

**Community Health, Transitional  
and Support Services**

**Specialist Community  
Nursing Services**

**Tier 2**

**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 NSFL	May 2003
Review of Specialist Community Nursing Services service specification (May 2003)	14 June 2012
<b>Amendments:</b> aligned with the Resource and Capability Framework for Integrated Adult Palliative Care Services (Ministry of Health 2013) and the Tier Two Specialist Palliative Care service specification. Added key components of the Palliative Care – Community service specification. New purchase unit code M80012	October 2014
<b>Amendment:</b> amended definition of M80012 to align with v20 of the Purchase Unit Data Dictionary	March 2015
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.

**Note:** Contact the Service Specification Programme Manager, National Health Board Business Unit, to discuss the process and guidance available in developing new or updating and revising existing service specifications. Web site address Nationwide Service Framework Library: [Nationwide Service Framework Library – Health New Zealand](#)

### 3. Introduction

The Tier Two Specialist Community Nursing Services (the Service) service specification is used in conjunction with the Tier One Community Health, Transitional and Support Services service specification so that the total service requirements are explicit. The Tier One service specification contains principles and content common to all the tiers of service specifications below it and is applicable to all service delivery.

This Tier Two service specification should also be read, as appropriate for relevant age groups, in conjunction with:

- the Age Related Residential Care (ARRC) services agreement
- Resource and Capability Framework for Integrated Adult Palliative Care Services (the Resource and Capability Framework) (Ministry of Health 2013 )
- the Guidance for Integrated Paediatric Palliative Care Services in New Zealand (Ministry of Health 2012)
- the following Tier Two service specifications: Home Support Services - Personal Care and Home Help, Specialist Palliative Care Services.

The Tier Two Specialist Community Nursing Services service specification includes common elements specific to this Service and generic requirements for the delivery of a range of services described in the Tier Three service specifications listed in the table below.

The following Tier Three service specifications must be used with this Tier Two service specification:

<b>Tier Three Service Specifications</b>	<b>Purchase Unit Codes</b>
Continence Education and Consumables Services	DOM104
Stomal Therapy Services	DOM103

### 4. Service Definition

This Service supports Service Users to remain in their own community by providing professional nursing services in the Service User's own home, or on an ambulatory basis, if their health needs can be managed in these locations in a cost effective manner.

Specialist Community Nursing services (also known as District Nursing services) include generalist and specialist nursing services for those Service Users whose level of need is such that they require professional nursing services delivered by Registered Nurses, or Enrolled Nurses under the immediate direction of Registered Nurses, and who are identified as eligible for services.

The Service may be intensive, short-term, or episodic care focused on health recovery, or more long-term in duration, focussed on health maintenance.

The Service also includes:

- clinical nursing for specialist palliative care services <sup>1</sup> provided in the community (M80012)

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<sup>1</sup> Palliative care is a holistic programme of care, provided by an inter-disciplinary team for people of all ages with a life-limiting illness. Refer to the Resource and Capability Framework for Integrated Adult Palliative Care Services (the Resource and Capability Framework) Ministry of Health 2013

- by, or under, the supervision of a specialist palliative care team, or,
- where there is no specialist palliative care team in the area, by a specialist palliative care nurse / care co-ordination
- support for end of life care, in collaboration with the primary palliative care provider
- nursing services and consumables to support enteral feeding (DOM109)
- nursing assessment, advice and education.

## 5. Service Objectives

### 5.1 General

See the Tier One Community Health, Transitional and Support Services service specification Section 4 Service Objectives.

Specialist Community Nursing Services will be delivered in collaboration with other hospital and primary care providers, taking an interdisciplinary approach using shared Service User goal centred care plans.

The Service will be delivered so that the Service User's clinical pathway is integrated and responsive to evidence and best practice in achieving desirable health outcomes.

To improve the quality of life for Service Users who are dying, and their families, and prepare them for death in a way that is satisfactory for the person and their family/whānau.

