

Disability Support Services

Tier Two Service Specification

Community Residential Support Services

Introduction

This Tier Two service specification provides the overarching service specification for Community Residential Services funded by Whaikaha - Ministry of Disabled People. It should be read in conjunction with the DSS Tier One Service Specification, which details requirements common to all services funded by Whaikaha.

The Provider must meet the requirements set out in the DSS Outcome Agreement, the Whaikaha DSS Tier One Service Specification and the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 and subsequent versions.

This specification defines the service requirements for both DSS1031 Community Residential Support services for people with Intellectual Disability (ID) and DSS1030 Community Residential Support services for people with Physical Disabilities (PD). Where requirements differ between the service groups (DSS1030, DSS1031) this specification will indicate how these differences apply.

Service Definition

The Ministry purchases community residential support services (the Services) for people with disabilities who need this level of support, so that they can enjoy a good quality of life and live in a place that feels like home, one that upholds personal dignity, independence and respects privacy. This service provides 24-hour support at the level necessary for people to have a safe and satisfying home life. This includes responsibility for People if they have to remain at home during the day for any reason.

People have a range of opportunities to foster relationships and to maximise their inclusion and participation in the community, both within the service and the wider society.

People are supported to achieve goals, engage in life enhancing activities (including those that may involve a degree of risk) have opportunities for learning and employment, participating in family and social life - like others at similar stages of life. This requires that people are supported by skilled staff who respect people's individuality, dignity and privacy and are sensitive and supportive of their aspirations, well-being and needs.

People are supported by staff who understand their means of communicating and can communicate effectively with them.

Providers work flexibly with the people they support to determine how support can best be provided in the home and community using the available funding, community resources and recognising individuals' aspirations, strengths, and abilities. Putting people at the centre of support enables them to have greater choice and control over their home and environment. This person centred approach enables people to receive quality supports within a safe and effective environment and reflects good leadership, skilled and experienced staff and effective management of resources.

2.1 Key Terms

2.1.1. The following are definitions of key terms used in this service specification:

Term	Definition
Advocacy	Advocacy means to advocate for or support the Person to express / defend how they feel about something and to advance their viewpoint. See http://advocacy.hdc.org.nz/resources for more information.
Behaviour Support	Behaviour support means a continuous process to manage challenging, complex or intrusive behaviours. There may be times when providers require specialist advice to assist them with behaviour support. The Ministry has contracted a provider of Specialist Behaviour Support Service that is accessed through NASC referral.
Dual diagnosis	Dual diagnosis means a condition whereby a person has two diagnoses e.g. a mental illness and an intellectual disability. People with dual diagnosis may require higher levels of support. Special expertise is needed to provide appropriate services for people with dual diagnosis.
Governance	Governance means the function of determining the organisation's direction, setting objectives and developing policy to guide the organisation in achieving its objectives and stated purpose. Effective governance arrangements recognise the interdependencies between corporate and clinical governance and integrate them to deliver safe and effective services to people with a disability.
Needs Assessment Service Co-ordination (NASC)	NASCs are services funded by the Ministry. Their roles are to determine eligibility, assess the Person's level of disability support needs, inform People / families / advocates of what the support package contains, discuss options and co-ordinate support services to meet those needs. NASCs co-ordinate such services, but do not themselves provide the services.

Term	Definition
People/Persons	“People” or “Person” means the individual/s using the services. It refers to the people who are eligible, have been referred by NASC, and are receiving the services described.
Primary Support Worker	Primary Support Worker means a staff member identified by the Person to support them. (This role may also be known by key worker or similar).
Personal Plan	Personal Plan means the document developed by the Person and the Provider to record the Person’s goals and objectives in the short and long term.
Specialist Behaviour Support Service	Specialist Behaviour Support Service means the provider contracted by the Disability Support Services group in the Ministry of Health to provide these services.
Quality of Life	Quality of Life means a conceptual model made up of eight core domains that include emotional wellbeing, interpersonal relationships, material wellbeing, personal development, physical wellbeing, self-determination, social inclusion and rights. By measuring a person’s quality of life individuals, organisations, and systems get information on what is enhancing quality of life and what needs to change (Reinder & Schalock, 2014).
Approved Service Standard	The Provider is required to maintain Certification as required under the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021. All overarching services must be compliant with partially new standards by 1 August 2023 and must be fully compliant with the new standards by 1 February 2024.

Service Objectives

3.1 The Provider will deliver on the following objectives:

- a. People will be encouraged and supported to increase their independence (to the capacity of the Person), self-reliance, and be provided with information that enables them choice and control.
- b. People will be supported to live in a home of their choice (where a choice of homes exists) and, as far as possible, with people with whom they are compatible. The home is accessible, homely, clean, well maintained and provides privacy and autonomy.
- c. People will live in an environment that safeguards them from abuse and neglect and ensures their personal security and safety needs are met.
- d. People will be encouraged to experience opportunities for optimum health, wellbeing, growth and personal development including staff proactively seeking opportunities and experiences for People they support.

