

**Community Health, Transitional  
and Support Services**

**Personal Care and Home  
Support 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
Approved	June 2011
Published on NSFL	June 2011
Reviewed: Home Support Services (Personal Care and Home Help) for People who are Chronically Medically Ill (September 2006)	May 2011
Amended: added reference to T1 Community Health, Transitional and Support Services service specification.	June 2013
Amended: minor formatting and editing	January 2015
Moved to Health NZ template. Updated links for PUDD and NSFL only. Amended DHB to become District/Region where appropriate. No other changes to content made.	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.

**Note:** Contact the NSF Team, Te Whatu Ora | Health New Zealand to discuss proposed amendments to the service specifications and guidance in developing new or updating and revising existing service specifications. [NSF@tewhatuora.govt.nz](mailto:NSF@tewhatuora.govt.nz)

Nationwide Service Framework Library web site [here](#)

### 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 Home Support Services for People with Chronic Health Conditions (the Service) is used in conjunction with the Tier One Community Health, Transitional and Support Services service specification.

#### 3.1 Background

A suite of four service specifications was prepared for District Health Boards (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 the purchase unit codes to preserve the capacity to track expenditure.

### 4. Service Definition

The Home Support Service (Personal Care and Household Support - the Service) is long term support provided by support workers for People with Chronic Health Conditions in their own home or other private accommodation in the community. It 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 Service will have a restorative focus that promotes and maintains the independence of the Service User.

The Service is provided on a long-term basis and is closely related to but is distinct from:

- Specialist Community Nursing Services
- Other specific support services, including Carer Support, Day Care / Day Programmes
- Ministry funded Home and Community Support Services or other DHB Home Support Services.

The Service includes:

- **The Support Plan:** documented agreed support arrangements to provide enough detail for the Service User and the Support worker to know what is required of them
- **Personal Care:** assistance with activities of daily living that enables the Service User to maintain their functional ability at an optimal level
- **Household Support:** (also known as Home Help or Domestic Assistance.) Services that enable Service Users to maintain, organise and control their household / home environment
- **Night Support:** assistance with Personal Care and Household Support tasks during an overnight period of stay where there is facility for the Support Worker to sleep. This is provided for eligible Service Users where this Service is not already funded under another contract.

## 5. Service objectives

### 5.1 General

The Service objectives are to:

- enable the Service User's early discharge from hospitalisation
- assist Service Users to maximise their independence, quality of life and self reliance
- assist Service Users to retain and / or maintain their functional ability
- enable Service Users requiring assistance to live safely in their own home for as long as possible
- enable families and whānau to support the Service User in other areas of their life
- provide flexible user centred supports that work in conjunction with other support services.

### 5.2 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.
- that services improve the health and independence of Māori by delivering services to best meet Māori need, and where possible to provide services by Māori for Māori.

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

## 6. Service Users

Service Users are people with chronic health conditions and long-term support needs mainly aged under 65 who are eligible for publicly funded services<sup>1</sup> and, who have been assessed by the Referrer as requiring this Service. In this service specification, the Referrer is a DHB approved needs assessment and service co-ordination service.

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<sup>1</sup> 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.

## 7. Access

### 7.1 Entry Criteria

Access to the Service is by authorised referral from the Referrer following confirmation of eligibility and an individual needs assessment process. The Provider must operate an effective and efficient system to receive and prioritise all referrals into the Service.

The assessment and service co-ordination processes followed by the Referrer will ensure that the criteria have been met for clients referred to the Provider. Service Users who hold a current Community Services Card may be offered Household Support services as part of this Service.

Service Users must meet **all** of the following criteria to be eligible for this Service:

- the person is aged under 65 and has one or more chronic health condition(s) that is / are expected to continue for six months or more and
- has very high need for long-term support services. Very high need for this service is defined as:
  - requiring assistance<sup>2</sup> with activities of daily living at least daily to remain safely in their own home
  - the person's wellbeing and functional status is deteriorating, their needs are increasing and safety issues are becoming apparent, and
- 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, and
- 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.

