedicated to residents transferred from aged residential care into hospital and the other from the hospital back to an aged residential care facility. The checklist will ensure the resident arrives at the hospital, and on discharge returns to their care facility accompanied by the necessary information. Inside is a Residential Care Transfer Form which should be completed and put inside the Yellow Envelope for all Transfers.

The 'yellow envelope' will ultimately improve resident safety and minimise errors and delays during transfer of care.

The care facilities have clarity about exactly what information needs to be supplied to help hospital staff provide the right care for the resident without delay. This assists the emergency department staff by having appropriate and timely information about the residents who have transferred in from a care facility. It also reduces time spent sourcing resident information between facilities and the hospital.

Who uses the 'Yellow envelope'

- **From aged residential care:**
  - Residents residing in care at aged residential care facilities who are being transferred to hospital need to have their 'yellow envelope' prepared by care staff and sent with them. A transfer/discharge form should also be completed and inserted inside the Yellow Envelope.
  - This is not for people who live in retirement villas or apartments at a residential care complex. This initiative is for those people who are in residential care.
- **From hospital:**
  - All existing ARC residents being transferred back to their aged residential care facility.
  - All new residents transferring to a permanent aged residential care facility.

How to obtain 'Yellow envelope' supplies:

District	Contact Details
Nelson Marlborough	NeedsAssessment@nmdhb.govt.nz
West Coast	general.ward@wcdhb.health.nz
Canterbury	You can order new supplies of the Yellow Envelope from your GNS. **Natalie Mcguffie** 027 836 0825 Natalie.Mcguffie@cdhb.health.nz **Sue Holland** 027 488 5952 Sue.Holland@cdhb.health.nz **Rachel Leary** 021 543 593 Rachel.Leary@cdhb.health.nz

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District	Contact Details
South Canterbury	**Tracey Foster – CNM for NASC Services** 027 837 6467 tfoster@scdhb.health.nz **Collect envelopes from:** Talbot Community Health Hub, Otipua Road, Timaru.
Southern	**The Dunedin Hospital Mailroom:** 03 474 0999 ext 9940 MailRoom@Southerndhb.govt.nz Please allow a few days for new supplies to reach you.

6.7 Eldernet Website

The Eldernet website provides information about existing and available aged residential care beds across Aotearoa New Zealand. Users of the website are largely NASC, social workers, and family members.

Aged residential care facilities are required to notify Eldernet on a Monday to Friday daily basis to update information on bed availability via the Eldernet website.

Compliance with this requirement is reported to the Te Waipounamu Older Persons Team three monthly.

The Te Waipounamu Older Persons team will use Eldernet to send all communications to ARCs. Please ensure that the email address you have provided to Eldernet for communications is viewed regularly and important information is passed on to the relevant staff at your facility.

Emergency Communications from Te Waipounamu's Older Persons Team will be via text. Please ensure that the mobile number you have provided Eldernet is always staffed. Each quarter you will receive a text message testing the system. Please respond to this text promptly. To change the number for emergency texts or email communications from Eldernet, contact team@eldernet.co.nz and let them know the updated information.

6.8 HealthLEARN

Health professionals across Te Waipounamu have access to an e-learning platform, HealthLEARN. The online learning system provides flexible 24/7 access to a range of courses for the health workforce, from any location, enabling staff to develop knowledge at their own pace.

Along with providing convenient access to educational material, the system also supports standardised learning and clinical processes across Te Waipounamu.

Another advantage of using HealthLEARN is the creation of a single record for each staff member. It ensures a mobile workforce by keeping a record of each person's learning, certificates and achievements. Staff can build their learning profile to use if they need a record for their performance appraisal or if they have to apply for another job. Organisations outside Health NZ are able to request access through an online access agreement.

Staff are encouraged to request a new account via the healthLearn page (please note - if staff already have an account, they should not create a new account but instead update their existing account details). Staff unable to access their healthLearn accounts should email NationalLearningManagement@tewhatuora.govt.nz.

6.9 ARC Forums

Online ARC Education Forums

These are typically held every two months, for all ARC providers in the South Island. An invitation is sent out at least two weeks beforehand providing information on the topic and speakers as well as the joining link.

Local ARC Forums

The Older Persons Team organises local ARC forums to offer face-to-face conversations, discussions and information sharing for ARC Facility Managers and Clinical Nurse Leads.

Many managers report how useful these meetings are. Some staff reference this as ongoing education in their audits.

6.10 HealthPathways

HealthPathways is an online clinical resource providing primary care clinicians with locally endorsed guidance to support decision-making at the point of care. Designed for use during consultations, each pathway offers clear, practical advice for assessing and managing specific symptoms or conditions, along with referral information for local services.

For those working in Aged Residential Care, the following sections are particularly relevant:

- Older Adult's Health.
- Public Health (including Infection Prevention and Control and Notifiable Diseases).