- e. People will be actively supported to integrate into their community and to be involved with friends, partners and family, in accordance with their choice and personal goals.
- f. Support staff will be well trained and competent, including culturally competent, to positively support the Person and meet their needs.
- g. The Person, their family / whānau / guardians / advocate (with the consent of the Person), will have opportunity for input into all aspects of the service (such as staffing, Personal Planning, and Governance).

Service Performance Measures

- 4.1 Performance measures specify the key service areas the Purchasing Agency and the Provider will monitor to help assess service delivery.
- 4.2 Performance measures and reporting requirements are detailed in Appendix 3 of the Outcome Agreement. It is anticipated the performance measures will evolve over time to reflect the Ministry's priorities.

Eligibility and Entry

5.1 Service entry criteria

- 5.1.1. Access to residential services as described is by referral from the NASC following an individual needs assessment process. The assessment and service co-ordination processes followed by the NASC will ensure that the following criteria have been met for People referred to the Provider:
 - a. The Person is eligible - i.e. has a physical disability, intellectual disability and/or ASD (as assessed by an appropriate specialised needs assessor / professional).
 - b. The NASC indicates the Person requires the level of care and support provided by a residential service.
 - c. The Person, and their family/whānau or guardians and advocate (with the consent of the Person), have been involved in the selection of the Provider.
 - d. The Person is aged 16 years or over.
- 5.1.2 If a Person living in a DSS-funded community residential home has a change in disability support needs the Provider will ensure the Person's disability support needs are reassessed by the NASC.
- 5.1.3 The Provider will ensure that compatibility of the People in the service is considered when accepting any new referral and/or on a regular and ongoing basis.

5.1.4 Providers may only receive NASC referrals for the community residential service they are contracted for i.e. ID, or PD or both.

5.2 Residential Support Subsidy

5.2.1. People receiving residential support services who are also receiving a Main benefit from the Ministry of Social Development (MSD) Work and Income will generally be required to contribute to the cost of residential support (there are some exceptions).

5.2.2. The Provider will lodge an application for the Residential Support Subsidy with MSD Work and Income to collect this benefit contribution. The Person has a right to receive their benefit directly and pass on the subsidy to the Provider. Alternatively the Person may authorise MSD Work and Income to pay the subsidy directly to the Provider.

5.2.3. The Provider will notify MSD Work and Income within 24 hours of a Person's entrance or exit from the service.

5.3 Access Exclusions

5.3.1. Excluded from services under this specification will be any Person entitled to support under the Accident Compensation Act 2001 or where this service is not considered appropriate to meet the Person's identified support needs as identified by NASC and negotiated with the Provider.

5.3.2. Funding for services for People who choose to live in the following situations are excluded from this Specification, except by specific case by case negotiation with NASC:

- a. Living with own family/whānau/guardian
- b. The range of scenarios where a person is supported to live independently in their own dwelling place
- c. Rehabilitation Services.

Service Components

6.1 Personal Planning

Guidance:

People living in community residential services can expect a service that values their aspirations, strengths, capacities and gifts and supports a positive vision for their future. A framework for Personal Planning is helpful to assist People to think about what is important to them, and what they want to achieve now and into the future. Planning tools not only aid in the creation of a positive and life affirming vision; they also invite collaboration, self-direction, create momentum and commitment and provide practical steps with which to turn that vision into reality.

It is important that People should be able to make some mistakes and take positive risks as long as they are aware of the possible outcomes.

The Ministry recognises that best practice in Personal Planning will evolve over time and that there are a number of planning tools available, so Providers are expected to develop expertise within their organisation around supporting effective planning.

Remember:

- The person owns the plan and is involved and central to all decisions
- The process should be flexible and responsive, and not intrusive.
- Family and friends may be partners in the planning process
- The plan focuses on aspirations, strengths, capacity and gifts and looks to the future
- Long-term aspirational goals should be broken down into achievable short-term goals
- Planning builds a shared commitment to action
- That planning is an on-going process.

6.1.1 The Provider, with the Person, will:

- a. Develop a documented Personal Plan with each Person, using a format tailored to meet the Person's needs, within three months of entry to the Service, and ensure the Personal Plan is signed off by the Person or their family/ whānau/ guardian/ advocate.
- b. Review and amend the Personal Plan as appropriate whenever requested by the Person, or whenever a significant change occurs in the Person's life or at least annually, and ensure the reviewed plan is signed by the Person or their family/ whānau/ guardian/ advocate.
- c. Ensure the planning process is person-centred and led by the Person, and where approved by the Person, their family/ whānau/ guardian/ advocate, with support provided to ensure the Person is listened to and the planning experience is positive and relevant.

6.1.2 The Personal Plan will document:

- a. How the Person's specific communication requirements will be met
- b. The Person's short and long term goals (including any therapeutic programmes that have been arranged)
- c. The services, activities, inputs, any identified safeguards and resources which will be required to achieve steps towards these goals
- d. Indicate steps to achieving goals, people who will support the person with them, and who will have responsibility for overseeing them (this may include family/whānau/guardian/advocate)
- e. Recognition of specific needs e.g. cultural, emotional, physical and spiritual needs
- f. Risks associated with achieving and not achieving the goals and how these will be mitigated.