Where people have complex needs that mean they are eligible for long term support services from more than one funder, joint funding arrangements may be considered.

The Service will endeavour to find a Support Worker who is acceptable to the Service User. The Service may only be declined if a Support Worker who is acceptable to the Service User cannot be arranged or when there are safety issues for the Support worker.

### 7.2 Exit Criteria

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.

The Provider will ensure that Service Users will be referred back to the Referrer, with the Service User's permission, if the Service User:

- has needs that can no longer be met by the Provider and / or
- no longer require the Service; and / or
- decides that they wish to access an alternative service provider. Service Users may at any time contact their Referrer to request a referral to another provider.

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<sup>2</sup> Assistance refers to physical hands on care or close supervision. For children and young people this refers to significantly higher levels of care than would normally be expected for their age.



## 7.3 Referral Response Time

The response time required for each referral to the Service is based on the Service User needs and the level of assessed risk for the Service User.

Contact (phone call / visit) will be made within two working days of receiving the referral and provision made for urgent responses in exceptional circumstances. Services will be provided within 5 working days of receipt of the referral in 95% of cases unless stipulated otherwise by the Referrer.

The Provider will include response times to referrals as a measure within their quality assurance programme.

## 7.4 Service Delivery Time

Services will be delivered at a time in consultation with and mutually agreed by the Service User (or when necessary, the Service User's representative) and the Provider.

**Personal Care and Night Support** will be available for 7 days a week, during hours negotiated between the Provider and Service User. The frequency of the Service provision will depend on the level of the Service User's assessed need. This will include arrangements for weekends and public holidays as appropriate and negotiated.

**Household Support** will generally be available Monday to Friday in normal day working hours, and at other times by arrangement. Where a Service User requires these services during the weekend or public holidays, these arrangements must be negotiated in advance.

# 8. Service Components

## 8.1 Processes

### 8.1.1 The Support Plan

The agreed support arrangements will be documented in a written Support Plan within two weeks of receiving the referral. The Support Plan will be clear and provide enough detail for the Service User and the Support worker to know what is required of them. The Support plan is to be signed by both the Service User and the Provider. The Support Plan will be based on the Service User's assessed needs and goals. It will include what services are required, when, and any sensitive issues the Service User wishes to be respected. Confirmation of the Support Plan will be sent to the Referrer. Service Users are referred to the Referrer at any time for review / reassessment if their needs change significantly.

The Provider will:

- include other people who are chosen by the Service User in the development of their Support Plan
- review the Support Plan annually, or as required, to ensure that the Service User's situation is monitored and the Support Plan is kept up to date as the Service User's needs change. The review is discussed with the Service User, and with the Service Users consent, their family and whānau / Support Worker and the Referrer (where appropriate). Changes to the plan are confirmed to the Referrer (where appropriate) and documented by the Provider, to form part of the Service monitoring and audit process

### **8.1.2 Personal Care**

Assistance with personal hygiene and the range of tasks required to support daily living are determined through the assessment process. Services may include but are not limited to assistance with:

- feeding
- shower / bath and dressing
- personal hygiene and grooming
- transfers and mobility
- observing / monitoring of skin and scalp
- overseeing the Service User's taking of medication
- toileting – including assistance with use of appliances and aids such as day / night urinary collection bags and associated hygiene

The Provider must identify any safety risks to ensure the Service User's safe mobility around the home and discuss these with the Service User and Referrer as appropriate. (See section 5.3).

Support Worker concerns around the wellbeing of a Service User will be reported to the Provider who will, if it is appropriate, discuss further with the Referrer. Wherever possible, this will be undertaken in discussion with the Service User and / or their family and whanau.

### **8.1.3 Household Support**

Assistance with tasks normally performed in and around the home is determined through the assessment process. Services may include but are not limited to:

- washing, drying, ironing and storage of laundry
- routine household cleaning, vacuuming and tidying
- meal preparation

Excludes tasks normally associated with spring cleaning or irregular events or those normally undertaken by trades people. There will be flexibility to negotiate additional specific tasks between the referrer and the Provider on a case by case basis.

