

**Community Health, Transitional
and Support Services**

**Community Residential
Services within Aged Care
Facilities for People with
Chronic Health Conditions**

Tier 2 Service Specification

September 2024

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1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY ☒ RECOMMENDED ☐

It is compulsory to use this Specification when purchasing services. No Districts should use a local service specification instead of this mandatory specification.

2. Review History

Review History	Date
First published on the Nationwide Service Framework Library	June 2011
Reviewed: Community Residential Services Within Aged Care Facilities For People Who Are Chronically Ill (2006)	May 2011
Amendment: Clarification of annual reporting requirement.	July 2011
Amendment: Correction to pg 4 re High Use Health Card.	June 2012
Amendment: References T1 Community Health, Transitional and Support Services service specification.	July 2012
Amendment: correction to numbering, section 9 Service Development reporting requirements moved into the reporting table for clarity.	September 2012
Amendment: Purchase Unit CHC0002 replaced by CHC0019, CHC0020, CHC0021, and CHC0022 to reflect different levels of care, updated reporting requirement table. Correction to numbering section 5.	November 2012
Amendment: Corrected numbering in section 5.9.3 a ii	January 2013
Amendment: Simplified reporting requirements	May 2016
Content moved to updated Health New Zealand format	September 2024
Consideration for next Service Specification Review	within five years

Note: In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

3. Introduction

The overarching Tier One Community Health, Transitional and Support Services specification contains generic principles and content common to all the tiers of specifications below it. This Tier Two service specification for Community Residential Services within Aged Care Facilities for People with Chronic Health Conditions (the Service) is used in conjunction with the Tier One Community Health, Transitional and Support Services service specification.

4. Background

A suite of service specifications was prepared for DHBs to assume funding responsibility on 1 July 2011 for the long-term support services for people under the age of 65 years who have chronic health conditions. As part of the ongoing service specifications review programme it is intended to integrate these service specifications with other similar service specifications to simplify purchasing arrangements but retain purchase unit codes to preserve the capacity to track expenditure.

5. Service Definition

The Service is for Community Residential Services within an Aged Care Facilities, for Eligible people¹ with a chronic health condition (who are mainly aged between 16 and 65 years old²) to provide 24-hour support at the level necessary for people to have a safe and satisfying home life.

The Service is delivered by organisations referred to in this document as Service Providers (the Provider), and these organisations are accountable for the quality of the services delivered. The Provider will meet holistic social, spiritual, emotional, physical and recreational needs of the person. The Service may be provided through a combination of services determined at the time of needs assessment for each individual Service User.

The Service will have a restorative focus that promotes and maintains the independence of the Service User.

¹ Not all Service Users who are referred or present to the Service are eligible for publicly funded services. The eligibility criteria for publicly funded health and disability services are prescribed by Ministerial Direction. Refer to <http://www.moh.govt.nz/eligibility> for information on the latest eligibility criteria.

² Although Service Users first access Chronic Health Long Term Support Services before age 65, they continue to receive services through this funding stream until they are reassessed by a DHB needs assessment service coordination service as needing residential aged care.

6. Service Objectives

6.1 General

The Service has the following objectives:

- to provide the Service User with support to live in an accessible, homelike and safe environment that provides maximum privacy, independence and self-reliance
- facilitate and assist the Service User's social, spiritual, cultural, emotional and recreational needs
- provide the opportunity for each Service User wherever possible, or the Service User's family and whānau / advocate to be involved in decisions affecting the Service User's life
- to provide flexible, integrated and responsive services
- acknowledge the significance of each Service User's family and whānau / guardian and or advocate and chosen support networks and
- support the Service User's integration into community life, in accordance with their needs and wishes.

6.2 Māori Health

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care, which might include but are not limited to matters such as:

- referrals and discharge planning
- ensuring that the services are culturally competent and that
- services are provided that meet the health needs of Māori.

It is expected that there will be Māori participation in the decision making around, and delivery of, the Service.

7. Service Users

Service Users are Eligible people with chronic health conditions and long-term support needs, who are aged between 16 and 65 years and, have been assessed by the Referrer³ as requiring the Service.

³ **Referrer:** a DHB approved needs assessment service co-ordination service.

8. Access

8.1 Entry Criteria

Referral to an aged care service should only be considered if this aligns with the Service User's needs (ie, he / she has high care needs) or if an aged care facility is the only residential service available in the area and moving to a less restrictive residential service is less desirable than being supported within aged care. The least restrictive principle should always be applied.

The needs assessment and service co-ordination process will ensure that the criteria have been met for people to be referred to the Provider, including:

- a clear rationale is provided to the Service User, their family and whānau / guardian and or advocate (if appropriate) as to why placement in an aged care facility is being recommended
- consideration that young people generally do not have the cognitive and physiological maturity to be cared for in the adult residential settings
- the person has one or more chronic health condition(s) that is / are expected to continue for six months or more and very high need for long-term support services. Very high need is defined as requiring assistance with activities of daily living at least daily to remain safely in their own home or needing residential care. The person's wellbeing and functional status is deteriorating, their needs are increasing and safety issues are becoming apparent. The person has limited opportunity to participate in age appropriate activity. The person is assessed as needing support daily, but some or most of it may be provided by family, whānau or friends.
- do not have an informal support system (family and whānau) or the caregiver is under considerable pressure and their ability to support the person is compromised
- are currently not eligible for Ministry funded disability support services or DHB funded long-term support services
- are not currently receiving Ministry funded disability support services or long term support services funded by a DHB (regardless of funding source).
- are currently not eligible for support services funded under the Accident Compensation Corporation Act (2001).