6.2 Primary Support Worker

Guidance:

A Primary Support Worker, chosen by the Person, acts as a key point of contact to build the foundation (over time) of a trusting and effective relationship. Ideally this will be a partnership where each other's strengths and capacities to contribute to the Person's good life are valued and form an ethical relationship with appropriate boundaries, both in personal interactions and formal roles.

6.2.1 The Provider will ensure:

- a. Every Person is supported to choose a staff member to be their Primary Support Worker and this is reviewed regularly to ensure the relationship is working well. (In the instance where a staff member is the preferred choice but is not available to function as a Person's Primary Support Worker, the Provider will work with the Person to explain the reasons why.)
- b. The Person, and their family/whānau/guardian/advocate (with the consent of the Person), are to be reasonably:
 - Kept informed of the Person's chosen Primary Support Worker
 - Informed in advance (when possible) of any staffing changes that necessitate a change to their Primary Support Worker and that they are presented with the opportunity to choose another Primary Support Worker. The Provider should work to minimise the frequency with which this is required.

6.2.2 The Primary Support Worker will be responsible for:

- a. Communicating effectively with the Person, their family / whānau / guardian / advocate as appropriate, using communication means known and understood by the person
- b. Building a relationship of trust with the Person so they get to know them well and are aware of the Person's daily interests and needs
- c. Supporting the Person to communicate with others as needed
- d. Supporting the development, implementation and review of the Personal Plan. This includes taking the lead where it is identified in the Personal Plan.

6.2.3 The Provider will ensure that the Primary Support Worker has undergone proper orientation, training and has access to ongoing support to perform their roles and responsibilities effectively.

6.3 Supervision, assistance and support

6.3.1. The Provider will supervise, assist, encourage and support People:

- a. To maintain or improve communication, behaviour, mobility, continence, responsibility and activities of daily living.
- b. To implement best practice interventions and rehabilitation strategies.
- c. To carry out activities of daily living and personal care as required, including using the toilet, dressing, bathing, hair washing, teeth cleaning, toe and finger nail care, eating and mobility. This includes supporting the Person's dignity of personal appearance appropriate to the place and conditions while maintaining choice.
- d. To develop skills and increase their ability to be independent.
- e. To maintain and strengthen relationships with family / whānau / guardians, advocates, friends, partners and/or spouse.
- f. 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.
- g. To take as much responsibility (including partial participation) as they can for domestic work such as laundry, cooking, cleaning in order to further independence.
- h. To be involved as much as possible in making decisions about their life and the way they live on a daily basis.
- i. To be aware of abuse prevention, including how to recognise if they or someone else is being abused, and what to do to report and stop that abuse and keep the Person safe.

- j. To understand their rights, including their right to access an independent advocate, and how they can access such a person.
- k. To independently manage their finances as far as is possible (as outlined in clause 6.5).
- l. To understand their right to make a complaint or express dissatisfaction without fear of recrimination.
- m. To have good emotional and physical health.

6.3.2 The Provider will:

- a. Ensure efficient running of the household.
- b. Provide opportunities for the Person to enjoy activities of the Person's choice including those agreed goals in the Person's Plan.

6.4 Access to the community

Guidance:

When People are supported as part of the community to contribute and share in activities and goals, this enables a connection with social networks, fosters personal development and social inclusion. Local communities are strongest when they enable all citizens to participate physically, socially, economically and politically.

6.4.1 The Provider will:

- a. Ensure People have access to the services of a general medical practitioner on a regular or as required basis. Every effort is made to enable People to access the GP of their choice including emergency / on call access to the services of a general medical practitioner 24 hours/day, seven days/week.
- b. Ensure People are supported to enroll with a local Primary Healthcare Organisation.
- c. Ensure the Person accesses specialist assessment and services as required – this may require the referral to be made by a GP or the NASC.
- d. Ensure People have regular access to services such as dentists, opticians, audiologists, hairdressers, solicitors and banking/financial services as required.
- e. Support the Person to explore their eligibility for and obtain a Community Services Card and/or High Health Users Card, as distributed by MSD Work and Income and that the card number is correctly referenced at the Person's GP/Medical Specialist and

Pharmacy.

- f. Ensure People have access to counselling, including sexuality education, gender identity counselling, relationship counselling and personal development as required.
- g. Support and encourage the Person to access vocational, educational, social, recreational and other interests.
- h. Ensure People have access to community facilities, leisure activities and opportunities for socialisation.
- i. Ensure People are supported so that they can participate in the New Zealand political process including but not limited to voting at national, regional and local levels as they choose.
- j. In DSS 1031 ID: The Provider will supply transport to People to attend day/vocational service (if transport is not funded by MSD Work and Income), educational (if not funded by the Ministry of Education), social, recreational and other interests to develop and maintain community links and networks.
- k. In DSS1030 PD: the Person is responsible for paying for transport to attend day / vocational service (if transport is not funded by MSD Work and Income), educational (if not funded by the Ministry of Education), social, recreational and other interests to develop and maintain community links and networks.

