Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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30 April 2020

9(2)(a) [redacted]

[redacted]

[redacted]

RE Official information request CDHB 10292

We refer to your email dated 24 February 2020 to the Ministry of Health and partially transferred to us on 18 March 2020 requesting the following information under the Official Information Act from Canterbury DHB regarding Older Persons Health. The Ministry of Health have transferred questions 1 and 4 as below:

1. **The NASC Manual for Older Persons Health**

Please find attached as **Appendix 1.**

4. **The number of over 65's receiving long term HCSS in each region (please record personal care and household management separately)**

a.	**1-10 hours**	4,386
b.	**11-20 hours**	843
c.	**21-30 hours**	322
d.	**31-40 hours**	196
e.	**40+ hours**	201

Home Care Support Services (HCSS) is not recorded in terms of household management or personal care, but as an overall package of care. The above numbers are representative of the hours of support provided to those clients 65 + who received services in February 2020. **Note** all services recorded under a full hour have been rounded up to an hour.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Needs Assessment & Service Co-ordination (NASC) Referral Guidelines

Contents

Policy

Needs Assessment & Service Co-ordination (NASC) Referral Guidelines.

Purpose

To ensure quality referrals and assessment processes for older people referred to the Ashburton Health Services for health care and/or support services.

Scope

- Needs Assessment and Service Co-ordinators
- Community Services

It excludes referrals for :

- paediatric services
- non-age related DSS referrals

- mental health services
- inpatient medical/surgical or other related specialist services
- ACC funded services
- primary care services
- specialised outreach nursing services e.g. continence, diabetes.

Associated Documents

- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Human Rights Regulations 1993
- Health Practitioner Competence Assurance Act 2003
- Health and Disability Services (Safety) Act 2001
- Health Information Privacy Code 1994
- CDHB Planning & Funding Service Specifications for Community Services November 2010

Referral process

Referrals will be received from:

- General Practitioners, Nurse Practitioners
- Visiting Geriatricians
- CDHB inpatient services (including Ashburton Hospital)
- Rest homes
- Home support agencies
- District Nurses
- CNS

Referrals can be made by ERMS referral process, fax, phone or in writing. Written referrals can be by letter or using the MR7-108 (dated June 2015). The latter is available via:

http://cdhbintranet/ruralhospitals/ASH/Documents/7-108%20Health%20Care%20of%20the%20Elderly%20Referral%20Form.pdf

During normal working hours referrals are to be sent to the:

Ashburton Health Services Needs Assessment and Services Coordination (NASC) Team
c/- Community Services
Ashburton Hospital
Fax: 03 3078460

Referral Management

All referrals will be:

- Processed within 1-2 working days.
- The referral will be triaged using the referral screening tool (see Appendix I) and allocated (Appendix II).
- Contact[1] must be made with the patient/service user as follows (see Appendix III 'Risk Level'):

Risk Level	Initial Contact (Voice to Voice)	Face to Face Contact
Low risk	Within 5 working days	Within 14 working days
Medium risk	Within 2 working days	Within 10 working days
High risk	Within 24 hours of receipt of referral	Within 2 days of referral

Assessment

The patient/service user will then be assessed depending on the outcome of the screening tool.

Assessment will:

- Be undertaken using the InterRAI assessment tool (a Minimum Data Set [MDS] Contact Assessment for non-complex patients, and MDS Home Care Assessment for complex patients).
- Complex clients may be assessed using contact assessment if going into permanent placement. However, if a client is to be discharged home a full assessment is required.
- Clients are assessed on a individual basis depending on need. Upon discharge short term supports may be required until a full/complex assessment is completed.

[1] Canterbury DHB (2010). *Community Services Service Specification.* Planning & Funding. Christchurch. Page 35-36.

- Include informed consent as required in the Code of Health & Disability Services Consumers' Rights (1996).
- Be conducted in a safe and appropriate setting as agreed with the patient/service user.
- Include an occupational safety risk assessment.
- Include, where necessary and appropriate, consultation with other health care professionals.
- If the services user identifies as Māori or Pacific Island, involve Māori or Pacific Island assistance and take into account Māori or Pacific Island cultural needs.
- If needed utilise interpreter services.

Review of assessment is to be undertaken as indicated in Appendix IV (see 'Provider Role'[2]).

Service Provision/Review Responsibilities

Service provision, including case review responsibilities for both non complex and complex service users will be provided as indicated in Appendix IV.

Quality

As per the Community Services annual quality plan.

