Community Health, Transitional and Support Services

Community Residential Support Services for People with Chronic Health Conditions

Tier 2

September 2024

Health New Zealand
Te Whatu Ora

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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 NSFL	**June 2011**
Reviewed: Community Residential Services for People Who Are Chronically Ill (2006)	**May 2011**
Amendment: Clarified annual reporting requirement	**July 2011**
Amendment: References T1 Community Health, Transitional and Support Services	**July 2012**
Amendments: 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 Support Services (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 Districts 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

Community Residential Support Services for People with Chronic Health Conditions is a community, facility based residential service for eligible people with a chronic health condition who are mainly aged between 16 and under 65 years.

The Service provides 24-hour support at the level necessary for people to have a safe and satisfying home life. The support for the Service User will meet holistic needs, including social, spiritual, emotional, physical and recreational needs and may be provided through a combination of services determined at the time of needs assessment.

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.

6. Service Objectives

6.1 General

The Service objectives are to:

- provide support for Service Users to live in an accessible, homelike environment that provides maximum privacy and autonomy
- enhance the Service User's personal growth, development (as needed) independence and self-reliance
- integrate the Service User into community life, in accordance with each Service User's 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
- ensuring that the services 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.

6.3 Service Users

Service Users are Eligible people[1] mainly aged between 16 and under 65 years with chronic health conditions and long-term support needs and have been assessed by a Referrer[2] as requiring the Service.

7. Access

7.1 Entry Criteria

The needs assessment and service co-ordination processes will ensure that the criteria have been met for people referred to the Provider, including the consideration that young people generally do not have the cognitive and physiological maturity to be cared for in adult settings.

Service Users must meet the following criteria to be eligible for this Service, they:

- have very high long-term support needs. Very high need is defined as requiring assistance with activities of daily living, at least daily, to remain safely in their own home, or 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 not currently receiving support services funded under the Accident Compensation Corporation Act (2001), Ministry funded disability support services or long term support services funded by a District (regardless of funding source).

7.2 Exit

7.2.1 General

After a long term support chronic health conditions funded service resident turns 65 years of age, if a review or reassessment undertaken by the Referrer indicates that the person's needs have changed to the extent they now require aged residential care in a rest home or hospital indefinitely[3], then responsibility for care will transfer to a District's health of older peoples services.

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[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] Referrer: a District approved needs assessment and co-ordination service.

[3] As opposed to long-term care in an aged residential facility in the absence of an appropriate alternative facility.

Exit from the Service is by way of:

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

7.2.2 Provider Responsibilities - Exits

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

a. requested by the Service User, their family / whānau / guardian or advocate (if appropriate), or

b. 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 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) will 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 changes in the Service User's needs.

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 (NHB) in the next information reporting (invoicing) cycle
- the District Portfolio Manager within 48 hours, during normal working hours.

8. Service Components

8.1 Processes

8.1.1 Individual Plans

An Individual Plan (IP) is to be developed within two months of the Service User's entry to the Service. The IP will be reviewed at least six monthly, or when there is a significant change in the needs of the Service User, or at the request of the Service User. The Service User will indicate acceptance of the IP by signing it. An interim plan that identifies the Service User's initial goals and provides guidance in relation to care needs will be completed within 2 weeks of entry to the Service.

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

- the Service User's short and long term goals (including any therapeutic programmes that have been put in place by allied health professionals); and the services, activities and inputs which will be required to achieve those goals; and
- the means by which goals that increase access and participation in the community are achieved and the name of the person responsible for seeing the goals are achieved
- family and whānau / guardian (with the consent of the Service User) / or advocate involvement
- skills attainment
- minimising potential harm for individuals, staff and others in the community
- recognition of Māori and other cultural aspects such as emotional, physical and spiritual aspects.

8.1.2 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 / or advocate, neighbours / other household members including staff
- development and maintenance of positive relationships with the immediate neighbouring community.

8.2 Settings

The Services will be provided in a range of community facility based residential settings. Each home will generally accommodate groups of 4 – 6 Service Users. The Service includes situations where Service Users are fully supported in groups less than 4 - 6 people. Variation to the number of Service Users per house (above 6) is to be approved on a situation by situation basis with the Referrer.

The Provider will provide a comfortable, accessible, and well-maintained home and grounds for Service Users to live in. The home will include aids and equipment for general use to enable Service Users to access their environment. The Provider will ensure secure, physically safe internal and external environments that meet the particular mobility and safety requirements of the Service User group. These requirements will include the necessary housing modifications to the home to ensure appropriate access, bathroom modifications such as wet area showers, adaptations to kitchens to enable participation in meal preparation, adaptations to telephones etc. Each Service User is to have their own bedroom unless it is the Service User's clear choice and preference not to do so.

Furnishings will reflect age appropriate living environments, particularly in the lounge and living areas. Where possible and appropriate, Service Users will be encouraged to have personal belongings and to bring in their own furniture and furnishings if they wish.

There will be no identifying features (signage) on the house or vehicles to denote the house / vehicle as different from others.

The location of the home will provide access to community facilities, leisure activities and opportunities for socialisation.