6.5 Personal Financial Management

Guidance:

Everyone handles their finances differently and everybody makes mistakes with their finances at times. Planning for how money will be handled, during the early planning and engagement process is important as this can assist the Person to better understand their personal finances.

Providers, from time to time, may need to assist People day to day with their money needs. It is recommended that staff do not directly handle a Person's money or use their PIN number, unless there is no other way to do it and there is a clearly documented and agreed process for how this works, including the organisation's oversight to prevent abuse of trust.

6.5.1 The Provider will:

- a. Support the Person in their right to control their own money (a Person has the right to control their own money unless this is removed under the Protection of Personal and Property Rights Act 1988 or other statutes).
- b. Develop and document a clear and auditable system and processes for

People who require assistance with their finances. This system must be understood and agreed by the Person and/or their family / whānau / guardian or advocate and staff involved.

- c. Ensure the Person has access to general financial advocacy or independent support, regardless of whether they have appointed a financial manager. It is desirable that different people are appointed to carry out the different roles.
- d. Ensure that in circumstances when the Person chooses to appoint a financial manager to manage their money for them, that this person or agency is not another Person in the home, nor employed by the Provider. The Person and/or their family / whānau/ guardian/ advocate will nominate someone external to the Provider as financial manager for his / her personal financial arrangements.
- e. Where the Person does not have a financial manager or a family / whānau / guardian / advocate to manage their money, and is unable to control their own finances, as a matter of last resort the Provider may act on behalf of the Person regarding financial decisions. The Provider must inform the Provider's governance body of these circumstances.
- f. Maintain documentation of financial matters for audit purposes by our evaluation agency when People do not control their own money. People should hold copies of the documentation of their finances when these are managed on their behalf.

6.6 Communication

Guidance:

Everyone communicates in different ways. They may include use of augmentative /alternative communication or body language. It's essential to understand a person's means of communication to be able to support them effectively and develop a meaningful relationship. Good interpersonal communication skills and the ability to communicate well with others have a positive impact on effectiveness of support (and the Person's life in general). To eliminate guesswork (and anxiety) staff should be open, honest, timely and transparent. Staff need to ensure that their words, feelings and actions match the intended message and they check that what has been heard and understood is the Person's point of view.

6.6.1 The Provider will:

- a. Understand a person's means of communication to engage and effectively interact with each Person they support. This may include, where required, learning and using tools such as Makaton, sign language or use of technology.
- b. Support the Person to make him/herself understood.

- c. Engage in effective and timely communication to build strong and trusting relationships with the Person, family/whānau/ guardian/ advocate, friends and others who are a part of the Person's life.
- d. Create an open environment where People and their family / whānau / guardian / advocate feel that their feedback – both positive and negative - about the service is welcomed by the Provider and used to improve outcomes for the Person.
- e. Develop, document and agree a communication protocol with People, their family/whānau/guardian/advocate as appropriate, neighbours and staff for use during emergency/crisis situations.

6.7 Involvement of the Person and their Family/Whānau and others

Guidance:

Many families wish to be involved in supporting their family member and can be a good foundation for the enhancement of the Person's inner strengths, gifts and talents, support, security, and identity. This requires Providers to be proactive, to facilitate, and value family/whānau and significant others in their unique role supporting the Person. The extent to which family/whānau and significant others are involved in the Person's life is ultimately the decision of the Person.

6.7.1 The Provider will:

- a. Proactively facilitate and value family / whānau / guardian / advocate in their role of supporting the Person to the extent that the Person wants this.
- b. Provide opportunity for the Person and their family /whānau / guardians / advocates to be involved in service operations and development as agreed with the Person. This should include:
 - Input into policies and procedures
 - Input into service planning and development
 - Input into staff selection/appointment
 - Involvement in internal quality monitoring
 - Input and active participation in the ongoing development, review and implementation of a Personal Plan
 - Representation on an advisory group and opportunity for input at Governance level
 - Involvement in planning, arranging and managing activities such as social and recreational activities
 - Full access to this service specification to enable the service user and their family / whānau / guardian / advocate to fully understand the nature of the service.

6.8 Staffing (including both paid staff and volunteers)

Guidance:

A key contributing factor to a high level of customer satisfaction with the service is staff with the necessary skills, knowledge, attitude and cultural competence. Research has shown that staff practices are one of the most reliable predictors of Quality of Life of People living in residential services. Physical and emotional well-being stems from positive and happy social interactions between People and staff or from enjoyment of activities initiated by staff. Often it is during the positive, warm and respectful interactions with staff that people visibly express their satisfaction.

The Ministry encourages Providers to support their staff to attain Foundation Skills Level 2 of the National Certificate in Health, Disability, and Aged Support as a minimum qualification.