Policy Owner	Director of Nursing & Clinical Services
Policy Authoriser	Director of Nursing & Clinical Services
Date of Authorisation	30 October 2015

[2] CanterburyDHB (2010). *Draft Community Services Service Specification*. Planning & Funding, Christchurch. Appendix I

Appendix I: Complex and Non-Complex Support Allocation Tool

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Older Persons Health & Rehabiltation

(Attach Label here or Complete Details)

NAME:_____
NHI:_____

GENDER: DOB: AGE:

Complex and Non Complex Support Allocation Tool

Please complete this tool to inform whether a client requires complex or non-complex case management

YES	Support Allocation (SAT) Tool	NO
☐ Complex Client	Does the client have a cognitive impairment (decreased ability to think, concentrate, formulate ideas or remember, that impacts on everyday life)	☐ Continue Screening
☐ Complex Client	Does the client have a progressive neurological condition (conditions that get worse as time goes on e.g. Parkinson's Disease, Multiple Sclerosis, Motor Neurone Disease, Huntington's Disease	☐ Continue Screening
☐ Complex Client	Is the client's carer unable to continue caring for the client or feeling overwhelmed or distressed	☐ Continue Screening
☐ Complex Client	Does the client require ***ongoing / long term*** physical assistance with daily dressing of their ***lower body*** (does not include application or removal of compression hosiery)	☐ Continue Screening
☐ Complex Client	Does the client require ***ongoing / long term*** verbal or physical assistance in managing their own medications	☐ Continue Screening
☐ Complex Client	Does the client have anxiety, low mood or other mental health condition that significantly impacts on daily living	☐ Continue Screening

Answering **yes** to **any** of these questions indicates the client's support needs are complex. However it is important to take into account your **clinical judgement** when determining if a client is complex or non-complex.

Any "YES" ticks = Complex

To be managed by Older Persons Health & Rehabilitation
Phone: 03 337 7765
Fax: 03 337 7720
Email: communityreferralcentre@cdhb.health.nz

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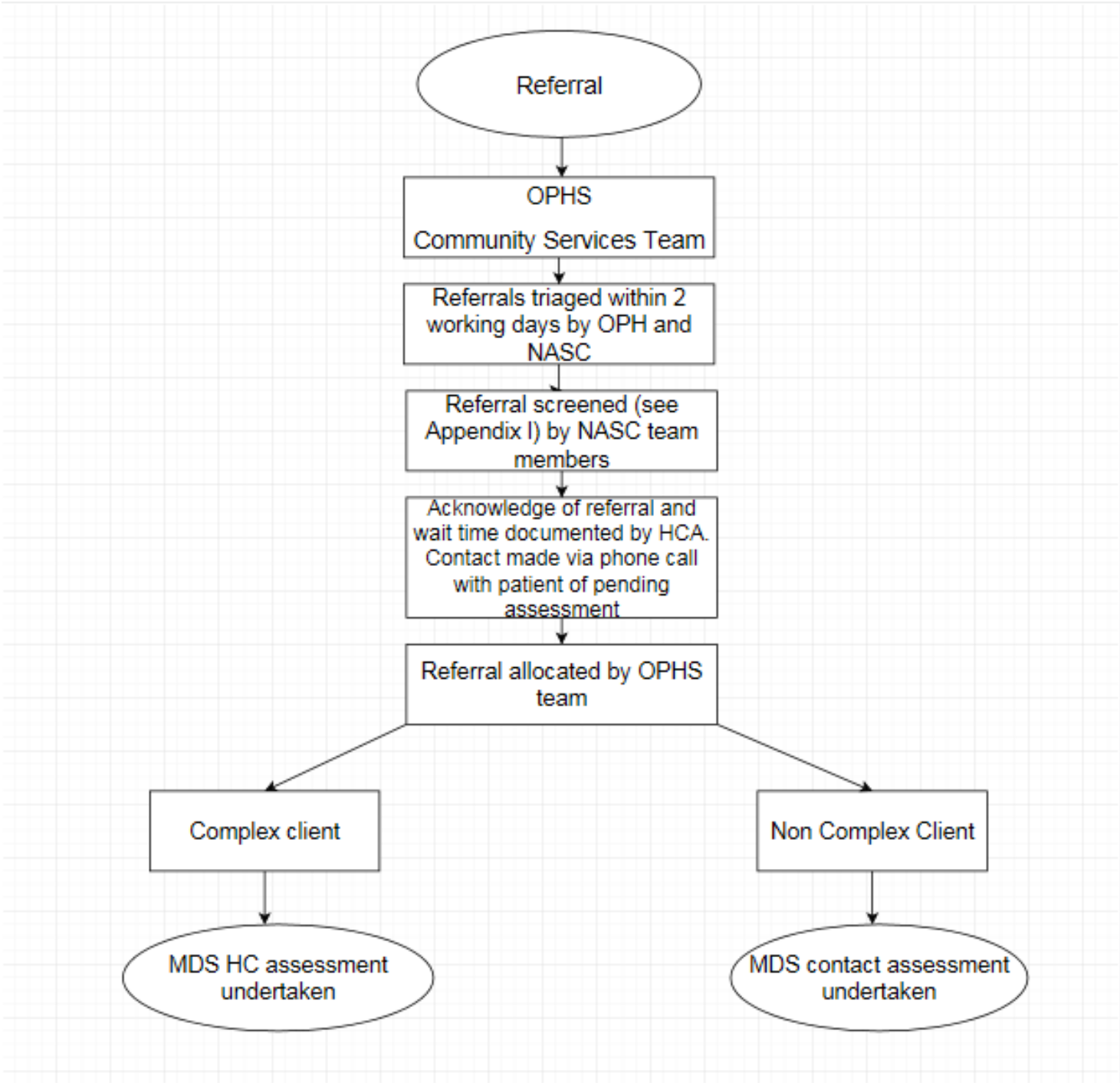
Printed copies may not reflect the most recent updates.