Please ensure you are familiar with these sections.

District	HealthPathways link	Username and Password
Nelson Marlborough	nm.communityhealthpathways.org	**Username:** aged **Password:** residential
West Coast	canterbury.communityhealthpathways.org	**Username:** aged **Password:** residential
Canterbury	canterbury.communityhealthpathways.org	**Username:** aged **Password:** residential
South Canterbury	canterbury.communityhealthpathways.org	**Username:** aged **Password:** residential
Southern	southern.communityhealthpathways.org	**Username:** aged **Password:** residential

6.11 HealthONE/Health Connect South

Aged residential care Clinicians can access relevant information about their residents from Health Connect South via Health One. All aged residential care facilities should have at least one RN who has access to Health One/Health Connect South. For access to Health Connect South, go to https://healthone.org.nz/arc.

A reminder that you need to access your account every 90 days in order to maintain access.

If you had a clinician with an account and it has expired or needs to be reactivated, you need to email healthone.access@pegasus.health.nz and provide the following:

- Email address that was provided when the account was created (this may be a personal email address).
- Health Professional Registration Number.
- Mobile number.

6.12 Supporting new IQNs

Please find two documents linked below to assist you in supporting Internationally Qualified Nurses.

- Internationally Qualified Nurses Te Waipounamu South Island Regional Orientation Framework.
- Nurses new to Aotearoa New Zealand – A support toolkit (for managers).

6.13 Nursing Workforce Development

Professional Development and Recognition Programme (PDRP)

The Professional Development Recognition Programme (PDRP) is a programme designed to recognise and reward nurses for their individual level of practice and their contribution to nursing. Nurses who are not part of an approved PDRP programme will have to individually meet NCNZ continuing competence requirements (e.g. participation in recertification audits).

Programme providers may have relationships with external agencies (e.g. Health New Zealand and an aged care facility) to deliver an existing programme. If this is the case, an MOU must be developed between providers to ensure quality and consistency of the programme. There are some aged residential care providers who have their own approved PDRP. Approved PDRP programmes can be found on the NCNZ website. Please contact your district PDRP coordinator for further information, or view the Health NZ website.

Graduate Nurse Support

There is structured Supported First Year of Practice (SFYP) transition (formerly known as Nurse Entry to Practice [NETP]) support available for graduate nurses should providers wish to employ a newly qualified registered or enrolled nurse.

There is funding available through Health NZ for employers of graduate registered nurses within primary and community settings, please see here for more further information including eligibility and application processes. Through this funding employers could potentially receive $15,000-$20,000 depending on their geographical area.

Your local SFYP team can also assist you with your recruitment of graduate nurses.

District	Nursing Workforce Development/SFYP Health New Zealand Team
Nelson Marlborough	**Jodi Miller - Associate Director of Nursing** 03 539 5358 jodi.miller@nmdhb.govt.nz
West Coast	**Kate Benner – Nurse Director (Workforce)** kate.benner@wcdhb.health.nz **Sarah Gilsenan – Director of Nursing** sarah.gilsenan@wcdhb.health.nz
Canterbury	**Jacinda King – Nurse Manager, Nursing Workforce Development** jacinda.king@cdhb.health.nz **Rebecca Heyward – Nurse Coordinator, Nursing Workforce Development - Aged Residential Care** 021 195 9946 rebecca.heyward@cdhb.health.nz
South Canterbury	**Anneke Dossett - New Graduate Coordinator** 03 687 2344 adossett@scdhb.health.nz
Southern - Otago	**Colette Parai - Dunedin SFYP Coordinator** 03 474 0999 x58775 colette.parai@southerndhb.govt.nz
Southern - Invercargill	**Sharon Tou - Invercargill SFYP Coordinator** sharon.tou@southerndhb.govt.nz

Postgraduate Nursing Education and the Gerontology Acceleration Programme (GAP)

Postgraduate (Level 8) Nurse Education

Postgraduate (PG) nursing study is designed to prepare nurses to meet the challenges of a changing healthcare environment and to provide enhancement of individual nursing practice. Tertiary providers offering Postgraduate study in Te Waipounamu include the University of Canterbury, and the University of Otago which has a Christchurch based Centre for Postgraduate Nursing Studies. Anyone interested in PG study is welcome to look at the PG options available through these providers, or they may wish to look at other providers across New Zealand. Many national tertiary providers also offer distance learning.

Depending on course of study and eligibility, there may be funding that nurses can access to support their study costs. Details of any scholarships or funding available can be found here.

Canterbury only: Gerontology Acceleration Programme

The Gerontology Acceleration Programme (GAP) commences mid-year and is a 12-month nursing acceleration programme which provides extended learning and experience for Registered Nurses working with our older adult population.

