Disability Support Services
Service Specification
Residential Support Services

1. Introduction

1.1 This is the overarching service specification for Community Residential Services in Community Group Homes funded by Disability Support Services (**DSS**) - Ministry of Social Development (**the Purchasing Agency**).

1.2 The Provider must meet the requirements set out in this service specification, as well as the:

a. Residential Services Panel Agreement (**Panel Agreement**), including the Residential Services Terms and Conditions, all Schedules that form part of the Panel Agreement, and any Improvement Plan, including any variations to any of the above; and

b. Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021) and subsequent versions; and

c. Tier One Service Specification.

1.3 This service specification defines the service requirements for:

a. Community Residential Support services for people with Intellectual Disability (**ID**); and

b. Community Residential Support services for people with Physical Disabilities (**PD**).

1.4 Where requirements differ between the service groups (ID, PD) this specification will indicate how those differences apply.

2. Service Definition

2.1 The Purchasing Agency funds Community Residential Services in Community Group Homes for Disabled People 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 (the **Services**).

2.2 The Services are defined as follows:

a. 24-hour support each day of the year at the level necessary for each Disabled Person to have a safe and satisfying home life. This includes responsibility for each Disabled Person if they have to remain at home during the day for any reason;

b. ensuring each Disabled Person has 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;

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

d. ensuring each Disabled Person is supported by staff who understand their means of communicating and can communicate effectively with them;

e. working flexibly with Disabled People 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; and

f. putting Disabled People at the centre of support so that they have greater choice and control over their home and environment. This person-centred approach enables Disabled People to receive quality supports within a safe and effective environment and reflects good leadership, skilled and experienced staff, and effective management of resources.

3. Key Terms

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

Term	Definition
Advocacy	To advocate for or support the Disabled Person to express / defend how they feel about something and to advance their viewpoint. See The Advocacy Service - a free and independent service — Health & Disability Commissioner for more information.
Approved Service Standard	The service standard that the Provider must meet to maintain Certification under the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021.
Authorised Support Coordination Agency	An entity or group authorised by the Purchasing Agency to allocate support (a NASC or an EGL Site).

Term	Definition
Behaviour Support	A continuous process to manage challenging, complex or intrusive behaviours. There may be times when a Provider requires specialist advice to assist them with behaviour support. The Purchasing Agency has a contracted provider of Specialist Behaviour Support Service that can be accessed through Authorised Support Coordination Agency referral.
Disabled Person/Disabled People	A person: • whom an Authorised Support Coordination Agency has assessed as requiring the Services; • for whom the Provider has received a Referral from an Authorised Support Coordination Agency relating to that person; and • for whom the Provider has accepted that Referral. .
Dual Diagnosis	A condition whereby a Disabled Person has two diagnoses e.g. a mental illness and an intellectual disability. Disabled People with dual diagnosis may require higher levels of support. Special expertise is needed to provide appropriate services for Disabled People with dual diagnosis.
EGL Site	A group within the Purchasing Agency responsible for facilitating access to disability support using the Enabling Good Lives approach.
Governance	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 Disabled People.
Needs Assessment Service Co-ordination (NASC)	A needs assessment service coordination organisation appointed by the Purchasing Agency to determine a person's residential care needs, and the level of care required for that person, such processes to be determined by the Purchasing Agency from time to time.
Personal Plan	The document developed by the Disabled Person and the Provider to record the Disabled Person's goals and objectives in the short and long term.
Primary Support Worker	A staff member of the service identified by the Disabled Person as being the main person to support them (this role may also be known by key worker or similar).
Quality of Life	A conceptual model made up of eight core domains that include emotional wellbeing, interpersonal relationships,

Term	Definition
	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).
Specialist Behaviour Support Service	A provider contracted by the Purchasing Agency to provide specialist behaviour support services.

3.2 Any capitalised terms that are not defined in this service specification have the same meaning as that specified in the Residential Services Terms and Conditions.