6.8.1 The Provider will:

- a. Recruit and orient staff to ensure they understand the particular needs of the People they will support.
- b. Employ sufficient experienced and competent staff to provide good quality services tailored to meet the needs of the People in the service.
- c. Undertake safe recruitment practices for all staff (paid and volunteer) including confirming identity, obtaining references, conducting interviews and a comprehensive Police vetting check. This includes renewal of staff safety checks at least every three years to ensure ongoing suitability and capability.
- d. Empower staff to seek opportunities for People to further extend their strengths and abilities in the home and community.
- e. Actively encourage and develop Māori, Pasifika and other ethnicity health and disability workers to be employed at all levels of the service to support the Provider to meet People's cultural needs.
- f. Ensure staff develop and maintain a respectful and strengths-based understanding of People.
- g. Support staff to work in a way that enables People to make choices, and experience different activities which enhances their lives and increases their ability to make choices.
- h. Ensure all staff have relevant knowledge and skills about People's disabilities, medical conditions, and the management of these including administration of medication, first aid and maintaining appropriate documentation. This includes ensuring staff can recognise changes in a person's condition and know how to respond.
- i. Involve the Person and/or whānau/families in the staff recruitment process.

- j. Ensure ongoing assessment, awareness and responsiveness to People's functioning, abilities, well-being and support needs occurs.
- k. Ensure all staff have/develop and maintain the following core staff competencies:
 - Knowledge about the rights of People with disabilities, including awareness of the Human Rights Act 1993, The Code of Health and Disability Services Consumers' Rights, the United Nations Convention on the Rights Of Persons With Disabilities and the New Zealand Disability Strategy
 - Knowledge about disability types including intellectual disability, physical disability, Autism Spectrum Disorder, dual diagnosis
 - Knowledge about how best to meet the needs of People with disabilities, including medical needs, personal cares, social functioning
 - Identification, prevention and reporting of abuse and neglect including how to support people when abuse or neglect has occurred. Staff must be informed of the Ministry's zero tolerance of abuse and neglect
 - Person-centred services and personal planning
 - Awareness of the cultural needs of People with different ethnicities, including Māori, Pasifika and Asian People
 - Awareness of how to work positively with families / whānau
 - Physical care of People and the importance of good nutrition and exercise
 - Communication skills
 - Behavioural management using positive behaviour support
 - Knowledge of restraint minimisation policies and processes
 - Understanding health and disability as they relate to Māori and other cultures
 - Knowing the particular needs of People as they develop and their needs and wants change
 - First aid training appropriate to the role
 - Knowledge and understanding of organisational policies and processes.

6.9 Home and settings

Guidance:

Providers should always remember that while the residential setting may be a place of work for staff, it is first and foremost a Person's home.

6.9.1 The Provider will:

- a. Ensure secure, physically safe internal and external environments that meet the particular mobility and safety requirements of the People in the home.
- b. Ensure a Home Agreement is developed for each Person stating their rights and responsibilities, fees payable, services provided, date of commencement, planning and funding of holiday arrangements, purchase of any “shared” items for the home and so on. In particular the agreement must state how the residential subsidy portion of the Person’s MSD Work and Income benefit will be paid to the Provider, the amount that is left (which will be retained by the Person), and what goods and services are the Person’s responsibility to fund with that portion of their MSD Work and Income benefit.
- c. With the Person, review the Home Agreement at least annually, update it as needed and get it signed by the Person or their financial manager where they have delegated their financial management to this person. The Provider will give a copy of the Home Agreement to the Person.
- d. Ensure the necessary housing modifications are made to the home to allow appropriate access, bathroom modifications such as wet area showers, adaptations to kitchens to enable participation in meal preparation, and adaptations to telephones or other modifications as needed.
- e. Provide a comfortable, accessible, clean and well-maintained home and grounds as the Person’s home. The home will:
 - Include aids and equipment for general use to enable People to access their environment
 - Have no identifying features (signage) on the house or vehicles to denote the house/vehicle as different from others.
- f. Ensure that staff and Provider documentation and office equipment is located appropriately for the maintenance of an ordinary home environment, and in a way that respects People’s choice.
- g. Ensure that furnishings reflect age appropriate living environments, particularly in the lounge and living areas.
- h. Ensure that each Person has their own bedroom unless it is their clear choice and preference not to do so.
- i. Ensure that each house generally accommodates no more than four to six People per house. Any increase in the number of People per house above six must only occur when approved by the NASC. Any house with more than six people will be regularly reviewed to ensure it is still appropriate.