COMPLEX AND NON COMPLEX SUPPORT ALLOCATION

No “YES” ticks = Non Complex	To be managed by the Community Services providers Referrals to: Canterbury Care Co-ordination Centre Phone: 03 355 5066 Fax: 03 355 5225 Email: referral@coordination.org.nz

Appendix II: Referral Triage and Allocation Process



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Appendix III: Risk Assessment Framework[3]

High Risk:

Failure to provide the service may result in the service user:

- Being in unnecessary pain.
- Imminently being admitted as an in-service user for symptom control.
- Experiencing irreversible deterioration of their health status requiring long term in-service user medical/surgical management.
- No longer being able to stay in their own residence.

Medium Risk:

Failure to provide the service may result in the person:

- Being unable to self-manage with resulting dependency on alternative options which may compromise their health status.
- Having to be referred to a specialist for consultation and/or management of a health condition.
- Continuing with compromised health status which is not life threatening but if left permanently unmanaged would lead to more extensive and/or additional problems.
- Being unable to self-manage thus placing significant pressure on the family, caregiver which may cause their health status to be compromised.
- Being admitted to short-term care to provide respite for the caregiver.

Low Risk:

Failure to provide this service may result in the person:

Living with a limited degree of compromised health status which is not in any way life threatening but intervention would enable them to return to optimal health status and/or function safely and independently.

[3] Canterbury DHB (2010) *Draft Community Services Service Specification*. Planning & Funding, Christchurch. Appendix II

Appendix IV: A&HS Community Service Team Responsibilities

	Roles/Responsibilities[4]	Complex Dual Service Client	Complex Single Service Client	Non complex Single Service Client
Assessment	**NASC Team:** • InterRAI assessment • InterRAI re-assessment • Service coordination	✓ ✓ annually[5] ✓	✓ ✓ annually ✓	✓ ✓ annually ✓
Service Provision	**Case Manager:** • Service provision • Case reviews • SW supervision • Direct advice/support	District R.N ✓ ✓3 monthly ✓3 monthly ✓	HBSS R.N ✓3 monthly ✓3 monthly ✓	HBSS R.N ✓
	SW Coordinator/Supervisor: • Case reviews • SW supervision			✓6 monthly ✓3 monthly
	Support Worker	✓	✓	✓
	Duty Manager • After hours advice/support	✓	✓	✓

NB:

- SW = Ashburton Health Service Home Based Support Worker
- HBSS = Home Based Support Services
- The above proposal excludes any linkages/responsibilities AHS may have with other community service providers e.g. ACCESS
- 'Direct advice /support' is required to be available from a registered health professional.

[4] As required in Community Service Specifications, November 2010
[5] As per the Community Service Specifications, November 2010

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ASHBURTON AND RURAL HEALTH SERVICES
OLDER PERSONS HEALTH ASHBURTON REFERRAL FORM

Patient Details: Mr/Mrs/Miss/Dr | Name:	**NHI:** | **Community Services Card No:** **Expiry Date:**
Address:	Phone: Mobile phone:
	D.O.B.
Support Person:	Relationship to Patient:
Address:	Phone: Mobile phone:
Service Requested: Admission to AT&R: ☐ Assessment by:- NASC ☐ - Geriatrician ☐ - Psycho-Geriatrician ☐ - Nurse Practitioner ☐ - Gerontology CNS ☐ - Medical Outpatient Clinic ☐ Other comments: ..... Height: ..... Weight:	**Priority** ☐ < If admission to ATR required, GP contact duty SMO at Hospital directly ☐ High 2-3 weeks ☐ Routine 8-10 weeks **Recommended place of assessment:** ☐ Community visit ☐ Outpatient clinic ☐ Inpatient admission ☐ Client/support person is aware of referral and agrees
Include diagnosis and medications: **Premorbid function / current function:** **Expected Outcome:**	
Referring Health Professional **Name:** **Signed:** **Date:**	**Please forward to:** Older Persons Health Ashburton C/- Community Services, Ashburton Health Services FAX: 03 3078460

HEALTH CARE OF THE ELDERLY REFERRAL

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