4. Service Objectives

4.1 The Provider will deliver on the following objectives when providing the Services:

a. Disabled People will be encouraged and supported to increase their independence (to the capacity of the Disabled Person), self-reliance, and be provided with information that enables them choice and control.

b. Disabled 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. Disabled People will live in an environment that safeguards them from abuse and neglect and ensures their personal security and safety needs are met.

d. Disabled People will be encouraged to experience opportunities for optimum health, wellbeing, growth and personal development including staff proactively seeking opportunities and experiences for Disabled People they support.

e. Disabled 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 Disabled People and meet their needs.

g. Disabled People (and, to the extent consistent with their will and preference or any relevant court order, their family/whānau, guardian or advocate), will have opportunity for input into all aspects of the service (such as staffing, Personal Planning, and Governance).

h. Disabled People may access support and Advocacy from existing community-based providers such as DAPAR or People for Us and other family violence or sexual violence community services.

i. Unless specifically permitted to do so under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, the Provider will not use seclusion, and will not use restraint where behavioural support interventions are better methods of ensuring the Disabled Person's safety. See Prevention and Management of Abuse: Guide for services funded by Disability Support Services (and any document that replaces this document in the future).

5. Performance Measures

5.1 The Purchasing Agency may notify the Provider, from time to time, of the Performance Measures it will use to monitor and assess the Provider's delivery of the Services, and its compliance with its obligations.

6. Eligibility and Entry

Service eligibility and entry criteria

6.1 Access to the Services described in this service specification is by referral from an Authorised Support Coordination Agency following an individual assessment process. The assessment and service co-ordination processes followed by the Authorised Support Coordination Agency will ensure that the following criteria have been met for each Disabled Person referred to the Provider:

a. the Disabled Person has a Physical Disability and/or Intellectual Disability[1] as assessed by an appropriate specialised needs assessor / professional;

b. the Authorised Support Coordination Agency determines that the Disabled Person requires a level of care and support that is provided by the Provider;

c. the Disabled Person (and, to the extent consistent with their will and preference or any relevant court order, their family/whānau, guardian or advocate), has been involved in the selection of the Provider; and

d. the Disabled Person is aged 16 years or over.

6.2 If a Disabled Person receiving Services from the Provider has a change in their disability support needs, the Provider will ensure the Disabled Person's

[1] Where a Person has another condition such as epilepsy, or a neurodevelopmental condition, they must also have an Intellectual Disability and/or Physical Disability to access Residential Care.

disability support needs are reassessed by the Authorised Support Coordination Agency.

6.3 The Provider will consider the compatibility of Disabled People in the Service when accepting any new referral and on a regular and ongoing basis.

6.4 The Provider may only receive Authorised Support Coordination Agency referrals for the Community Residential Service they are contracted for (i.e. ID, PD, or both).

Residential Support Subsidy

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

6.6 For each Disabled Person who may be entitled to receive, or is receiving, the Residential Support Subsidy (**Subsidy**), the Provider will lodge an application for the Residential Support Subsidy with MSD Work and Income to collect this benefit contribution. A Disabled Person has a right to receive the Subsidy directly and pass on the Subsidy to the Provider. Alternatively, a Disabled Person may authorise MSD Work and Income to pay the Subsidy directly to the Provider.

6.7 The Provider must notify MSD Work and Income within 24 hours of a Disabled Person's entry to or exit from the Service.

Access Exclusions

6.8 The following people are not eligible for the Services:

a. a person who is entitled to support under the Accident Compensation Act 2001;

b. where this service is not considered appropriate to meet the person's identified disability support needs as identified by the Authorised Support Coordination Agency and discussed with the Provider;

c. a person who has Autism Spectrum Disorder and does not also have an Intellectual Disability and/or Physical Disability.

6.9 Funding for services for people in the following living arrangements is excluded from this service specification, unless agreed on a specific case by case basis by the Authorised Support Coordination Agency and the Purchasing Agency:

a. people living with their family/whānau/guardian;

b. people supported to live independently in their own dwelling place;

c. people living in specialist rehabilitation services.

7 Service Components

Personal Planning

Guidance:

Disabled 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 the Disabled Person 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 the Disabled Person is allowed to make some mistakes and take positive risks with their personal plans as long as they are aware of the possible outcomes.