### **8.1.4 Night Support**

Assistance with Personal Care and Household Support tasks for up to 12 hours as determined through the assessment process.

Services may include but are not limited to:

- preparing for bed
- meeting nutritional needs
- up to two hours of support during the night, recognising that a person who requires more than this level of support should be considered for residential services
- shower / bath and dressing
- making bed and tidying as necessary.



## 8.2 Settings

The Service is primarily provided in the Service User's home (usual place of dwelling) provided that no contractual arrangement exists whereby the resident pays for, or the facility owner is obliged to provide the Service purchased by the DHB.

Exceptions (when the Service is not delivered in the usual place of dwelling) will be recorded in the Service User's Support Plan where appropriate.

The Provider may be asked to provide services to a Service User normally resident in another locality, eg, when staying with family or holidaying. The level of care to be provided will be determined by the Service User's usual Referrer, but will usually involve meeting the Service User's personal care needs only.

## 8.3 Risk Management Plan

As the Service is provided in a person's home, any hazards specific to that environment must be identified and a plan developed to manage these. The Provider / Support Worker will report to the Service User and / or family / whanau:

- any hazards or unsafe features of the Service User's immediate environment according to the agencies written policies, or the Health and Safety in Employment Act
- an extraordinary event or the need for extra assistance while the Support Worker is in the Service User's home.

## 8.4 Key Inputs

### 8.4.1 Staffing

The Provider will provide a suitable Support Worker who is acceptable to the Service User and arrange an alternative Support Worker if requested by the Service User. A Support Worker is a person, who assists and facilitates the process to meet the needs and goals of the Service User as identified on the individual Service User's Support Plan.

The Provider will have in place written protocols that ensure:

- staff competency levels, training needs and compliance with training requirements are identified and monitored
- Support Workers are trained relevant to the level of services they provide to each Service User and work within the boundaries of this training
- all staff are aware of the Privacy Act and its implications and maintain Service User confidentiality
- Support Workers are directed and supervised as appropriate. The level of supervision required by each individual Support Worker will be determined by the complexity of the services being delivered and by the skills and experience of the worker
- new workers receive a minimum of 2 days training and be assessed as competent on issues relevant to the development of effective Service User / worker relationships prior to being allocated Service Users
- recruitment procedures include a requirement for prospective staff to declare any criminal convictions.

## 8.5 Equipment

Service Users are responsible for:

- all materials required for carrying out household support tasks and personal care
- meeting reasonable costs associated with meeting their basic needs (eg, cleaning equipment, purchase of food or petrol).

## 9. Service Linkages

The Provider will ensure, where required by the needs of individual Service Users, that their access to appropriate services are co-ordinated into a single package centred on the Service User's need. This will be done in conjunction with the Referrer.

Linked Service Provider	Nature of Linkage	Accountabilities
Advocacy services	Liaison, consultation, coordination of services and referral	Improve access to services, support seamless service delivery and continuity of care
Appropriate ethnic and cultural services	Liaison, coordination of services	Ensure culturally appropriate support is provided
Behavioural specialist support teams (if applicable)	Consultation and referral	Ongoing support, continuity of care
Child health services (if applicable)	Consultation and referral	Clinical consultation and referral services that support continuity of care
Community health services, including professional community services, home help and meals on wheels	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	Support seamless service delivery and continuity of care
Education providers where appropriate	Liaison, consultation, coordination of services and referral	Improve access to educational opportunities
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	Provision of information	Service Users have timely access to appropriately presented information and relevant advice on how to access services