Specialist Community Nurses' clinical competencies are matched to Service User's needs and resources of the Service.

### 5.2 Māori Health

See the Tier One Community Health, Transitional and Support Services service specification Section 4.2 Māori Health.

## 6. Service Users

The Service Users are those eligible people<sup>2</sup> of all ages experiencing a personal health problem who meet the following criteria:

- for whom without intervention from specialist community nursing services, will be placed at risk of further deterioration of their personal health status
- for whom provision of care in their normal living environment would not further compromise their health status
- their health problem may be appropriately managed in the community setting / their normal living environment.

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<http://www.health.govt.nz/publication/resource-and-capability-framework-integrated-adult-palliative-care-services-new-zealand> and Guidance for Integrated Paediatric Palliative Care Services in New Zealand (Ministry of Health 2012) <http://www.health.govt.nz/publication/guidance-integrated-paediatric-palliative-care-services-new-zealand>

<sup>2</sup> The Eligibility Direction describes the groups of people who are eligible for publicly funded (free or subsidised) health and disability services in New Zealand. <http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/eligibility-direction>

This Service includes:

- people with a disability / impairment (including assessed palliative care needs) who require specialist nursing services
- people with a tracheostomy / gastrostomy. Other ostomies are covered by the Tier Three Stomal Therapy Services service specification
- residents of residential homes for people with sensory disabilities, chronic health conditions, or mental illness and/ or addictions (where these facilities do not have nursing staff as an integral part of their service) are eligible for nursing services, supplies and equipment under the same criteria as people living in their own homes, if not otherwise funded.
- residents of Aged Related Residential Care facilities, where nursing staff are a requirement under the ARRC agreement are eligible for access to specialist nursing assessment, advice and sharing specialist clinical competencies but not routine nursing treatment, supplies or equipment.
- Nursing assessment, advice and education, for patients / carers / other service providers, for example for: chronic / complex wound care, enteral feeding, intravenous / subcutaneous medication administration

## 7. Access

### 7.1 Entry and Exit Criteria

The Risk Assessment Framework (Appendix 1) guides the determination of entry to the Service and priority for entry, and forms the basis for discharge or transfer of care from the Service.)

### 7.2 Referral to the Service

Referral to the Service must be from a medical practitioner, a practice nurse, or other health professional.

The Service will have processes and methods for evaluating the priority of the referral and will allocate an appropriate response time required for each referral, based on the person's level of risk assessed from the information given with the referral.

Where not otherwise specified, the time from receipt of referral, by the Specialist Community Nurse, to first contact with the Service User will meet the requirements below:

Urgency for Initiation of Service Provision According to risk level assessed from referral	Receipt / Acknowledgement of the Referral by the Service to the Service User	Specialist Nurse response to assessed risk for provision of the Service
High or excessive level of risk	within 8 – 24 hours of receipt of referral	within 8 – 24 hours of receipt of referral
Medium risk	within 1 working day (Monday to Friday) of receipt of referral	within 3 days of receipt of referral
Low Risk	within 2 working days (Monday to Friday) of receipt of referral	within 1 week of receipt of referral according to assessed need



## 8. Service Components

### 8.1 General

Additional detail to the generic information and principles applied to the service components in the Tier One Community Health, Transitional and Support Services service specification are provided in the table below:

Service Component	Description
<b>Referral management</b>	The referral system will be operated by staff who understand the scope and nature of the Service.
<b>Assessment</b>	<p>The Service provider will:</p> <ul style="list-style-type: none"><li>• assess clinical / health status and required support (such as carer availability) functional needs of the Service User and the environment</li><li>• review the Service User's progress as necessary and making appropriate referrals to, and co-ordination with other services as needed</li><li>• use existing Service Users' comprehensive health needs assessments (e.g. interRAI<sup>3</sup> MDS Home Care Tool) as the base to conduct and document an assessment, where available and as appropriate</li><li>• provide as required, initial assessments and service co-ordination in those areas where these components are not provided by either a local hospice or a DHB hospital-based specialist palliative care team.</li></ul>
<b>Planning and Provision</b>	<p>The Service provider will:</p> <ul style="list-style-type: none"><li>• ascertain the clinical appropriateness and the cost effectiveness of providing the Service to manage the Service User's health need and adjust the treatment programme according to the Service User's response and the need to achieve clinical benefit</li><li>• provide services that will restore or maintain health status including, as appropriate, input from any relevant external sources to ensure that people receive the necessary range of services, care and support within the timeframes required by their health need</li><li>• as appropriate, engage in advance care planning processes initiated by the primary palliative care provider.</li></ul> <p>Planning and provision includes:</p> <ul style="list-style-type: none"><li>• prevention and management of physiological symptoms, eg. pain or nausea</li><li>• medication administration: oral, topical, enteral, IV or subcutaneous</li><li>• maintenance / improvement of skin integrity, nutritional status, continence and personal hygiene</li></ul>

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<sup>3</sup> From 30 June 2013, the use of interRAI assessments to facilitate access to long term publicly funded support services was mandatory.

Service Component	Description
	<ul style="list-style-type: none"> <li>• personal health / short-term equipment and rehabilitation to support safety and functional independence</li> <li>• education and support where patients / carers / other service providers need up-skilling and supervision in administration of certain complex procedures until appropriate skills are attained</li> <li>• support of informal and formal carers in their role as carer</li> <li>• delivering a palliative approach to patients with life-limiting or life-threatening conditions supported by the specialist palliative care team and psychosocial support, as required.</li> </ul>
<b>Self-Management and Wellness Education</b>	Refer to the Tier One Community Health, Transitional and Support Services service specification.
<b>Information, Education and Advice</b>	Specialist Community Nurses have an important role, in the short term, in sharing their specialist knowledge and skills as support for nursing staff in Aged Related Residential Care facilities.
<b>Evaluation - monitoring and assessment</b>	<p>The Service Provider will:</p> <ul style="list-style-type: none"> <li>• undertake and document a formal reassessment against the care plan or treatment goals, based on evidence and within time frame, using assessment tools as appropriate. For Service Users with acute needs, assessments are undertaken at each interaction, weekly or at one month whichever is the more appropriate to safely meet the needs of the Service User</li> <li>• if the Service User stays within the Service, undertake a reassessment for Service Users with long term conditions six weeks following commencement of service provision and at least every six months thereafter to monitor the effectiveness, acceptability and appropriateness of continuing the provision of the Service</li> <li>• where progress is different from expected, make changes to the Service User's care delivery plan and update referrer and the Service User's GP</li> <li>• document demonstration of achievement of desired outcomes</li> <li>• account for utilisation of consumables</li> <li>• account for Service User contact activities e.g. telephone versus face to face contacts.</li> </ul>
<b>Life - long service provision</b>	For life long service provision, refer to the Tier One Community Health, Transitional and Support Services service specification.
<b>End of life care guidance</b>	<p>The Service provider will:</p> <ul style="list-style-type: none"> <li>• engage in and utilises an end-of-life pathway programme, such as according to the written management /care plan</li> <li>• collaborate in developing a systematic district approach to end of life care</li> <li>• implement end of life care in non-specialist settings.</li> </ul>



