NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

Health of Older People (HOP) Community Specialist Nursing Team

Phone 09-4304131 or 0800 8888 90 **Fax** to 09-430-4128 **Email** hop@northlanddhb.org.nz

Clinical Nurse Specialist-Gerontology (Whangarei, Dargaville, Bay of Islands and Kaitaia)	**Post Discharge Care Co-ordination Nurse** (Whangarei with limited service in Bay of Islands, Dargaville & Kaitaia by Clinical Nurse Specialist)	**Clinical Nurse Specialist-Fracture Liaison Service** (All NDHB)	**Clinical Nurse Specialist Stroke** (All NDHB)	**Nurse Coordinator Practice Development Aged Residential Care**	**Nurse Coordinator Practice Development Health of Older People**	**Clinical Nurse Manager**
Criteria	**Criteria** (two or more to be eligible)	**Criteria**	**Criteria**	Where		
▪ Under or needing HOP service and ▪ Recent admission to hospital or in community with concerns raised and ▪ Clinically fragile/complex health conditions and need to be clinically assessed or ▪ On the wait list for geriatricians & have safety or memory concerns or ▪ Medication-poly-pharmacy issues	▪ Over 65 years European (over 55 years for Maori) ▪ Recent admission to hospital ▪ Lives alone or dependent spouse ▪ Have long term condition ▪ Recurrent presentations ▪ Multiple medications ▪ Have two or more services already in place ▪ ACC ▪ High risk diagnosis ▪ Concern raised by patient/family/staff	▪ ≥ 50 years and ▪ Sustain fragility fracture i.e. non-traumatic from standing height or less and ▪ Presents NDHB Hospital Emergency Department with fragility fracture or incidental finding of fragility fracture while at hospital or suffers fragility fracture while in hospital	Any patient that has experienced a stroke or TIA	All Aged Residential Care Facilities in Northland District Health Board	Northland District Health Board	Northland District Health Board
Time frame of Follow up				What do they do?		
As soon as possible after referral or discharge. Clients who have not been in hospital but have concerns in community should be seen within 2 months, or prior to geriatrician review. Follow-up varies on case by case basis.	As soon as possible after discharge. Will be involved for 1-4 weeks (some exceptions where it will be longer).	As soon as possible after fracture (gold standard within 8 weeks). Brief engagement for assessment and then f/u phone call at 3-6 months	If complex patient may meet during admission and assist with transition back to home, otherwise within first few weeks of stroke/TIA event	▪ Support ▪ (peer/project) ▪ Quality Improvement ▪ Coaching ▪ Important link between DHB and ARC ▪ Resources ▪ Education	▪ Support to NASC/HOP/Secondary Care/ARC ▪ interRAI resource/contact ▪ Support project work ▪ Support NDHB Funder ▪ Quality improvement	• Manage specialist nurses • Manage Elder Clinics • Manage Falls & Fragility Fracture Care Coordination Service
What do we do?						
▪ Comprehensive clinical nursing assessment ▪ Liaise with geriatricians ▪ Link in with GP and other community services ▪ Refer to other services ▪ Education	▪ Comprehensive nursing assessment ▪ If applicable notify GP of involvement and inform them of any concerns ▪ Refer to other services ▪ Liaise with Clinical Nurse Specialists	▪ Assessment of secondary fracture risk ▪ Referral for treatment or prevention programmes ▪ Link in with GP ▪ Liaise with geriatricians ▪ Education	▪ Support and education to patients and their families ▪ Support and education to NDHB staff ▪ Assessment of TIA/Stroke patients ▪ Liaison with primary care/stroke physicians ▪ Liaise with community rehab teams ▪ Research			

As at April 2018