8.2 Exit Criteria

After a long term support chronic health conditions funded service resident turns 65 years old, if a review or reassessment undertaken by the Referrer indicates that the person's needs have changed to the extent they may now require aged residential care in a rest home or hospital indefinitely⁴, then the responsibility transfers to the DHB health of older people services.

Exit from the Service is by way of:

- transfer
- admission to another service
- voluntary exit
- death

9. Service Components

9.1 General

The Provider will be responsible for:

- a. the ongoing assessment and being responsive to the functioning, abilities, well-being and support needs of the Service User
- b. referral to the appropriate service when there is a need for specialist assessment – some services may require the referral to be made by the General Practitioner (GP) or other referrer
- c. ensuring and overseeing the procurement, administration and safe storage of prescribed pharmaceuticals. Where medication cannot be managed by the Service User then it must be administered by a competent staff member
- d. ensuring access to services such as, community dentists, opticians, audiologists hairdressers, solicitors and banking / financial services
- e. ensuring the Service User holds a current Community Services Card (if eligible) and / or High Use Health Card, and that the card number is correctly referenced at the Service User's GP / Medical Specialist and Pharmacy
- f. supervision, assistance, encouragement and support to complement and reinforce interventions and rehabilitation strategies to improve or maintain communication, behaviour, mobility, continence and activities of daily living
- g. supervision, oversight and / or assistance with activities of daily living and personal care as required by the Service User, including using the toilet, bathing, hair washing, teeth cleaning, nail care, eating and mobility
- h. ensure access to planned education and counselling requirements, including requirements for sexuality education, gender identity counselling, relationship counselling and personal development
- i. staff support as required to ensure the Service User is assisted to develop skills and increase their ability to be independent

⁴ as opposed to long-term care in an aged residential facility in the absence of an appropriate alternative facility.

- j. privacy in the form of, but not limited to:
 - access to private telephone
 - access to private space for social and other reasons
 - respect for personal mail, for example, the ability to open letters and read in private unless assistance is required by the Service User
 - use of bathroom and toilet
- k. support to maintain and strengthen relationships with family and whānau / guardians, friends and partners
- l. vocational, educational, social, recreational and other interests are actively supported and encouraged
- m. where the Service User is not involved in structured day time support activities the Provider will ensure that the Service User has access to a range of appropriate activities, at the facility and outside of the facility.

9.2 Processes

9.2.1 Clinical Record System

The Provider must ensure that every caregiver, Primary Support Worker,⁵ and a Registered Nurse maintains a record of progress for each Service User who is under the care of that caregiver, Primary Support Worker and Registered Nurse. The Provider must ensure that all entries in to the clinical records are legible, dated and signed by the relevant caregiver, or nurse, indicating their designation.

9.2.2 Attendance by General Practitioner or other Health Professional

If a GP or other health professional has cause to visit the Service User, the Provider will ensure that the GP or other health professional enters findings and any treatment given to or ordered for the Service User into the relevant clinical record maintained on site at the time of attendance. The Provider must ensure that all such entries are legible, dated and signed by the GP or other health professional, indicating their designation.

9.2.3 Handover Report

The Provider must ensure that at the commencement of a shift, each nurse or other caregiver who will be responsible for providing care to the Service User receives a report on the status of and care required for that Service User.

9.2.4 Provider Responsibilities - Exits

The Provider must ensure that the Service User is not shifted from the facility unless:

- requested by the Service User, their family / whānau / guardian and or advocate (if appropriate), or
- the Service User is assessed prior to being shifted by the Referrer and with the involvement of any appropriate specialist support services.

In addition to the Discharge Planning Provisions in the Provider Quality Specifications and the Health and Disability Sector Standards, any decision that a Service User moves from

⁵ Primary Support Worker: is a person, who assists and facilitates as identified on the individual support plan, the process to meet the needs and goals of the Service User.

one home to another must be based on the needs of the Service User, not the needs of the Provider. Any variation to this must have agreement from the Referrer prior to the move taking place. The Service User, or the family and whānau / guardian and or advocate (with the permission of the Service User) should provide written authority of agreement to such change. The Referrer must be involved in decisions where a Service User is changing providers, service type or region.

Where a Service User requires admission to another service (eg, a mental health setting) this change will involve input from a relevant 'specialist' eg, Psychiatrist. The relevant Referrer may be involved to assess change in the Service User's needs.

In a situation where the Service User voluntarily exits the home or dies, the Provider will notify the following:

- family and whānau / guardian or advocate immediately
- the Referrer within 48 hours, and
- the National Health Board Business Unit through the next information reporting (invoicing) cycle
- the DHB representative within 48 hours, during normal working hours.

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9.2.5 Care Plans

The following requirements are in addition to those specified in the Provider Quality Specifications and Health and Disability Sector Standards:

The Provider is responsible for the development of a care plan (CP), developed collaboratively with other relevant, available support service providers and in conjunction with the Service User and their family and whānau / guardian and or advocate. A Registered Nurse must develop a CP within 3 weeks of a Service User's entry into the Service.