- j. Use staffing levels, behavioural management techniques and alternative activities as the primary means for providing physical safety for People rather than physical security features such as gates or fencing.
- k. Ensure availability of access to supplies of toothpaste, shaving equipment, sanitary supplies, and other toiletries which are not included in normal household supplies for occasions when a Person's own supply is not available.
- l. Provide laundry services, including personal laundry and care and maintenance of clothing.
- m. Provide cleaning services and supplies.
- n. Provide all furniture, furnishings, bedding and utensils. However People are encouraged to bring in their own furniture and furnishings if they wish and these are cared for appropriately. The Provider will list all personal items that belong to the Person and keep this inventory on the Person's file.
- o. Provide meals that meet generally accepted principles of good nutrition and cater to the needs of People on special diets including dietary supplements, and equipment for special requirements for eating/feeding. People should be offered choice and variety within these requirements, with provision for cultural preferences.
- p. Seek feedback regularly and at least annually from the People using the service, and their whānau/family, that the service is meeting their needs, is of good quality and identifying any areas for improvement.
- q. Support and encourage People to be actively involved in household tasks such as meal preparation (including planning and shopping), laundry and other everyday activities as much as they are able to be.
- r. Encourage People to make their home their own. Staff and People will be encouraged to make both the private and communal areas homely.
- s. Encourage People to have their personal belongings within the home and ensuring that these are respected.
- t. Support People to hold regular hui or home meetings at least monthly. This meeting can cover anything they choose to discuss, however ideally it will provide an opportunity to talk about People's rights, the service effectiveness and acceptability.
- u. Develop and maintain positive relationships within the home and with the immediate neighbouring community.
- v. Ensure People's privacy in the form of, but not limited to:
 - Access to a private telephone (including for toll calls, although the cost of this may be charged to the Person).

- Access to private space for social and other reasons.
 - Respect for a Person’s communications (including electronic and physical communication) for example, the ability to open letters and read in private unless assistance is required by the Person.
 - Use of bathroom and toilet.
- w. Ensure that the Person has access to a range of appropriate and meaningful activities, at home and/or outside of home when the Person is home during the day for any reason.

6.10 Health, medicine and first aid

6.10.1 The Provider will:

- a. Ensure and oversee the procurement, administration and safe storage of prescribed pharmaceuticals. Where medication cannot be managed by the Person then it must be administered by a competent employee.
- b. Provide first aid and emergency treatment appropriate for the degree of risk associated with the provision of the service.
- c. Ensure access to appropriate dressings and incontinence supplies/aids.
- d. Ensure People have the opportunity to maintain optimum health including, but not limited to, assisting with personal hygiene as required, providing healthy meals, opportunities for regular exercise and regular visits to health professionals.

6.10.2 In DSS1030 PD: The Provider will ensure Registered Nurse support to work with People who have high medical needs.

6.11 Risk Management

Guidance:

Allowing People the “dignity of risk” means respecting a Person’s autonomy and self-determination to make his or her own choices even if we may disagree. The goal is therefore not to eliminate risk, but to support the Person with appropriate safeguards, information and strategies to minimise the risk of harm, so the Person can take positive risks and make choices that are right for them. Staff must consider the rights of the People they support and should not restrict choices or actions unnecessarily.

6.11.1 The Provider will:

- a. Support People to make their own choices and identify and understand any areas of potential risk as a result of their choices.
- b. Support People to explore ways to mitigate potential harm and apply

appropriate safeguards.

- c. Maintain service user records to reflect clear, current, accurate and complete information.

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

- a. The safety and security of People while in the home and away from home. There will be times when responsibility transfers to another funded provider e.g. education provider or day programme. Such transfers must be clearly documented and agreed in advance.
- b. Dealing with challenging behaviours – when and how to access behaviour support services and when to access the NASC for reassessment/review.
- c. Ensuring first aid kit and Civil Defence supplies are stocked and updated as necessary.
- d. Emergency management and evacuation plans.

6.12 Supported Decision Making

Guidance:

Article 12 of the United Nations Convention on the Rights of Persons with Disabilities recognises that persons with disabilities have legal capacity on an equal basis with others. People should make their own decisions wherever possible, and if they need help, they should get the support that they need to make decisions. The aim is to provide support, instead of appointing another person to make decisions for them.

6.12.1 The Provider will:

- a. Support the Person to be the ultimate decision-maker about his/her life by giving them the assistance they need to make decisions for themselves.
- b. Develop and/or adopt effective supported decision making processes.

Exit Criteria

7.1 Voluntary Exit

7.1.1. In a situation where a Person voluntarily exits the home the Provider will notify the following:

- a. Family/whānau/guardian/advocate immediately
- b. MSD Work and Income Residential Support Subsidy unit within 24

- hours
- c. The NASC within 48 hours
- d. The Ministry (for payment processing purposes) through the next information reporting (invoicing) cycle.

7.2 Involuntary exit

- 7.2.1. The Ministry does not support the involuntary exit of a Person from a residential support service and views this as contrary to both the terms and conditions of the service Provider's contract.

If the Provider seeks to arrange an involuntary exit of a Person from their residential home and when an impasse has been reached between the service Provider and the Person or their family/ whānau/ guardian/ advocate, the Ministry of Health's policy "Disability Support Services Operational Policy for the Exceptional Circumstances when a Community Residential Support Service Provider requests the Exit of a Service User" must be followed.