The Purchasing Agency recognises that best practice in personal planning will evolve over time and that there are a number of planning tools available, so the Provider is expected to develop expertise within their organisation to support effective planning.

Remember:

- The Disabled Person owns the plan and is involved and central to all decisions.
- The process should be flexible and responsive, and not intrusive.
- To the extent consistent with the Disabled Person's will and preference or any relevant court order family/whānau/guardians/advocates 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.

7.1 The Provider, with the Disabled Person, will:

a. Develop a documented Personal Plan, using a format tailored to meet the Disabled Person’s needs, within three months of entry to the Service, and ensure the Personal Plan is signed by the Disabled Person and/or as appropriate in the circumstances, their family/whānau/guardian/ advocate.

b. Review and amend the Personal Plan as appropriate whenever requested by the Disabled Person, or whenever a significant change occurs in the Disabled Person’s life or at least annually, and ensure the reviewed plan is signed by the Disabled Person and/or as appropriate in the circumstances, their family/whānau/guardian/advocate.

c. Ensure the planning process is person-centred and led by the Disabled

Person, and, where approved by the Disabled Person, their family/whānau/ guardian/ advocate, with support provided to ensure the Disabled Person is listened to and the planning experience is positive and relevant.

7.2 The Personal Plan will document:

a. how the Disabled Person's specific communication requirements will be met;

b. the Disabled Person's short and long-term goals (including any therapeutic programmes that have been arranged);

c. steps to achieving goals, people who will support the Disabled Person with them, and who will have responsibility for overseeing them (this may include family/whānau/guardian/advocate);

d. the services, activities, inputs, any identified safeguards, and resources which will be required to achieve steps towards these goals;

e. recognition of specific needs e.g. cultural, emotional, physical and spiritual needs; and

f. risks associated with achieving and not achieving the goals and how those risks will be mitigated.

Primary Support Worker

Guidance:

A Primary Support Worker, chosen by the Disabled 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 Disabled Person's good life are valued and form an ethical relationship with appropriate boundaries, both in personal interactions and formal roles.

7.3 The Provider will ensure:

a. the Disabled 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 the Disabled Person's Primary Support Worker, the Provider will work with the Disabled Person to explain the reasons why; and

b. the Disabled Person, and their family/whānau/guardian/advocate (with the consent of the Disabled Person), are to be reasonably:

- kept informed of the Disabled Person's chosen Primary Support Worker; and
- 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.

7.4 The Provider will ensure that the Primary Support Worker is responsible for:

a. communicating effectively with the Disabled Person, their family/whānau/guardian/advocate as appropriate in the circumstances, using communication means known and understood by the Disabled Person;

b. building a relationship of trust with the Disabled Person so they get to know them well and are aware of the Disabled Person's daily interests and needs;

c. supporting the Disabled Person to communicate with others as needed; and

d. supporting the development, implementation and review of the Personal Plan. This includes taking the lead where it is identified in the Personal Plan.

7.5 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.

Supervision, assistance and support

7.6 The Provider will supervise, assist, encourage and support the Disabled Person to:

a. maintain or improve communication, behaviour, mobility, continence, responsibility and activities of daily living;

b. implement best practice interventions and rehabilitation strategies;

c. 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 Disabled Person's dignity of personal appearance appropriate to the place and conditions while maintaining choice;

d. develop skills and increase their ability to be independent;

e. maintain and strengthen relationships, as appropriate in the circumstances, with family/whānau/guardians, advocates, friends, partners and/or spouses;

f. 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. take as much responsibility (including partial participation) as they can

for domestic work such as laundry, cooking and cleaning in order to further independence;

h. be involved as much as possible in making decisions about their life and the way they live on a daily basis;

i. 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 Disabled Person safe;

j. understand their rights, including their right to access an independent advocate, and how they can access such a person;

k. independently manage their finances as far as is possible (as outlined in clause 7.11);

l. understand their right to make a complaint or express dissatisfaction without fear of recrimination (as outlined in clause 12); and

m. have good emotional and physical health.