The CP will cover all aspects of the Service User's support needs and timeframes for achievement including:

- the Service Users' short and long term goals (including goals relating to any therapeutic programmes that have been put in place by allied health professionals); the services, activities and inputs which will be required to achieve those goals; and the means by which goals of increasing access, participation and integration in the community will be achieved
- how family and whānau / guardian and or advocate involvement will be supported
- how Māori and other cultural aspects such as emotional, physical and spiritual aspects will be acknowledged and provided for
- the name of the person responsible for seeing the goal is achieved.

The CP must specifically address the Service User's:

- current abilities, level of independence, identified needs / deficits and take in to account as far as practicable their personal preferences and individual habits.
- personal care needs
- health care needs
- rehabilitation / habilitation needs
- assessed physical needs
- developmental learning needs

- psychosocial, emotional and spiritual needs
- where appropriate, behavioural support needs (eg, for people with dementia and challenging behaviour).

The CP must be available to all staff so that it is used to guide the care provided according to the relevant staff member's level of responsibility.

9.2.6 Evaluation

The Provider must ensure that each Service User's CP is evaluated, reviewed, and amended:

- when clinically indicated or
- by a change in the Service User's needs or
- at least every six months, whichever is earlier.
- A Registered Nurse will be responsible for reviewing and amending the CP for the Service User.
- The opportunity is to be made for family/whānau involvement in revision of CP if requested by the Service User.

The Provider must notify the Service User's family and whānau / guardian and or advocate (with the Service User's consent, if appropriate) as soon as possible if the Service User's needs change significantly.

9.2.7 Primary Medical Treatment

If required the Provider must ensure that:

- a. each Service User is examined by a medical practitioner within two working days of admission, except where the Service User has been examined not more than 2 days prior to admission, and there is a summary of the medical practitioner's examination notes. After the initial examination, the Service User must be examined not less than once a month and as clinically indicated (as assessed by a Registered Nurse) **except** where the Service User's medical condition is stable as assessed by the GP, in which case the Service User may be examined by a GP less frequently than monthly, but at least every three months. This exception must be noted and signed in the Service User's medical records by the GP
- b. the GP reviews each Service User's medication at least every three months. The Service User's medication chart must be noted and signed by the GP at each review.
- c. on-call emergency medical services are available to all Service Users at all times. All costs of such emergency medical services must be covered by the Provider
- d. a Service User may choose to be attended by a GP of their own choice who agrees to visit the facility and maintain the facility's medical records as prescribed in this contract. If a Service User retains his or her own GP, that Service User is responsible for any cost over and above that which the Provider pays per Service User for the GP contracted by them
- e. if a Service User initiates a visit from a GP without the prior approval of the Registered Nurse or Manager, the Provider may require the Service User to bear the full cost of the visit if such a visit is not in accordance with point a above
- f. the Provider must provide the treatment programme prescribed by a GP to assist the Service User to develop and maintain functional ability. This may include such goal and outcome orientated treatment as physiotherapy, occupational therapy, speech-language therapy, dietetics and podiatry. This treatment programme shall be reviewed

at such regular intervals as are specified by a GP, Registered Nurse, or applicable health professional involved in the treatment

- g. the Provider must ensure that the Service User has access to such services listed below and if the Provider chooses to refer the Service Users to private therapists, the Provider must meet the costs of such private therapists
- Service User's are given access to specialist assessment services (eg, where there has been a marked deterioration in the Service User's functionality or health status)
 - a GP refers a Service User to either rehabilitation services (eg, assessment, treatment and rehabilitation services) or specialist allied health services (available through community health providers).

9.2.8 Risk Management Plan for the Provider

The Provider's Risk Management Plan shall address matters such as:

- the safety and security of Service Users and staff while at home and away from home. There will be times when responsibility transfers to another service. Such transfers must be clearly documented and agreed in advance
- dealing with challenging behaviours – when and how to access support services and when to access for reassessment / review
- management of crises and incidents - incidents and crisis situations must be documented, which includes an Incident Register. This includes review and implementation of corrective actions
- relationships and communication in crisis situations with family and whānau / guardian and or advocate, neighbours / other household members including staff
- development and maintenance of positive relationships with the immediate neighbouring community.

9.3 Settings

The buildings and facilities must meet the accommodation needs of the Service User. Furnishings will reflect age appropriate living environments. Service Users will be encouraged, where possible and appropriate, to have personal belongings that reflect age and gender appropriateness. Each Service User is to have their own bedroom unless it is the Service Users' clear choice and preference not to do so.

The Provider will ensure secure, physically safe internal and external environments that meet the particular mobility and safety requirements of the Service User group. This will include the necessary modifications to the facility to ensure appropriate access, bathroom modifications such as wet area showers, adaptations to kitchens to enable participation in meal preparation, adaptations to telephones etc.

The outside / recreational area must incorporate sheltered seating and must be accessible to the Service User.

9.4 Equipment

Service Users are eligible for the provision of environment support services where it is for the sole use of the Service User. To access funding for the Service, a Service User must be assessed by an Accredited Assessor.⁶

The Provider must provide communal aids and equipment (which are not considered for individual use) for personal care or the general mobility needs of the Service Users who require them.

The Provider must at all times have available sufficient clinical equipment for general use to meet the needs of the Service Users including, but not limited to:

- scissors and forceps for basic wound care
- thermometers
- sphygmomanometers
- stethoscopes
- weighing scales and
- blood glucose testing equipment.