<http://www.health.govt.nz/our-work/disability-services/disability-support-services-operational-policy>

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7.3 Moving homes

- 7.3.1. (This section refers to a service user moving from their existing home to another home with the same Provider or moving to a new home with a different provider.)
- 7.3.2. In addition to the requirements set out in section '7.10 Exit from Service' of the Tier 1 Service Specification, any decision that a Person 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 NASC agency prior to the move taking place. The service user, or the family / whānau / guardian and or advocate (with the permission of the service user) should provide written authority of agreement to such change. The NASC Agency must be involved in decisions where a service user is changing providers, service type or region.
- 7.3.3. The Provider will ensure that the service user is not moved from the home unless:
- a. Requested by the service user, their family / whānau / guardian and or advocate (if appropriate), or
 - b. Assessed prior to being moved by the NASC and with the involvement of any appropriate specialist support services; or
 - c. As agreed by the Ministry.

7.4 Admission to a Specialist Service

- 7.4.1 Where a Person requires admission to a mental health service or to a specialist provider, this change will involve input from a relevant specialist e.g. Psychiatrist or Behaviour Support team. The Provider will inform the relevant NASC and involve the NASC in assessing the change in the Person's needs.

7.5 Death

- 7.5.1. The Provider will notify the following on the death of any Person:
- a. Family / whānau / guardian / advocate immediately
 - b. MSD Work and Income Residential Support Subsidy unit within 24 hours
 - c. The NASC within 48 hours
 - d. The Ministry (for payment processing purposes) through the next information reporting (invoicing) cycle. If the death meets the definition of a critical incident, then reporting the death to the Ministry must be within the time frame specified for a critical incident in the Outcome Agreement.
 - e. The DSS Contract Relationship Manager as soon as is reasonably practicable.

Guidelines, Policies and Legislation

8.1 Legislation

- 8.1.1 The Provider will meet all relevant legislative and regulatory requirements, including the requirement for Certification for homes of five or more People as required under the Health and Disability Services (Safety) Act 2001.
- 8.1.2 For homes of less than five People, the Provider will meet the Home and Community Support Services Standards.

8.2 Policies

- 8.2.1 In addition to the requirements for certification, or elsewhere specified, the Provider will have regularly maintained documented policies/protocols for the following aspects of service delivery:
- a. Managing challenging behaviour in the least restrictive way possible
 - b. Medication administration and review
 - c. Prevention, management and risk reduction of abuse and support for People receiving support
 - d. Clinical aspects of support delivery
 - e. Healthy lifestyle issues including: fostering respectful relationships,

contraception and sexually transmitted disease/safe sex.

8.3 Guidelines, frameworks and research

- 8.3.1. The Ministry is developing guidelines for the prevention and management of abuse in DSS residential services. Providers should use these as they, and any future updates, are issued. They will be available through the Ministry of Health Publications Website.
- 8.3.2. Providers are encouraged to make use of the Let's Get Real: Disability Framework. <http://www.tepou.co.nz/library/tepou/lets-get-real-disability>
- 8.3.3. The Provider will adapt their Services to respond to new research findings, best practice developments, policies and guidelines in the disability field, to improve outcomes for People.

Linkages

- 9.1 The Provider will have linkages to ensure that People have access to the following as required:
 - a. Primary and secondary medical services
 - b. Needs Assessment and Service Coordination (NASC) services
 - c. Independent advocates and advocacy services
 - d. Equipment Management Services (EMS)
 - e. Specialised assessment services
 - f. Mental Health Services
 - g. Behavioural Support Services
 - h. Assessment Treatment & Rehabilitation Services
 - i. Appropriate ethnic and cultural groups
 - j. Disability consumer groups and Disabled Persons' Organisations
 - k. Government departments such as MSD Work and Income
 - l. Māori social and community services and support groups e.g. local Kaumatua, marae, whānau groups, counselling, budget and family support services
 - m. Supported work and other employment programmes
 - n. Day activity/vocational/educational services
 - o. Community services, e.g. Libraries, swimming pools.

9.2 Equipment Services

- 9.2.1. People eligible for DSS-funded equipment may retain any equipment they have been issued that is intended for their sole use when they move to live in a community residential support home. Any other equipment should be returned to the EMS provider.
- 9.2.2. If a Person needs new personal equipment while living in community residential support services, they will need to have an assessment and a service request may be made. The assessment for People living in community residential support should be undertaken by an appropriately accredited EMS Assessor.
- 9.2.3. The equipment must be primarily for the Person's individual use or may be shared with another resident. Factors for consideration are:
 - a. The availability or suitability of other equipment within their residential setting to meet the Person's needs
 - b. Equipment may have a shared use (e.g. a hoist) where other People living in the same home have similar equipment needs
 - c. The impact of the equipment not being provided, such as:
 - Increased level of assistance the Person might require from support staff
 - Risk of deterioration of their functional skills
 - Risk to their personal health and safety such as skin breakdown, development of joint contractures or escalation of challenging behaviour.
- 9.2.4. When a Person leaves one residential service and moves to another or if they leave community residential support services they can take their equipment to their new home. The Provider will supply equipment necessary for general use by the People in the home.
- 9.2.5. Refer to the Equipment Manual for further details:
<http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/519>.