Service Component	Description
<b>Provision of loan equipment (for personal health and disability need).</b>	<p>The Service provider will provide equipment for eligible people of all age groups who have been assessed as needing DHB funded short-term loan of equipment for the following reasons:</p> <ul style="list-style-type: none"> <li>• to allow people with personal health and disability needs to remain at home, where appropriate</li> <li>• to provide equipment for people to meet their assessed needs</li> <li>• as an interim solution whilst awaiting long-term loan equipment.</li> </ul> <p>Note: Following a needs assessment, the Ministry of Health funds or contributes to the cost of equipment and modifications where a person with a disability meets specified criteria.</p> <p>DHB equipment for short-term loan will include, but is not limited to:</p> <p><b>A. Standard mobility aids:</b> walking frames, walking sticks, crutches.</p> <p><b>B. Basic wheelchairs:</b> transit and self-propelling wheelchairs</p> <p><b>C. Standard personal care equipment:</b></p> <ul style="list-style-type: none"> <li>• commodes, raised toilet seats, perch and shower stools, bath boards</li> <li>• portable rails and ramps</li> <li>• mobile patient lifters / hoists, bariatric equipment</li> <li>• nebulisers, transcutaneous electrical nerve stimulation (TENS) units</li> <li>• pressure / positioning mattresses, adjustable beds.</li> </ul>
<b>Discharge Planning</b>	<p>The Service provider will:</p> <ul style="list-style-type: none"> <li>• plan discharge in consultation with the Service User and agencies as appropriate</li> <li>• liaise, and share information, with the Service User's Primary Health Care Team to ensure a continuum of care</li> <li>• refer the Service User to other services as required and notify the Primary Health Care Team of the referrals</li> <li>• ensure that transition of responsibility of care for the Service User to other providers has occurred in a manner which promotes continuous care and minimises gaps in service provision wherever possible</li> <li>• make a written discharge report available to the Service User, the referrer and the GP.</li> </ul>
<b>Key Worker / Service Co-ordinator</b>	<p>People with complex needs that span services, disciplines and settings will have a single Key Worker / Service Coordinator as agreed with the Service User and their whānau or family.</p> <p>This Key Worker / Service Co-ordinator may or may not be provided by this Service. Refer to the Tier One Community Health, Transitional and Support service specification.</p>

## 8.2 Settings

See the Tier One Community Health, Transitional and Support services service specification Section 5.4 Settings. In addition, the Service is a mobile service and must be responsive to the needs of the Service User.

Access to appropriate services will be provided after hours to ensure clinical safety.

### 8.3 Key Inputs

The Provider will ensure that there is sufficient, appropriately trained nursing staff available to safely meet the assessed needs of the Service Users within the timeframes set.

The Service's staff will participate in palliative care education programmes provided by specialist palliative care services, as required.

The Service will supply or facilitate access to identified / prescribed consumables and / or supplies and / or equipment that are required for the nursing treatment programme. This will include ongoing long-term supplies, such as wound dressings only where it is identified that the patient's level of health care need requires ongoing management and oversight from the Service.

## 9. Service Linkages

See Tier One Community Health, Transitional and Support services service specification

Section 8 Service Linkages. In addition, the Service will demonstrate effective relationships with the following services:

Linked Providers	Nature of Linkage
Home support services, community allied health services and other community based services. Support needs assessment and co-ordination services Primary palliative care services.	Refer and liaise with re individual as required to achieve continuum of care. Provide expert opinion, information.
Aged Related Residential Care Facilities	Provide advice re Nursing assessments and therapies. Sharing clinical competencies and up skilling of ARRC Facility staff as required. Refer and liaise with re individual as required to achieve continuity of care.
Residential Care homes for people with intellectual, physical or sensory disabilities, chronic health conditions, or mental illness and/ or addictions	Refer and liaise with re individual as required to achieve continuum of care. Provide expert opinion, information.
Primary Community Health Care Services Primary medical and nursing services Pharmacies	Manage transfer of care from secondary to primary care. Specialist Community Nursing Service will enable transfer of care to GPs to occur so that they can be responsive to facilitating Service User