Applications for the programme open in January of each year. For further information please contact arcnursing@cdhb.health.nz.

7 OTHER RESOURCES FOR NEW MANAGERS

7.1 Emergency Management Support

All facilities are required to develop and implement a Major Incident and Health Emergency Plan, as per Section D19.6 of the ARRC Agreement.

Health NZ is committed to supporting Aged residential care (ARC) facilities across Te Waipounamu with education and guidance on emergency preparedness and business continuity planning. This supports continuity of care during health emergencies, civil defence events, or other disruptions.

Common Emergency Impacts:

- Power outages.
- Disruption to supply chains (food, medicine, fuel, consumables).
- Partial or full building uninhabitability.
- Loss of water and/or sewage services.
- IT system failures.
- Reduced staffing resources.

These impacts may result from events such as severe weather/flooding, fire, earthquakes, cyber-attacks, pandemic or supply chain disruptions. Your emergency and business continuity plans must address these scenarios. If you're unsure where to begin, please contact the Older Persons Team for support. Know the hazardscape for your location and plan accordingly.

Evacuation Planning

If evacuation of any part of your facility becomes necessary, consult the Older Persons Team immediately and activate your business continuity plan.

Please note: During major emergencies, routine hospital admissions and transport via St John Ambulance is likely to also be compromised. ARC facilities should have contingency arrangements in place, including partnerships with nearby facilities and access to local transport services. Hospitals and St John will continue to support acutely unwell residents, but alternative plans are essential for others.

Shelter in Place Planning

Your emergency management plan must include provisions to shelter in place for up to seven days. To support this, each ARC facility should maintain a well-stocked emergency kit.

At a minimum, this resource should include:

- Portable lighting.
- Food and water for 7 days.
- Alternative power sources.
- Alternative options for heating and supplying hot water.
- Head torch and spare batteries.
- Basic DIY or hardware tools.
- Reliable communication devices.

These preparations are vital to ensure staff and resident safety and continuity of care.

Your emergency management plans should be updated annually with copies maintained at both on and off-site locations which are easily accessible. Involving your staff as much as possible in the planning and review process helps with familiarity and response when really needed.

If a disruptive event escalates beyond your capability, contact the Health NZ Older Persons team or if outside of normal business hours contact the Health NZ Emergency Management on-call team on 0800 GET HNZ (0800 438 469).

7.2 Dementia and Delirium Services and Resources

Seventy percent of people in aged residential care have some form of cognitive impairment or dementia. This highlights the need for completion of enduring powers of attorney (EPOA) for all residents while they have capacity.

When a resident is assessed as eligible for specialty dementia-level care, they often present with complex needs that may raise concerns about their safety or the wellbeing of those supporting them. These needs may include signs of emotional distress, resistance to personal care, or a strong desire to leave the facility.

In such situations, it is essential that staff are given adequate time and leadership support to understand and respond to the resident's needs. Collaboration with the resident's general practice team is also important to identify any physical or mental health issues that may be contributing to their behaviour.

If you believe a resident would benefit from care in a dementia unit, you must first:

- Ensure sufficient staffing is in place to provide supervision at their current level of care.
- Work with the general practice team to determine if the resident is acutely unwell and if this is affecting their behaviour.
- Confirm the resident has a current interRAI assessment.
- Refer the resident to NASC for evaluation.

Residents cannot be routinely placed in a dementia care unit without appropriate legal and clinical justification. Always consult NASC for guidance.

Selected resources are available to support dementia care.

The National Alzheimer's website contains information on a wide range of related topics.

See the NZ Dementia Foundation for:

- Guidance on supporting culturally and linguistically diverse people living with dementia in ARC.
- Excellent delirium resources.
- Dementia STARs - free education sessions to reinforce person-centered dementia care.

7.3 ARC Pressure injury prevention toolkit

Pressure injuries (PIs) are a significant and preventable source of harm in ARC, with Māori and Pacific Peoples disproportionately affected. In 2025 an ARC pressure injury prevention toolkit was developed and piloted, with a focus on educating Healthcare Assistants (HCAs) to prevent and identify early-stage pressure injuries.

The toolkit contains 14 resources such as presentations, posters, guides, communication tools, and patient leaflets. It is designed to be culturally responsive, practical, and adaptable to diverse ARC settings, focusing on empowering HCAs and promoting equitable care.

Learn more in this short video with Natalie McGuffie, GNS and Kim Brown, Head of Clinical Quality, Arvida.

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8 RECOMMENDED READING

- **Being Mortal: Medicine and What Matters in the End** by Atul Gawande.
- **With the End in Mind: Dying, Death and Wisdom in and Age of Denial** by Kathryn Mannix.
- **Leadership for Person-Centered Dementia Care** by Buzz Loveday.
- **Excellence in Care: A Guide for Managers and Nurses** by Gillian Robinson-Gibb.