7.7 The Provider must:

a. ensure efficient running of the Disabled Person's household; and

b. provide opportunities for the Disabled Person to enjoy activities of the Disabled Person's choice, including those agreed goals in the Disabled Person's Plan.

Access to the community

> ***Guidance***:
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> When the Disabled Person is 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.

7.8 The Provider must:

a. ensure the Disabled Person has access to the services of a general medical practitioner (**GP**) on a regular or as required basis. Every effort must be made to enable the Disabled Person 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 the Disabled Person is supported to enrol with a local Primary Healthcare Organisation;

c. ensure the Disabled Person accesses specialist assessment and services as required – this may require the referral to be made by a GP or the Authorised Support Coordination Agency;

d. ensure the Disabled Person has regular access to services such as dentists, opticians, audiologists, hairdressers, solicitors and banking/financial services as required;

e. support the Disabled 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 Disabled Person's GP/Medical Specialist and Pharmacy;

f. ensure the Disabled Person has access to counselling, including sexuality education, gender identity counselling, relationship counselling and personal development as required;

g. support and encourage the Disabled Person to access vocational, educational, social, recreational and other interests;

h. ensure the Disabled Person has access to community facilities, leisure activities and opportunities for socialisation; and

i. ensure the Disabled Person is 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.

7.9 In ID Services, the Provider must provide transport for the Disabled Person to attend day/vocational services (if transport is not funded by MSD Work and Income), educational services (if not funded by the Ministry of Education),social, recreational and other activities to develop and maintain community links and networks.

7.10 In PD Services, the Disabled Person is responsible for paying for transport to attend day/vocational service (if transport is not funded by MSD Work and Income), educational services (if not funded by the Ministry of Education), social, recreational and other activities to develop and maintain community links and networks.

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 Disabled Person to better understand their personal finances.

Providers, from time to time, may need to assist the Disabled Person day to day with their money needs. The Provider must have adequate controls in place to manage the risk of abuse of trust.

7.11 The Provider must:

a. support the Disabled Person in their right to control their own money (a Disabled 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 Law);

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 Disabled Person and/or their family/whānau/ guardian or advocate and staff involved;

c. ensure that staff do not directly handle the Disabled Person's money or use their PIN number unless there is no reasonable alternative, in which case the Provider must have in place adequate controls to manage the risk of abuse of trust including clearly documented and agreed processes and Provider oversight;

d. ensure the Disabled 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;

e. ensure that in circumstances when the Disabled Person chooses to appoint a financial manager to manage their money for them, that this person or agency is not another Disabled Person in the home, nor a person employed by the Provider. The Disabled Person and/or as is appropriate in the circumstances, their family/whānau/ guardian/ advocate will nominate someone external to the Provider as financial manager for their personal financial arrangements;

f. where the Disabled 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 Disabled Person regarding financial decisions. The Provider must ensure that its Governance body is made aware if the Provider will be making financial decisions on behalf of the Disabled Person; and

g. create and maintain documentation of financial matters for audit purposes when Disabled People do not control their own money. Disabled People should hold copies of the documentation of their finances when these are managed on their behalf.

Communication

Guidance:

Everyone communicates in different ways. They may include use of augmentative /alternative communication or body language.

It is 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 Disabled 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 Disabled Person's point of view.

7.12 The Provider must:

a. understand the Disabled Person's means of communication to engage and effectively interact with each Disabled Person they support. This may include, where required, learning and using tools such as Makaton, sign language or use of technology;

b. support the Disabled Person to make themselves understood;

c. engage in effective and timely communication to build strong and trusting relationships with the Disabled Person, and as is appropriate in the circumstances, family/whānau/ guardian/advocate, friends and others who are a part of the Disabled Person's life;

d. create an open environment where the Disabled Person and, as is appropriate in the circumstances, their family/whānau/guardian/ advocate feel that their feedback – both positive and negative - about the Services is welcomed by the Provider and used to improve outcomes for the Disabled Person; and

e. develop, document and agree a communication protocol with the Disabled Person to form part of their Personal Plan, and as is appropriate in the circumstances, their family/whānau/guardian/advocate, neighbours and staff for use during emergency/crisis situations.