9.5 Support and Care Intervention

Support and care provided by the Provider must be focused on the Service User and delivered in a timely and competent manner. The Provider's routines and practices within the facility must reflect as much as possible community norms, encourage each Service User's autonomy, respect their dignity and privacy and meet their cultural requirements, and be documented in the Service User's CP.

Staff must be available at all times to meet the needs of the Service Users, as identified in the Service Users' CPs and when necessary.

9.6 Accommodation and Household Support Services

The Provider will be responsible for:

- a. lodging with the use of all furniture, fittings, fixtures, bedding and utensils, except to the extent that Service User chooses, with the Provider's agreement, to use their own furniture and possessions where they can be reasonably accommodated
- b. a food service of adequate and nutritious meals and refreshments, snacks at morning / afternoon tea and supper times, which as much as possible take into account personal likes / dislikes of the Service User, address medical / cultural and religious restrictions and are provided at times that reflect community norms
- c. drawing up an agreement for each Service User stating rights and responsibilities, fees payable, services provided, date of commencement, planning and funding of holiday arrangements etc. In particular the agreement must state how the residential subsidy portion of the Service User's Work and Income benefit will be paid to the Provider, the amount that is left, which will be retained by the Service User, and what goods and services (refer 7.3) are the Service User's responsibility to fund with that portion of their Work and Income benefit

⁶ Accredited Assessors can be accessed by contacting District Health Board (DHB) community services.

- d. Service Users are assisted to independently manage their finances as far as possible (see 8.6). If the Service User requires assistance with managing their finances then a clear and auditable system for management must be established. This system must be understood by the Service User and / or their family and whānau / guardian and or advocate and staff involved
- e. cleaning services, laundry services and supplies that maintain the facility in a clean, hygienic and tidy state. The Provider will take all reasonable care to minimise damage to or loss of personal clothing caused by laundering.

9.7 Complaints Resolution

To maintain a harmonious and friendly environment, the Provider will ensure there is:

- a process to resolve the complaints or air any grievances either between the Service Users or the Provider and the Service User
- mediation support available if the parties are unable to resolve the complaint through the above forum. The mediator should be agreeable to both parties
- a complaints register where the Provider logs all complaints written or verbal
- access to independent advocacy services.

9.8 Facilities

The Provider must have sufficient and safe storage facilities for equipment, aids and supplies including the required storage facilities for all types of medications as required by relevant legislation and standards.

The Provider must have procedures in place that ensure the security and safety of the Service User and enable Service Users to enter and leave the facility as appropriate to their level of care.

9.9 Key inputs

9.9.1 Staffing

The Provider will be responsible to ensure that the Service User has an identified person as a Primary Support Worker. The Primary Support Worker is a person, who assists and facilitates as identified on the individual support plan, the process to meet the needs and goals of the Service User. In addition to this Primary Support Worker performs the same functions as a key worker and has been given induction, training, information and regular supervision by the provider about the role and functions of primary support worker.

The person could be a staff member such as a care worker or Registered Nurse. The Service User will (where appropriate) be actively involved in nominating the Primary Support Worker.

The Primary Support Worker will be responsible for the following functions:

- act as primary contact for the Service User in liaison with other support care workers and services
- participate in the development, implementation and review of the care plan
- assist and facilitate advocates as required.

9.9.2 Rest Homes

- a. At all times in every **Facility** where there are:
 - i. 10 or fewer Service Users, there must be one Care Staff member On Duty
 - ii. up to 29 Service Users, there must be one Care Staff member On Duty and one Care Staff member On-call
 - iii. more than 30 Service Users, at least two Care Staff members must be On Duty
 - iv. more than 60 Service Users, at least three Care Staff members must be On Duty.
- b. Where the Registered Nurse or Manager at any time considers that additional staff are required to meet the needs of all Service Users,⁷ the Provider shall ensure that those extra staff are On Duty for the period of time that the Registered Nurse or Manager recommends.
- c. Where the Provider provides more than one category of services at the Facility, one of the staff members may, if qualified, provide On-call assistance in respect of another category of service, provided that the Provider continues to meet the obligations to provide sufficient staff to meet the health and personal care needs of all Service Users at all times.
- d. **Manager**
 - i. Every Rest Home must engage a Manager who holds a current qualification or has experience relevant to both management and the health and personal care of people with chronic health conditions, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a Rest Home; and
 - ii. The role of the Manager includes, but is not limited to, ensuring the Service Users of the Rest Home are adequately cared for in respect of their everyday needs, and that services provided to Service Users are consistent with obligations under legislation and the terms of this Agreement.
- e. **Registered Nurse**

The Provider must employ, contract or otherwise engage at least one Registered Nurse, excluding a Registered Psychiatric Nurse, who will be responsible for working with staff and (where that Registered Nurse is not the Manager) the Manager to assess Service Users:

 - i. on admission
 - ii. when the Service User's health status changes
 - iii. when the Service User's level of dependency changes
 - iv. at each 6 month review date identified in the CP, and
 - v. develop and / or review the CP in consultation with the Service User and family and whānau and primary support worker
 - vi. advise on care and administration of medication, possible side effects and reported errors / incidents

⁷ Having regard to the layout of the Facility, the health and personal care needs of Service User and the ease with which the Service User can be supervised.