8.3 Key Inputs

8.3.1 Primary Support Worker

The Provider must ensure that every Service User has an identified person, who acts in the role of a Primary Support Worker. The Primary Support Worker could be a staff member such as care worker or Registered Nurse. The Service User will 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
- co-ordinate the development, implementation and review of the Service User's IP
- assist and facilitate the referral to other supports and advocates as required.

The Primary Support Worker will have orientation, training and ongoing support to perform their roles and responsibilities effectively. Supervision of their practice is by a person trained and experienced in Primary Support Worker role.

8.3.2 Staffing

The Provider is responsible for employing competent staff for adequate hours for the needs of the Service User group to ensure 24-hour service provision. The Provider will have sufficient experienced staff to provide a level of service relative to the Service User's assessed needs such as risk management, dual diagnosis, physical disability, high medical needs, personal cares and social functioning.

The Provider will recruit and orient staff to meet the core staff competence components and is responsible to ensure the particular needs of Service Users are addressed in the orientation and ongoing training programmes.

Core staff competence should include, but not be limited to the areas of: disability knowledge, values (inclusion, least restrictive alternatives, the right to live in the community, knowledge about the Human Rights Act (1993) and the New Zealand Disability Strategy), person-centred services, physical care of people, communication skills and behavioural management, understanding health and disability as they relate to Māori and other cultures and as appropriate, particular needs of Service Users as they change.

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

8.4 Equipment

The Provider will supply equipment necessary for general use by the residents.

Service Users are eligible for the provision of environment and modification services where it is for the sole use of the Service User and they meet access and eligibility criteria that apply.

To access funding for equipment a person must be assessed by a Specialised Assessor. Specialised Assessors can be accessed by contacting the District.

8.5 Support Services

8.5.1 Individual Service User Support Services

The Provider is responsible for:

- the ongoing assessment and responsiveness to the Service User's well-being and support needs
- providing staff support as required to ensure Service Users are assisted to develop skills and increase their ability to be independent
- ensuring access to a Registered Nurse to work with Service Users who have high medical needs or who have invasive personal care needs
- referral to the appropriate service when there is a need for specialist assessment – some Services may require the referral to be made by a General Practitioner (GP) or other Referrer
- 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
- ensuring Service Users hold a current Community Services Card (if eligible) and or High Health Users Card, as distributed by Work and Income and that the card number is correctly referenced at the Service Users GP / Medical Specialist and Pharmacy

- 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
- supervision, oversight and / or assistance with activities of daily living and personal care as required by the individual, including but not limited to using the toilet, bathing, hair washing, teeth cleaning, toe and finger nail care, eating and mobility
- privacy in the form of, but not limited to:
  - access to private telephone (including for toll calls, although the cost of this may be charged to the Service User
  - 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
- support to maintain and strengthen relationships with family and whānau / guardians, friends and partners
- vocational, educational, social, recreational and other interests are actively supported and encouraged
- where the Service User is not involved in structured day time support activities the Provider will ensure that the person has access to a range of appropriate activities, at home and outside of home

8.5.2 Providing Access for an Individual Service User to Other Services

The following services are purchased through a separate service agreement, or another service funder. The Provider must ensure the Service User has access to:

- GP services on a regular or as required basis. Every effort is made to enable Service Users to access the GP of their choice including emergency / on call services 24 hours per day, 7 days a week
- appropriate first aid materials and dressings
- services such as: community dentists, opticians, audiologists hairdressers, solicitors and banking / financial services
- planning education and counselling requirements, including requirements for sexuality education, gender identity counselling, relationship counselling and personal development
- specialist assessment services - including assessment for individual equipment via an appropriate specialist equipment / seating service. The supply of Service User's sole use equipment is through Equipment and Modification Services (EMS).
- equipment, assistive devices, medical and continence supplies / aids, or services that relate to conditions covered by Personal Health funding except where these have been specified in the service specification.
- vocational service fees and travel to vocational services as funded by Work and Income through the Disability Allowance
- educational services and travel to those services as funded through the Ministry of Education
- day programmes and other personal health services such as District Nursing.

8.5.3 Accommodation and Household Support Services

The Provider is responsible for:

- Service Users must be encouraged to participate in the operation of the home or decisions regarding the same eg, Service User representation or participation on the Board of the governing body for the home. Service Users are encouraged to do as much for themselves and others as is appropriate to their ability and / or the arrangements that have been made with others living in the house for domestic work such as laundry, cooking, cleaning, and are supported to develop skills and their level of self-reliance
- the drawing up of a home agreement for each Service User stating rights and responsibilities, fees payable, services provided, date of commencement, planning and funding of holiday arrangements, and the purchase of any 'shared' items for the home. 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 will be retained by the Service User, and what goods and services the Service User will fund with that portion of their Work and Income benefit
- ensuring Service Users are assisted to independently manage their finances as far as possible. If Service Users require 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 or advocate and staff involved
- adequate meals that meet generally accepted principles of good nutrition and cater to the needs of Service Users on special diets including dietary supplements and equipment for special requirements for eating / feeding
- laundry, including personal laundry and care and maintenance of clothing, cleaning services and supplies. The Provider must also provide emergency access to supplies of toothpaste, shaving equipment, sanitary supplies, and other toiletries which are not included in normal household supplies for occasions when a Service User's own supply is not available
- all furniture, furnishings, bedding and utensils. The Provider must list all personal items that belong to the Service User and keep this list on the Service User's file.