9.3 Behaviour Support

- 9.3.1. When delivering behaviour support the Provider will:
 - a. Ensure implementation of Behaviour Support is consistent with relevant Ministry guidelines and policies.
 - b. Ensure that challenging behavior is identified early and a referral is initiated to the Specialist Behaviour Support Service where the Provider requires support to manage the behaviour effectively. The Specialist Behaviour Support Service may be consulted for advice outside of a formal referral.
 - c. Cooperatively support the Specialist Behaviour Support Service, Dual

Diagnosis or Assessment Treatment & Rehabilitation Service to develop and implement any behaviour support or treatment plan for a Person.

- d. Ensure the home has and operates a policy of using positive behaviour support for managing challenging behaviours that incorporates the principle that a Person's freedom should be restricted only for safety reasons.
- e. Manage any behaviour support through the use of a formal written plan so that a consistent and supportive approach is demonstrated. The behaviour support plan will be integrated with the Personal Plan and other planning done by the Provider to support the Person. The behaviour support plan has the following components:
 - Assessment (including measurement and quantification of the behaviours of concern)
 - Implementation planning (including training of support people)
 - Implementation
 - Review of progress
 - Maintenance.
- f. Document and measure progress when implementing a behaviour support plan by gathering the appropriate data (advised by the behaviour support specialist) on the frequency, duration and impact of the behaviours being managed.
- g. Ensure all people assisting with the behaviour support plan are trained in how to use the techniques specified in the plan prior to the plan implementation. The Provider will support training delivered by the Specialist Behaviour Support Service and support staff to apply the skills learned.
- h. Ensure behaviour support plans are only written by people with specialist skills in behaviour support. Plans must be signed off by a Registered Psychologist who is experienced in the management of challenging behaviour prior to the behaviour support plan commencing.

Excluded from purchase price

10.1 The following items are excluded from the purchase price. The Person is responsible for:

- a. Clothing and personal toiletries, other than ordinary household supplies (e.g. household cleaning supplies etc). However, the Provider will ensure these items are purchased by the Person, next of kin or agent as required and that items purchased are consistent with the preferences of the person

- b. Telecommunications made by the Person
- c. Services such as community dentists, opticians, hairdressers and solicitors. If the costs of these services fall beyond their ability to pay the Person will be supported to negotiate with MSD Work and Income for access to special funds under their entitlements
- d. User part-charges for pharmaceuticals and medical costs e.g. GP, Medical Specialists
- e. Transport costs to family/whānau/guardian visits outside their local community.

10.2 The following items are generally purchased by the Ministry through a separate service agreement, or another service purchaser. However the Provider will ensure the Person has access to:

- a. Educational services and travel to those services as funded through the Ministry of Education
- b. Specialist dental services as funded directly by the Ministry of Health through District Health Boards (DHB) or directly with dental practitioners for specialist dental services requiring general anaesthetic
- c. Incontinence supplies (these are funded by DHBs¹)
- d. Specialist behaviour support service
- e. Day programmes
- f. Other personal health services such as District Nursing.

Note: The Provider may be required to support the implementation of plans or strategies developed by these other services, such as implementation of a Behaviour Support Plan.

Complaints Resolution

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

- a. There is a process to resolve the complaints or air any grievances either between People or between the Provider and other Person(s), Family/Whānau and other people significant to the Person. People, family/whānau are aware and know how to access the Provider's complaints process.
- b. There is mediation support available if the parties are unable to resolve the complaint through the above forum. The mediator should be agreeable to both parties. As part of the complaints process People,

¹ Section 4.14 of the Ministry of Health. 2014. *2014/15 Service Coverage Schedule*. Wellington: Ministry of Health.

family/whānau must be made aware of other avenues they can approach with their concern should a satisfactory resolution be unable to be reached.

- c. People have support to access independent advocacy services. People are informed they have the right to an advocate or support person to help them express their wishes (especially those who cannot speak for themselves), and the Provider will support the Person to access advocacy of their choice. The support/advocacy may be accessed through a Disabled Persons' Organisation, Health and Disability Commission Advocacy provider, friends and family, other residents or other sources.

Purchase Units

12.1 Purchase Units are defined in the joint DHB and Ministry of Health's Nationwide Service Framework Purchase Unit Data Dictionary published on [Contracts and service specifications | Whaikaha - Ministry of Disabled People](#)

12.2 The following Purchase Units apply to this Service.

Purchase Unit Code	Purchase Unit Description	Purchase Unit Definition	Unit of Measure
DSS1030	Residential Care: Community: Physical Disability	Residential Care services that provide short and long term care in the community setting for clients with a lifelong physical disability.	Occupied bed day
DSS1031	Residential Care: Community: Intellectual Disability	Residential Care services that provide short and long term care in the community setting for clients with a lifelong intellectual disability.	Occupied bed day

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.
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Reporting Requirements

13.1 Reporting Requirements (including any provider specific reporting requirements) are included in Appendix 3 of the Outcome Agreement.