- vii. provide and supervise care
 - viii. act as a resource person and fulfill an education role
 - ix. monitor the competence of other nursing and care staff (including the Primary Support Worker) to ensure safe practice
 - x. advise management of the staff's training needs
 - xi. assist in the development of policies and procedures.
- f. Where there is more than one Registered Nurse in the Facility, the duties and responsibilities assigned to the Registered Nurse may be shared between the Registered Nurses on duty over a 24 hour period.

g. Care Staff for Rest Homes

The Provider must maintain records that document the hours worked by Care Staff in the Facility. The hours documented in the records must list only the actual hours worked by Care Staff in providing the services at the Facility for which payment is claimed under this Agreement. For the avoidance of doubt, staff hours spent working in flats or apartments associated with the Facility do not qualify as hours spent working in the Facility.

9.9.3 Hospitals

- a. In every Hospital there shall at all times be On Duty at least one Registered Nurse, excluding a Registered Psychiatric Nurse.
- i. The distribution of Care Staff over a 24 hour period shall be in accordance with the needs of the Service Users as determined by a Registered Nurse. A minimum of 2 Care Staff are required to be On Duty at all times
 - ii. The lay out of the Facility must also be taken into consideration when determining the number and the distribution of Care Staff required to meet the needs of the Service Users under 5.9.2 b above.
- b. **Manager**
- i. The Provider must engage a Manager who is either a GP or a Registered Nurse (excluding a Registered Psychiatric Nurse) and holds a current Practicing Certificate. The Manager must hold a current qualification or have experience relevant to both management and the health and personal care of people with lifelong disabilities, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a Hospital
 - ii. The role of the Manager includes ensuring the Service Users of the Hospital are adequately cared for in respect of their everyday needs, and that services provided to the Service User are consistent with obligations under legislation and the terms of this Agreement.

c. Registered Nurse

Registered Nurses must be employed, contracted or otherwise engaged by the Provider and are responsible for:

- i. the development of an initial CP within 24 hours of admission
- ii. the co-ordination and documentation of a comprehensive CP within 3 weeks of admission
- iii. ensuring that the CP reflects the assessments and the recommendation of other health professionals where their input is required

- iv. on-going re-assessment and review of care
- v. implementation/delegation of nursing tasks
- vi. supervision and provision of care according to each Service User's CP
- vii. acting as a resource person and fulfilling an education role
- viii. monitoring the competence of nursing and Care Staff to ensure safe practice
- ix. providing advice and assistance to management on the staff's training needs.

d. Manager of a Facility providing Services in more than one category

Where the Provider provides both Rest Home and Hospital care at the same Facility, a Manager that holds a nursing qualification recognised by the Nursing Council of New Zealand that is relevant to care of people with lifelong disabilities, may act as Manager of both these services so long as they are being delivered at a single Facility.

9.9.4 Orientation and Competency of Newly Employed Staff

The Provider must ensure that all newly employed staff receive a planned orientation programme that familiarises them with the philosophy and vision, physical layout of the facility, their job description, policies, procedures, protocols and guidelines relevant to their engagement and non-clinical and clinical emergency protocols.

The Provider shall ensure all staff in direct contact with the Service Users have completed education that is related to their care. Those staff that have not completed the training at the time of their appointment must complete appropriate training within six months. The training must address:

- support and care of people with chronic health conditions needs
- practical care skills
- awareness of cultural issues
- communication, including sensory and cognitive loss and other barriers to communication, communication aids
- observation and reporting
- promotion of independence and recognition of individuality
- rehabilitation / habilitation concepts; and
- understanding of Service Users' rights.

The Provider may arrange the education referred to above at the Facility or externally. Any staff member carrying out tasks, procedures, or treatment must have demonstrated they are competent at performing the task, procedure and treatment, and follow documented policies, and protocols developed by the Provider to ensure safe practice.

9.9.5 Staff Support and Guidance

Any Registered Nurse or health professional carrying out a delegated medical task or a specialised procedure or treatment must have demonstrated prior competency in the task, procedure or treatment, and follow documented policies, and protocols developed by the facility to ensure safe practice.

Tasks specified above shall be carried out in accordance with the relevant accepted ethical and professional standards.

Where certification is required to carry out a particular task or specialised procedure (for example, an I.V. Certificate) Care Staff must have such certification.

Strategies and / or protocols must be operational to ensure that advice and / or support is available to On Duty Staff at all times.

The Provider must implement protocols to guide staff managing clinical and non-clinical emergencies.

The Provider must plan and undertake ongoing staff performance appraisals. Such appraisals must be documented at least annually.

9.9.6 5.9.6 Ongoing Programme of Staff Development

The Provider must undertake a planned, documented programme of staff development or in-service education, with at least 8 hours of programmes being provided annually, including courses attended other than at the Facility. The Provider must keep a written record of staff attendance at such programmes.

The Provider will actively encourage, promote and develop Māori health and disability workers to be employed at all levels of the service to reflect the Service User population.