8.5.4 Complaints Resolution Support Service

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

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

9. Service Linkages

Providers must establish and maintain co-operative working relationships with, and must ensure timely access where appropriate to, all relevant service providers and appropriate community agencies. The Providers listed below marked with * must meet the costs of transport, including specialised transport required, to the services.

The Service 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
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 / vocational 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
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
Needs assessment and service co-ordination services (eg, 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
Major incident management including civil defence	Liaison, coordination of services	Ensure appropriate and timely response in the event of an emergency

Linked Service Provider	Nature of Linkage	Accountabilities
Māori health and disability support services providers	Liaison, coordination of services	Responsible for liaising with one another regarding outcomes of assessment, care plans, ongoing care as required to ensure Service Users receive care that meets their needs in a timely and appropriate manner.
Mental health services* if applicable	Consultation and referral	Clinical consultation and referral services that support continuity of care
Other Government departments and agencies	Liaison, coordination of services	Support seamless service delivery and continuity of care
Palliative care* if applicable	Liaison, coordination of services	Support seamless service delivery and continuity of care is maintained
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	All services are responsible for liaising with one another to ensure Service Users receive care that meets their needs in a timely and appropriate manner.
Voluntary organisations, eg Asthma Society, Cancer Society, National Heart Foundation	Liaison, coordination of services	Support seamless service delivery and continuity of care is maintained
Work and Income	Coordination of services	Notify Work and Income of a person's entrance or exit from the service within 24 hours

10. Exclusions

10.1 General

Residential services under this service specification do not include:

- short-term residential care, including convalescent care (eg, following an acute illness or surgery) and palliative care
- services needed as a result of an injury that meets ACC's cover and entitlement criteria under the Accident Compensation Act 2001
- services needed primarily as a result of a disability that meets Ministry of Health funded disability support services eligibility and access criteria
- services needed primarily as a result of a mental illness and/or addiction
- services for people aged 65 or older or for people aged between 50 and 65 who have been assessed as 'close in interest' to older people.

Where a person aged under 65 years is assessed as needing long-term residential services as a result of a combination of a chronic health condition and another condition(s)/disability(ies) for which another funder(s) has support funding responsibility, the District will negotiate a pragmatic shared funding arrangement with the relevant other funder(s).

10.2 Individual Service User Responsibility

The following items are excluded from the contract price of the Service and are the responsibility of the individual Service User:

- clothing and personal toiletries, other than ordinary household supplies. However, the Provider is responsible for ensuring these items are purchased by the Service User, next of kin or agent as required and that items purchased are consistent with the preferences of individual Service Users
- telephone call charges for toll calls made by the Service User
- services such as community dentists, opticians, hairdressers and solicitors. If the cost of these services fall beyond their ability to pay the Service User will negotiate with Work and Income for access to special funds under their entitlement as part of their Invalids / Sickness Benefit
- transport costs to and activity fees incurred at vocational services (if not covered by Work and Income or the funder of the vocational service), individual social functions and family and whānau / guardian visits outside the local community
- part user charges for pharmaceuticals and medical costs eg, General Practitioner / Medical Specialists.

11. Quality Requirements

11.1 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 2008[4] as applicable.

11.2 Safety and Efficiency

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

These indicators include:

- adaptability of the Service to respond to new research developments and policy guidelines in the chronic health condition field. It is also expected that there is development in best practice programmes for strategies to increase the inclusion of people with disabling chronic health conditions in the day to day management of their home environment
- development of professional relationships with referrers
- comprehensiveness of the programme to cater for diversity amongst residents
- maintenance of Service User records to reflect clear, current, accurate and complete information.

11.3 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.

[4] 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

11.4 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 and whānau / 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.

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.

When Service Users do not control their own money, appropriate safeguards must be in place. The Manager of the home 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.

12. 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
COOC112	Community Residential services for people with Chronic Health Conditions	This service provides 24-hour support for eligible people aged 16 years and over with a chronic health condition at the level assessed as being necessary for people to have a safe and satisfying home life.	Occupied Bed Day

Unit of Measure	Unit of Measure Definition
Occupied Bed Day	Total number of beds that are occupied each day over a designated period. For reporting purposes, count beds occupied as at 12 midnight of each day. Leave days, when the bed is not occupied at midnight are not counted. Counting formula is discharge date less admission date less leave days.

13. 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 The Performance Reporting Team, Sector Operations at performance_reporting@moh.govt.nz

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

PU Code	Frequency	Reporting Requirements
COOC112	Quarterly	**Narrative Report** • 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.

13.1 Quality Measures

The Provider is to immediately report to the Funder Representative any critical incident[5] 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 Providers[6] are required to report as in section 31(5) of the Health and Disability Services (Safety) Act 2001.[7]

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

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[5] 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

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

[7] 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.

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