<b>Linked Service Provider</b>	<b>Nature of Linkage</b>	<b>Accountabilities</b>
Major incident management including civil defence	Liaison, coordination of services	Ensure appropriate and timely response in the event of an emergency
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
Needs assessment and service co-ordination (eg, NASC)	Referral and consultation	Service Users needing long-term support services have timely access to individual needs assessment and service coordination services
Other relevant Government departments and agencies (eg MSD, CYF)	Liaison, coordination of services	Support seamless service delivery and continuity of care is maintained
Palliative care if applicable	Liaison, coordination of services	Clinical consultation and referral services that support 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
Transport services, including Total Mobility, to recreational and/or day activities etc	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.
Travel and accommodation services	Liaison, coordination of services	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	Ensure relevant and accurate information is available to support service delivery

## 10. Exclusions

People who are ineligible for this Service are:

- eligible for services funded under the Accident Compensation Act 2001
- receiving home support services under other public funding arrangements such as ACC, DHB or the Ministry of Health (unless formal written agreements have been made for joint funding for individuals with complex needs)
- eligible for DHB Health of Older People funded support services, including people between age 50 and 65 assessed by a DHB as being 'close in interest' to an older person through having conditions more commonly experienced by older people.
- requiring home support services for additional needs arising from a condition in the palliative stage
- residing in a residential care facility funded by the Ministry or DHB, that provides housekeeping and care services, and is licensed and / or registered as a residential facility, or are contracted by the Ministry or DHB to provide residential services or who have home support funded by a private insurer

People with a mental health or addiction need should have their specific mental health and addiction needs met through mental health services, but they are not excluded from having their chronic health conditions needs assessed and funded through these specifications.

## 11. Quality Requirements

### 11.1 General

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

The Ministry's Standards for Home and Community Support Sector Standards (NZS8158:2003) will apply to this Service.

The Service User's Support Plan prepared by the Provider will include:

- a record of the Service User's relevant ethnic and demographic data
- the Service User's support needs in regard to Home Based Support, expressed in specific tasks and hours per week
- a reassessment date where an end date cannot be defined
- names of the Service Users': contact person in an emergency, General Practitioner, assessor, Māori advocate or support person (where appropriate)
- the name designation and contact information of the referrer
- the name of the Support Worker, and information about how the Support Worker will be relieved during their holidays, or if on sick leave.

A copy of the current Service User's Support Plan will be held in the Service User's home.

The Provider will ensure that all long-term Service Users receive written information regarding Service Users' rights and needs and the Health and Disability Standards.

## 11.2 Risk Management

The Provider will:

- Support Worker concerns about safety of equipment will be passed on to the Provider who will refer on to the appropriate agency.
- ensure contingency plans are developed to enable continuation of care in the event of untoward circumstances eg, major flooding, earthquake etc, for those Service Users whose safety would be at risk if personal care needs were not met
- monitor and review the relationship between Service User and Support Worker and the quality of care provided.

## 11.3 Acceptability

Acceptability of the Service will be monitored by undertaking:

- development of a short-term written service agreement<sup>3</sup> within 24 hours of consultation with the Service User and a long-term plan is developed within three weeks of the referral being accepted
- reviews of long-term plans at least 12 monthly, or at the Service User's request
- consumer surveys in conjunction with the Maori community will show Māori report satisfaction with the Service.

The Service User (and carer where appropriate) is centrally involved in developing the service agreement, and signs the finished agreement. The Service agreement informs Service User of their right to request a different Support Worker Service User and carer satisfaction surveys explicitly measure satisfaction with relationship with Support Worker.

Wherever possible, the Service User will be offered a choice of Support Worker to ensure compatibility. The Service User (or carer where appropriate) has veto over choice of Support Worker, where a helper is provided for long term care.

The Provider will demonstrate (as per the narrative reporting requirements) how effective the Service has been in achieving the goals of the Service User's Support Plan. This includes ensuring feedback from the Service User perspective, which includes the Support Worker's respect of Service User's privacy and acknowledgement of the Service User's rights as a consumer

The Provider will ensure that there is an open complaints process and that a complaint register is maintained with all complaints, either written or verbal, are logged on the register.