9.9.7 Supplies

a. Emergency Provision of Personal Supplies

The Provider must provide emergency supplies of toothpaste, toothbrushes, disposable razors, shampoo, sanitary supplies, soap and other toiletries on those occasions when the Service User's own supply is not available.

b. Provision of Pharmaceuticals

- The Provider's liability for payment of prescribed medication is limited to the payment of the Government's prescription charge, any manufacturer's surcharge and any package and delivery charge by the Pharmacist.
- The Provider is also responsible for:
 - discussing with the Service User's GP the prescribing of medications that are listed in the pharmaceutical schedule maintained and managed by PHARMAC under the Act
 - encouraging the GP to prescribe generically to lessen the occasions when a manufacturer's surcharge applies; and
 - informing the Service User in writing that they may be required to pay the cost of any pharmaceutical over and above the charges stated above.

c. Provision of Dressing Supplies

The Provider must provide all dressings and supplies used in treatments. These must be of an appropriate standard, as determined by a Registered Nurse, to meet the need of the Service User.

d. Provision of Continence Supplies

- The Provider must provide continence management products that are of an appropriate standard to meet the assessed needs of the Service User, as set out in the CP.
- For those Service Users identified as requiring specialist continence advice and support, the Provider must obtain appropriate continence management advice, which may be (but is not required to be) from the continence advisory service of the DHB community support services.

10. Service Linkages

The initial link for respite services will be with the Referrer. Co-operative relationships must be developed with Referrer ensuring that the Service develops to meet the needs of specific Service Users in the district.

The Providers listed below marked with * must meet the costs of transport, including specialised transport required, to the services. The Provider must inform each Service User about any specialist travel and accommodation funding to which the Service User may be entitled and refer them to the DHB or Work and Income for information about this funding as appropriate.

The Provider will develop relationships with the following:

Linked Service Provider	Nature of Linkage	Accountabilities
Advocacy services	Liaison, consultation, coordination of services and referral	Improve access, support seamless service delivery and continuity of care.
Appropriate ethnic and cultural groups	Liaison, coordination of services	Support seamless service delivery and continuity of care is maintained.
Assessment, Treatment and Rehabilitation (AT&R)*	Consultation and referral	Ongoing support, service coordination that supports continuity of care.
Behavioural specialist support teams if applicable*	Consultation and referral	Ongoing support, service coordination that supports continuity of care.
Community health services, including district nursing, podiatry*	Consultation and referral	Clinical consultation and referral services that support continuity of care.
Day and / or recreational activities	Liaison, consultation, coordination of services and referral.	Improve access, support seamless service delivery and continuity of care.
Dental Services*	Consultation and referral.	Clinical consultation and referral services that support continuity of care.

Linked Service Provider	Nature of Linkage	Accountabilities
Equipment and Modification Services (eg, long-term equipment, including specialist assessment services, home modifications) to assist with essential daily activities	Referral and consultation.	Service Users needing environmental support services receive appropriate equipment and environmental modifications.
Information and advisory services (eg, on available services and how to access these)	Referral.	Service Users have timely access to appropriately presented information and relevant advice.
Laboratory Services*	Referral and consultation	Clinical consultation and referral services that support continuity of care.
Major incident management including Civil Defence	Liaison, coordination of services.	Support seamless service delivery and continuity of care.
Mental Health services*	Consultation and referral.	Clinical consultation and referral services that support continuity of care.
Needs assessment and service co-ordination (eg, a NASC or other Referrer) *	Referral and consultation.	Service Users needing long-term support services have timely access to individual needs assessment and service coordination services.
Palliative care*	Liaison, coordination of services	Support seamless service delivery and continuity of care.
Primary care services*	Consultation and referral	Clinical consultation and referral services that support continuity of care.
Public health service communicable disease programmes and the Medical Officer of Health	Consultation and referral	Clinical consultation and referral services that support continuity of care.
Social Workers	Consultation and referral.	Consultation and referral services that support continuity of care.
Specialist Medical services	Consultation and referral.	Clinical consultation and referral services that support continuity of care.
Travel and accommodation services	Liaison, consultation, coordination of services and referral.	Improve access.
Voluntary organisations, eg Asthma Society, Cancer Society, National Heart Foundation	Liaison, coordination of services.	Support seamless service delivery and continuity of care.

In addition, the Provider links with Work and Income are required including agreement to notify Work and Income of a person's entrance or exit from the Service within five working days.

10.1 Accompanying the Service User

As part of the Service the Provider will:

- use best endeavours to ensure that the Service User is accompanied to such appointments by an appropriate relative or friend; or
- if a relative or friend is not available, provide staff to accompany the Service User to appointments with the providers referred to above and any other appointments for which the Service User reasonably requires an accompanying person.

11. Exclusions

11.1 General

People excluded from services funded under this service specification are those:

- who are admitted to the facility because of short-term acute illness
- who are specifically funded for residential care under the Accident Compensation Act (2001)
- for whom funding is provided for their primary care needs under another contract or notice, including arrangements relating to palliative care and convalescent care
- whose need for community residential services is primarily as a result of a physical, intellectual and / or sensory disability ie those funded by Ministry Disability Support Services
- whose needs arise solely as a result of a mental health or addiction condition; or
- where this service is not considered appropriate by the DHB to meet the individual's identified support needs.

11.1.1 Service Specific Exclusions

The Service does not include:

- specialised assessment and rehabilitation services – including specialist assessment for, and advice on, rehabilitation and specialised assessment (by accredited assessors) for individual customised equipment via ACC or Ministry funded Equipment and Modification Services providers
- customised equipment, accessed through services funded by the relevant DHB or through specialised accredited assessors, such as wheelchairs modified for the Service User, seating systems for postural support, specialised communication equipment and other customised and personal care and mobility equipment
- the provision of equipment, aids, medical supplies or services that relate to conditions covered by DHB funding
- specialist dental services as funded directly by the Ministry of Health through DHB or with Dental Practitioners for specialist dental services requiring general anaesthetic
- services such as those provided by, opticians, audiologists, chaplains, hairdressers, dry cleaners and solicitors. However, the Service continues to be responsible for ensuring the Service User has access to these services
- clothing and personal toiletries, other than ordinary household supplies. However the Provider is responsible for ensuring that these items are purchased by the Service User or their family or agent as required and are consistent with the preferences of the Service User
- charges for toll calls and internet use by the Service User
- insurance of the Service User's personal belongings
- educational services and travel to those services as funded through the Ministry of Education
- day programmes
- any other service covered by another Head Agreement and / or service specification funded by the Ministry of Health or DHB.