Linked Providers	Nature of Linkage
	<p>discharge from secondary services and prevent hospital admission.</p> <p>Refer / accept referrals from and liaise with re individual as required to achieve continuum of care</p> <p>Liaise with re medication advice and drug information.</p>
<p>Specialist services such as:</p> <ul style="list-style-type: none"> <li>• Gerontology, mental health and addiction services, specialist medical and surgical, and maternity services.</li> <li>• Oncology specialist services</li> <li>• Emergency medical services</li> <li>• Assessment Rehabilitation and Support Services (AT&amp;R) inpatient services for younger and older people</li> <li>• Specialist Palliative Care Teams</li> <li>• children and young people's health</li> </ul>	<p>Refer / accept referrals from and liaise with re-individual as required to achieve continuity of care.</p>
<p>Related health / non-government organisations and services such as:</p> <ul style="list-style-type: none"> <li>• Māori primary health and community care services and organisations</li> <li>• Pacific people primary health and community care services</li> <li>• Consumer advocacy services, including Māori and Pacific advocacy services</li> </ul>	<p>Refer / accept referrals from and liaise with re individual as required to achieve continuum of care.</p>
<p>Support Organisations such as:</p> <ul style="list-style-type: none"> <li>• other community and social services</li> <li>• consumer support / advocacy groups and services, including Family Violence, Elder Abuse and Neglect Prevention</li> </ul>	<p>Refer and liaise with re individual as required to achieve continuity of care.</p>

The Service will develop and implement protocols for relationships with each of these services / agencies to facilitate open communication, continuity and smooth referral, follow-up and discharge processes.

## 10. Exclusions

See the Tier One Community Health, Transitional and Support Services service specification Section 3. Exclusions. In addition, this Service will not duplicate services already contracted for by the Ministry of Health, Accident Compensation Corporation (ACC), or other Government Departments and Agencies or District Health Boards (DHBs).

The Service is not intended to form an integral part of another specialist secondary services clinic or Primary Health Organisation (PHO) Practice Nurse delivered service.

Continence and stomal therapy consumable supplies are covered under their relevant funded service.

## **11. Quality Requirements**

### **11.1 General**

Refer to Tier One Community Health, Transitional and Support Services service specification Section 7 Quality Requirements. In addition, the following specific quality requirements also apply.

### **11.2 Consumables and Equipment**

The Service will supply or facilitate access to identified / prescribed consumables and / or supplies and / or equipment that are required for the delivery of the Service User's care or treatment programme. This will include on-going long-term supplies, such as wound dressings only where it is identified that the Service User's level of health care need requires ongoing management and oversight from the Service.

Nursing Services to support enteral feeding DOM109 is included in this Service.

No co-payment will be sought from Service Users for prescribed supplies and equipment unless otherwise stated or specified under the current Crown Funding Agreement Service Coverage Schedule for the Provision of Equipment and Modifications and other Services and Supplies.

Service Users requiring additional supplies over and above what is prescribed will need to pay for these additional supplies.

## 12. Purchase Units

Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Units apply to this Service.

Service User contacts in Hospital / Primary Health Care Team clinics are reported for the purchase codes below, if they are not a part of another service contract.

Purchase Code	PU Description	PU Definition	PU Measure	Reporting to National Collections
DOM 101	Community Services – Specialist Community Nursing	Professional nursing services provided in the community to people requiring personal health services. Includes post-discharge community services. (Refer to service specifications for details) Excludes costs of supplies for chronic conditions which are funded in other Community Services purchase units.	Contact	National Non Admitted Patient Collection (NNPAC)
DOM109	Community Services - enteral feeding	Enteral feeding supplies.	Service	NNPAC
M80012	Specialist Palliative care-community nursing	Specialist palliative care delivered in the community by specialist community nurses. Includes care co-ordination. Service can be provided as a nurse-led clinic in the community. Excludes primary palliative care nursing services funded under DOM101.	Client	NNPAC

Unit of measure	Unit of measure definitions
Client	Number of clients managed by the service in the reporting period (period is annual 1st July - 30th June) e.g. caseload at the beginning of the period plus all new cases in the period. 'Client' and 'Service User' are interchangeable.
Contact	The number of face to face contacts between a health professional and client or group of clients, for the provision of clinical services/interventions described in the services specification. A contact is equivalent to a visit. A contact excludes: phone consultations, discussions between health professionals about a client's care, and where the sole purpose of the contact is provision of supplies or consumables. Where a service is provided to a group of people simultaneously by one health professional it will be counted as one contact, one event.
Service	Service purchased in a block arrangement uniquely agreed between the parties to the agreement

## 13. Reporting Requirements

**These reporting requirements are for the National Non Admitted Patient Collection (NNPAC).**

Service User contacts in Hospital / Primary Health Care Team clinics are reported in Specialist Community Nursing Services (DOM101) if they are not a part of another service contract. The Service must comply with the requirements of national data collections for DOM101.

