Nurse Practitioner Older Adult - Southern Rural Health Services

ADMISSION GUIDELINES

For people aged 65 years and older and others like in age or interest including
- Maori and Pacific People 55 years and older (earlier onset of age-related conditions)
- People with age-related chronic conditions and disability (eg neurological conditions)

Clinical Focus

Medically complex or moderately to severely frail older adults with high use of health care services

1) Assess for potentially reversible causes of disease and geriatric syndromes
2) Support self-management (directly or via care provider) of disease, functional limitations and polypharmacy to maintain maximum possible wellness and quality of life, until life ends

Section 1: INDICATOR FOR REFERRAL (more ticks more likely to need NP support)

- ☐ ≥ 2 hospital admissions / presentations to Emergency Dept in last 6 months
- ☐ ≥ 5 acute visits to GP in last 12 months
- ☐ Re-presenting / re-admitted for same age-related issue
- ☐ Residential aged care clients
- ☐ Those likely to benefit from a managed transistion between hospital and home
- ☐ Needing advance care planning
- ☐ Deterioration in functional state (eg loss abilty to self-care, percieved "not-coping")
- ☐ Suspected cognitive impairment (behaviour change, bills unpaid, ↓socialising)
- ☐ Progessive neurological conditions
- ☐ Constipation resulting in hospital admission or presentation
- ☐ ≥ 2 falls in last 6 months
- ☐ Frailty syndrome (weight loss, slowed mobility, fatigue, loss of strength)
- ☐ Polypharmacy (more than 9 regular medications)

ACCEPTED

Section 2: NEGOTIATED ACCEPTANCE

- ☐ Social situation impacting in admission
- ☐ Care giver stress

NEGOTIATE (work with SW)

Section 3: EXCLUSIONS

Older adults whose need is for DSL assessment
Older adults under START programme
Adults who do not meet the definition or older adult or like in age or interest

EXCLUDED

What will Nurse Practitioner do?

- Work across traditional boundaries to support health (e.g. home, hospital, clinic, PHC, aged care)
- Comprehensive assessment (history, exam, diagnositics & prescribing) for reversible causes of ill health
- Develop patient centred plan of care on collaboration with patient/family/primary/secondary care
- Case manage small number of high needs older adults with mulitiple morbidity
- Provide consultation for specific gerontology issue for other providers
- Refer on for identified need

Referral process (any of the following)

- ✓ Rural and community Nursing Referral From (R1098HWF) fax to CRC 07 858 1071 internal ext 22071 or scan and email to ruralreferralcentre@waikatodhb.health.nz
- ✓ Professional to professional fax to CRC 07 8581071 or internal extension 22071
- ✓ e - referral via best practice: under Community Services - District Nursing - add Julie Daltrey