11.2 Service User Payment Responsibilities

The following items are excluded from the negotiated contract price. They are the responsibility of the Service User:

- a. clothing and personal toiletries, other than ordinary household supplies. However, the Provider is responsible for ensuring these items are purchased by the Service User, their family or agent as required and that items purchased are consistent with the preferences of the Service User
- b. charges for toll calls and internet use by the Service User
- c. services such as community dentists, opticians, audiologists, chaplains, drycleaners, hairdressers and solicitors. If the cost of these services fall beyond their ability to pay the

Service User or advocate will negotiate with Work and Income for access to special funds under their entitlement as part of their Invalids / Sickness Benefit

- d. transport costs to vocational services (if not covered by Work and Income). Also refer to Clause 6 for Service User responsibilities for travel
- e. Service Users must make a part payment through their benefit towards the cost of service provision as assessed and agreed with Work and Income.

12. Quality Requirements

12.1 General

The Service must comply with the General Contract Terms; the Provider Quality Standards described in the agreement and the Health and Disability Services Standards 2008⁸ as applicable.

In accordance with the Provider Quality Service Specifications other quality indicators will be incorporated as part of your internal evaluation and service development plan.

12.2 Quality Improvement Programme

The Provider shall develop and implement a Quality Improvement Programme to enable a high standard of service to be provided in accordance with the Ministry Approved Standards and otherwise in accordance with this Agreement, and to ensure the Services are provided so as to achieve the best outcome for Service Users.

The Provider must document a Quality Improvement Plan as part of the Quality Improvement Programme and must ensure that such a plan is implemented, evaluated for its effectiveness and that any necessary corrective action is taken.

The Quality Improvement Plan must include (but is not limited to):

- an explicit quality philosophy
 - clear quality objectives
 - quality improvement risk management systems
 - systems for monitoring Quality Audit compliance
 - designated organisational and staff responsibilities
- resident input into Services and into development of the Quality Improvement Plan

The Provider is expected to monitor and evaluate the delivery of Services against the Quality Improvement Plan, including standards of service. Such quality monitoring mechanisms must include, but are not limited to, the following:

- Service User feedback surveys
- quality review procedures as a demonstrable part of service delivery; and external reviews

⁸ Hospitals, rest homes, and some providers of residential disability care need to meet the Health and Disability Services Standards 2008. <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standards>

- Policy / Protocol for:
 - managing challenging behaviour in the least restrictive way possible
 - potential risk to the Service User of physical or sexual abuse from others
 - healthy lifestyle issues including: fostering respectful relationships, contraception and sexually transmitted disease / safe sex.

12.3 Service User / Family / Whānau / Guardian / Advocate Involvement

The Provider will have a number of means by which the Service User, his / her family / whānau / guardians or advocate (with the consent of the Service User) can provide input into service operations and development. These include:

- a. input into policies and procedures
- b. input into service planning and development
- c. input into staff selection/appointment
- d. involvement in internal quality monitoring
- e. input and active participation in the development of the CP
- f. representation on an advisory board
- g. involvement in audit of expenditure from Service User trust accounts
- h. involvement in, including planning, arranging and managing age appropriate activities such as social and recreational activities suitable for people under 65 years of age
- i. Māori input and involvement in all service planning and review processes
- j. full access to this service specification to enable the Service Users to fully understand the nature of the Service.

12.4 Acceptability

The Service will be acceptable to Service Users. This will be supported by feedback contained in Service User satisfaction surveys conducted annually, and by Service User participation in on-going evaluation of the Service.

13. Safety and Efficiency

13.1 Risk Management

The Providers Risk Management Plan shall address matters such as:

- the safety and security of Service Users and staff while at the facility and away from the facility. There will be times when responsibility transfers to another funded provider eg, day programmes. Such transfers must be clearly documented and agreed in advance
- dealing with challenging behaviours – when and how to access support services and when to access the Referrer for reassessment / review
- management of crises and incidents - incidents and crisis situations should be documented, which includes an Incident Register. This includes review and implementation of corrective actions
- relationships and communication in crisis situations with family / whanau / guardian / advocate, neighbours / other Service Users, and staff
- development and maintenance of positive relationships with the immediate neighbouring community.

The Provider must document and implement policies, processes and procedures for:

- identifying key risks⁹ to health and safety
- evaluating and prioritising those risks based on their severity, the effectiveness of any controls the Provider has and the probability of occurrence
- dealing with those risks and where possible reducing them
- minimising the adverse impact of the internal emergencies and external or environmental disasters on the Service Users, visitors and staff
- working with the organisations who have responsibility for co-ordinating internal and external (environmental) disaster services
- accident and hazard management that safeguard Service Users, visitors and staff from avoidable incidents, accidents and hazards.