Primary palliative care contacts provided by specialist community nurses are included in DOM101.

Service Users receiving specialist palliative care delivered in the community by specialist community nurses are counted against M80012 and are able to be reported to NNPAC.

### 13.1 Additional Information and Reporting Requirements

A core set of information will be collected and provided on request to the Funder for monitoring service provision purposes and to support national consistency for service development and benchmarking.

For each Service User record the following information (not available from NNPAC)

- a. Service User complexity (high, medium or low) as defined in Appendix 1, The Risk Assessment Framework
- b. The referring Practitioner's name
- c. The reason for referral (Accident / non accident / other)
- d. Type of Service provided at each visit:
  - i. dressings and vacuum equipment for wound care
  - ii. intravenous catheters and associated equipment for IV antibiotic therapy
  - iii. urinary catheters
  - iv. gastrostomy and tracheostomy equipment and consumables
  - v. enteral feeding
  - vi. Specialist Community Nursing
  - vii. Palliative care services not covered by M80012

The Service must collect all data relevant to the business of the Service in line with the current National Specialist Palliative Care Data Definitions Standard<sup>4</sup>. This data must be readily available, at Service User/patient activity level, upon request by the DHB or the Ministry of Health.

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<sup>4</sup> HISO standards are periodically reviewed to assess and maintain their currency and new editions are published. Visit HISO website <http://w3www.ithealthboard.health.nz/who-we-work/hiso>



## 14. Glossary

Not Required

## 15. Appendices

### 15.1 APPENDIX 1 - RISK ASSESSMENT FRAMEWORK

#### **High Risk:**

##### **Failure to provide the service may result in the person:**

- being in unnecessary pain
- imminently being admitted as an in-patient for symptom control
- experiencing irreversible deterioration of their health status requiring their long-term inpatient medical/surgical management
- no longer being able to stay in their own residence
- where there is a risk of readmission to acute services following post-surgical discharge.

#### **Medium Risk:**

##### **Failure to provide the service may result in the person:**

- being unable to self-manage with resulting dependency on alternative options which may compromise their health status
- needing to be referred to a specialist for consultation and /or management of a health condition
- continuing with compromised health status which is not life-threatening but if left permanently unmanaged would lead to more extensive and/or additional problems
- being unable to self-manage thus placing significant pressure on the family, caregiver which may cause their health status to be compromised
- being admitted to short-term care to provide respite for the caregiver

#### **Low Risk:**

##### **Failure to provide the service may result in the person:**

- Living with a limited degree of compromised health status which is not in any way life threatening but intervention would enable them to return to optimal health status and/or function safely and independently

This framework is presented as a continuum of risk in terms of the Service User's health there will, therefore be people who will not be eligible for the Service as a result of assessment, or reassessment of their risk. This would relate to Service Users who on assessment or reassessment present with needs that are:

- **beyond** those suggested in the Framework as 'High Risk'. They have excessive and complex needs requiring:
  - management in an alternative environment eg, residential palliative care
  - continuous intervention by a clinical team which includes specialist medical involvement eg, inpatient facility
- **below** those suggested in the Framework as 'Medium Risk'. They are functionally independent and a level of compromised health status, which does not require specialist services. The services to meet their level of need could appropriately be provided by the GP and / or practice nurse alone where such services are available in the Service User's area
- **below** those suggested in the Framework as 'Low Risk'. They are Service Users for whom the sole purpose of the service would be to provide comfort, convenience or emotional security for them and / or family but for whom no clinical benefit would be gained by the provision of the Service.