## 11.4 Safety and Efficiency

The number of workers attending Service Users should be minimised, to ensure that service delivery remains cost effective (in terms of time taken to become familiar with each Service User's Support Plan requirements and to develop an effective working relationship) and that there is continuity of care for Service Users. However a sufficient number of workers should be maintained to ensure Service Users have a choice of Support Worker.

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<sup>3</sup> The service agreement details rights, responsibilities etc and is a generic document that the Provider develops to tell Service Users information about the Provider and the service at a more generic level.

To ensure that the Service goals within this specification are met, the Provider will have in place written protocols that ensure:

- staff awareness of all aspects of the Service delivery, including:
  - food management
  - shopping including money handling
  - assistance with medication
  - incident reporting systems
  - abuse / neglect policy including information to staff as to what constitutes abuse / neglect
  - safety issues and risk assessment while working in Service User homes
  - written protocols on Service User informed consent and protection of privacy
  - changes in Service Users health status.

The Provider will have in place written protocols to ensure the safety of workers is maintained. Such protocols will include policies for withdrawal of services where workers are at risk.

The Provider will ensure that risk to staff is assessed prior to the commencement of the Service to the Service User. This includes the development and implementation of health and safety policies in accordance with the Health and Safety in Employment Act 1992.

The Provider will demonstrate and have in place sound recruitment practices and policies that do not jeopardise staff or Service User safety.

Where cultural sensitivity is identified as an issue, an advocate or support person of the Service User's choice may support Service Users as the event is discussed and managed.

## 11.5 Effectiveness

Staff will perform the agreed tasks competently and respect the Service User's personal belongings, and the Service User's ownership and control of the in-home environment.

Staff will ensure that Service User's cultural values and beliefs and cultural requirements are acknowledged and respected at all times.



## 12. Purchase Units

Purchase Unit Codes are defined in Health New Zealand's Nationwide Service Framework Purchase Unit Data Dictionary. The following codes apply to this Service.

PU Code	PU Description	PU Definition	Unit of Measure
CHC0004	Household Support Services for People with Chronic Health Conditions	The service provides assistance with tasks normally performed in and around the home to enable eligible people with chronic health conditions to remain in or to return to their own home / private accommodation in the community. The level of service is determined through the needs assessment process.	Hour
CHC0005	Personal Care Services for People with Chronic Health Conditions	Provides assistance with personal hygiene and the range of tasks required to support daily living to enable eligible people with chronic health conditions to remain in or return to their own home / private accommodation in the community. The level of service is determined through the needs assessment process.	Hour
CHC0006	Night Support Services for People with Chronic Health Conditions	Provides assistance with personal care and household support tasks for up to 12 hours during an overnight period of stay, where there is facility for the Support Worker to sleep. The level of service is determined through the needs assessment process.	Hour

Explanations of the units of measure (UOM) from the purchase unit table.

Unit of Measure	Unit of Measure Definition
Hour	Number of hours provided.

## 13. Reporting Requirements

Narrative reports are required on a six-monthly basis. Information to be included is on any issues or suggestions pertaining to the following:

- quality requirements
- access (Section 4 – Access)
- care plans
- client and family / whanau involvement
- outcomes – can be measured by population level reporting on changes to admission rates to hospital, and / or changes to level of support required through use of restorative model
- follow-up
- provision of services to Māori; and
- staffing including training and retention / recruitment issues.

	Reporting Requirements
Total Service Users	<p>The total number of Service Users receiving care under each service sub-unit (and in total) on the first day of the reported month.</p> <p>A Service User receiving more than one service will be included in the Service User volumes of each service sub-unit from which they receive care.</p>

The Provider is to immediately report to the Funder Representative any Critical Incident<sup>4</sup> or crisis in which serious harm has occurred resulting in police involvement, hospitalisation of a person as the result of an accident and / or incidents in which could result in media or political attention.

## 14. Glossary

Not required

## 15. Appendices

Not required

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<sup>4</sup> **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.