Each policy, process, or procedure must include definitions of all incidents and accidents, and must clearly outline the responsibilities of all staff, including:

- taking immediate action
- reporting, monitoring and corrective action to minimise incidents, accidents and hazards, and improve safety; and debriefing all staff support as necessary.

The Provider must maintain a record of any accidents or incidents, and must notify the DHB and family / whanau / guardian / advocate immediately of serious accidents or incidents involving or affecting any Service User.

⁹ Key risks include, but are not limited to, the following:

- theft / burglary / fire
- accidents / incidents
- chemicals incidents; and disposal of waste
- natural disasters such as floods and earthquakes.

14. Financial Accountability

A Service User has the right to control their own money unless this is removed under the Protection of Personal and Property Rights Act 1988, and a Welfare Guardian is appointed for them.

Occasionally a Service User may choose to have their money managed for them by another person or agency. When this occurs, the Service User and or family / whanau / guardian and or advocate, will nominate someone as manager for his or her personal financial arrangements. A financial manager in this area will not be another Service User in the home, nor someone employed by the Provider.

When Service Users do not control their own money, appropriate safeguards must be in place. The Manager of the facility is to provide documentation of financial matters for audit purposes by our evaluation agency. Service Users should hold copies of the documentation of their finances when these are managed on their behalf.

The appointment of a financial manager does not remove the need for access to general advocacy or independent support; however it is desirable that different people are appointed to carry out the different roles.

15. Purchase Units

Purchase Units are defined in the Nationwide Service Framework Purchase Unit Data Dictionary. The Service must comply with the requirements of national data collections where applicable. The following Purchase Unit codes (PU) apply to this Service.

PU Code	PU Description	PU Definition	Unit of Measure
CHC0019	Community Residential Services in Aged Care Facilities for people with CHC - Rest home level care	This Service provides 24 hour rest home level support within Aged Care Facilities, for eligible people with chronic health conditions, aged 16 years or over, at the level assessed as being necessary for people to have a safe and satisfying home life.	Residential Bed Day
CHC0020	Community Residential Services in Aged Care Facilities for people with CHC - Hospital level care	This Service provides 24 hour hospital level support within Aged Care Facilities, for eligible people with chronic health conditions, aged 16 years or over, at the level assessed as being necessary for people to have a safe and satisfying home life.	Residential Bed Day
CHC0021	Community Residential Services in Aged Care Facilities for people with CHC - Dementia level care	This Service provides 24 hour dementia level support within Aged Care Facilities, for eligible people with chronic health conditions, aged 16 years or over, at the level assessed as being necessary for people to have a safe and satisfying home life.	Residential Bed Day

CHC0022	Community Residential Services in Aged Care Facilities for people with CHC - Special Hospital care	This Service provides 24 hour specialised hospital (psychogeriatric) support within Aged Care Facilities, for eligible people with chronic health conditions, aged 16 years or over, at the level assessed as being necessary for people to have a safe and satisfying home life.	Residential Bed Day
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Unit of Measure	Unit of Measure Definition
Residential Bed Day	Total number of beds that are occupied each day in a community residential facility over a designated period. Part days at start and end of the period are both counted as full days. Leave days up to an agreed maximum are also counted. Counting formula is service end date less service start date plus one(1) less leave days over agreed maximum.

16. Reporting Requirements

The reporting information is used by the Provider and Funder to monitor the scope and quality of service delivery. Other local specific reporting requirements for the Service may be specified by the Funder in the agreement Provider Specific Terms and Conditions.

Unless otherwise specified in the agreement, the following reporting information will be emailed to: performance_reporting@health.govt.nz

The following information is to be reported as per the Information and Reporting Requirements.

PU Code	Frequency	Reporting Requirements
CHC0019 CHC0020 CHC0021 CHC0022	Quarterly	Narrative Report <ul style="list-style-type: none"> • Feedback from Service Users on their experience • Summary of complaints and action taken. • Reason for any rejected referrals. • Update on any service issues, including design, development and delivery of new initiatives. • Describe any issues including risk management issues. • Identify gaps in service delivery.

17. Quality Measures

The Provider is to immediately report to the Funder Representative any critical incident¹⁰ or crisis in which serious harm has occurred resulting in police involvement, hospitalisation of a child, young adult, or adult as the result of an accident and / or incidents in which could result in media or political attention.

Certified Providers¹¹ are required to report as in section 31(5) of the Health and Disability Services (Safety) Act 2001.¹²

In addition to the general quality requirements, the following quality requirements apply to this Service:

- assessment of effectiveness and acceptability of the service through a hui or regular Service User meetings held at least monthly and / or as required.
- seek feedback at least annually from the family / whānau / guardian and Service Users that the Service is meeting the Service User's needs.

¹⁰ Critical Incident: is any unusual event, which could:

- be life threatening for the Service User
- be dangerous – safety of the Service User at risk with grave harm
- have significant consequences such as Service User involved in criminal activity
- be a serious and grave crisis that may result in media or political attention

¹¹ Homes for five or more people with disabilities must be certified under the Health and Disability Services (Safety) Act 2001.

¹² Sub-section (5) *Refer Reporting guidelines

- any incident or situation that puts at risk (or potentially could put at risk) the health or safety of the people for whom the service is being provided
- any investigation commenced by a member of the police into any aspects of the service
- any death of a person to whom you have provided services, or occurring in any premises in which services are provided, that is required to be reported to a coroner under the Coroners Act 1988.