Involvement of the Disabled 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 Disabled 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 Disabled Person. The extent to which family/whānau and significant others are involved in the Disabled Person's life is ultimately the decision of the Disabled Person.

7.13 The Provider must:

a. proactively facilitate and value family/whānau/guardian/advocate in their role of supporting the Disabled Person, to the extent that the Disabled Person wants this;

b. provide opportunity for the Disabled Person and their family/whānau/ guardians/advocates to be involved in service operations and development as agreed with the Disabled Person. This will 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 opportunities for input at the Provider's Governance level;
- involvement in planning, arranging and managing activities such as social and recreational activities; and
- full access to this service specification to enable the Disabled Person and their family/whānau/guardian/advocate to fully understand the nature of the Services.

Staffing (including both paid staff and volunteers)

Guidance:

A key contributing factor to a high level of a Disabled Person's 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 Disabled People living in residential services.

Physical and emotional well-being stems from positive and happy social interactions between Disabled 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 Purchasing Agency encourages Providers to support their staff to attain New Zealand Certificate in Health and Wellbeing (Level 2).

7.14 The Provider must:

a. recruit and orient staff to ensure they understand the particular needs of each Disabled Person they will support;

b. employ sufficient experienced and competent staff to provide good quality services tailored to meet the needs of each Disabled Person 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. 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 each Disabled Person to further extend their strengths and abilities in the home and community;

e. actively encourage and develop Māori, Pacific and other ethnicity health and disability workers to be employed at all levels of the service to support the Provider to meet each Disabled Person's cultural needs;

f. ensure staff develop and maintain a respectful and strengths-based understanding of Disabled People;

g. support staff to work in a way that enables each Disabled Person 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 each Disabled Person'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 Disabled Person's condition and know how to respond;

i. involve the Disabled Person and/or, where appropriate in the circumstances, their family/whānau/guardian/advocate in the staff recruitment process;

j. ensure ongoing assessment, awareness and responsiveness to each Disabled Person'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 and Dual Diagnosis;
- knowledge about how best to meet the needs of Disabled People including medical needs, personal cares, social functioning;
- trauma-informed practices;
- identification, prevention, responding to, and reporting abuse and neglect including how to support people when abuse or neglect has occurred. Staff must be informed of the Purchasing Agency's zero tolerance of abuse and neglect;
- person-centred services and personal planning;

- awareness of the cultural needs of Disabled People with different ethnicities, including Māori, Pacific and Asian People, and cultural safety;
- awareness of how to work positively with families/ whānau/guardians/advocates;
- physical care of Disabled People and the importance of good nutrition and exercise;
- communication skills;
- behavioural management using positive Behaviour Support;
- knowledge of restraint minimisation and safeguarding policies and processes;
- understanding health and disability as they relate to Māori and other cultures;
- knowing the particular needs of each Disabled Person as they develop and their needs and wants change;
- first aid training appropriate to the role; and
- knowledge and understanding of the Provider's organisational policies and processes.

Home and settings

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

7.15 The Provider must:

a. ensure secure, physically safe internal and external environments that meet the particular mobility and safety requirements of each Disabled Person in the home;

b. ensure an agreement is developed for each Disabled 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 (**Home Agreement**). In particular the Home Agreement must state how the Subsidy portion of the Disabled Person's MSD Work and Income benefit will be paid to the Provider, any amount that is left (which will be retained by the Disabled Person), and what goods and services are the Disabled Person's responsibility to fund with that portion of their MSD Work and Income benefit. The Home Agreement must be signed by the Disabled Person or their financial manager (where they have delegated their

financial management to this person). Once agreed, the Provider will give a copy of the Home Agreement to the Disabled Person;

c. with the Disabled Person, review the Home Agreement at least annually, update it as needed and get any changes signed by the Disabled Person or their financial manager, and provide a copy of the updated Home Agreement to the Disabled 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. adhere to the Purchasing Agency's operational policy that it may have relating to exceptional modifications or damages;

f. provide a comfortable, accessible, clean and well-maintained home and grounds as the Disabled Person's home. The home will:

- include aids and equipment for general use to enable the Disabled Person to access their environment; and
- have no identifying features (signage) on the house or vehicles to denote the house/vehicle as different from others;

g. 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 the Disabled Person's choice;

h. ensure that furnishings reflect age-appropriate living environments, particularly in the lounge and living areas;

i. ensure that the Disabled Person has their own bedroom unless it is their clear choice and preference not to do so;

j. ensure that each house generally accommodates no more than four to six Disabled People per house. Any increase in the number of Disabled People per house above six must only occur when approved by the Authorised Support Coordination Agency. Any house with more than six people will be regularly reviewed by the Authorised Support Coordination Agency ensure it is still appropriate;

k. ensure implementation of mechanisms to minimise restraint such as behavioural management techniques, alternative activities and staffing levels, as the primary means for ensuring physical safety for Disabled People rather than physical security features such as gates or fencing;

l. 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 Disabled Person's own supply is not available;

m. provide laundry services, including personal laundry and care and maintenance of clothing;

n. provide cleaning services and supplies;

o. provide all furniture, furnishings, bedding and utensils. However, the Disabled Person should be encouraged to bring in their own furniture and furnishings if they wish and these must be cared for appropriately. The Provider will list all personal items that belong to the Disabled Person and keep this inventory on the Disabled Person's file;

p. provide meals that meet generally accepted principles of good nutrition and cater to the needs of the Disabled Person on special diets including dietary supplements, and equipment for special requirements for eating/feeding. The Disabled Person should be offered choice and variety within these requirements, with provision for cultural preferences;

q. seek feedback regularly and at least annually from the Disabled People receiving the Service, and, as is appropriate in the circumstances, their family/whānau/guardian/advocate, that the Service is meeting their needs, is of good quality and identifying any areas for improvement, and use that feedback to improve the quality of the services;

r. support and encourage the Disabled Person 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;

s. encourage the Disabled Person to make their home their own. Staff and the Disabled Person will be encouraged to make both the private and communal areas homely;

t. encourage the Disabled Person to have their personal belongings within the home and ensuring that these are respected;

u. support Disabled 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 Disabled People's rights, the service effectiveness and acceptability;

v. develop and maintain positive relationships within the home and with the immediate neighbouring community;

w. ensure the Disabled Person'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 Disabled Person);
- access to private space for social and other reasons, including meeting with any external support service providers;
- respect for a Disabled 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 Disabled Person; and

- use of bathroom and toilet.

x. ensure that the Disabled Person has access to a range of appropriate and meaningful activities, at home and/or outside of home when the Disabled Person is home during the day for any reason.

Health, medicine and first aid

7.16 The Provider must:

a. ensure and oversee the procurement, administration and safe storage of the Disabled Person's prescribed pharmaceuticals. Where medication cannot be managed by the Disabled Person, then it must be administered by a competent employee. Medication procurement, administration and safe storage should be documented in the Disabled Person's Personal Plan;

b. provide first aid and emergency treatment appropriate for the degree of risk associated with the provision of the service for the Disabled Person;

c. ensure access to appropriate dressings and incontinence supplies/aids; and

d. ensure the Disabled Person has 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.

7.17 In PD Services, the Provider will ensure that there is support from a Registered Nurse to work with each Disabled Person who has high medical needs.

Risk Management

Guidance:

Allowing Disabled People the “dignity of risk” means respecting a Disabled 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 Disabled Person with appropriate safeguards, information, and strategies to minimise the risk of harm, so the Disabled Person can take positive risks and make choices that are right for them.

Staff must consider the rights of the Disabled People they support and should not restrict choices or actions unnecessarily.

7.18 The Provider must:

a. support the Disabled Person to make their own choices and identify and understand any areas of potential risk as a result of their choices;

b. support the Disabled Person to explore ways to mitigate potential harm and apply appropriate safeguards; and

c. maintain the Disabled Person's records, including their Care Record and Personal Plan, to reflect clear, current, accurate and complete information.

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

a. the safety and security of each Disabled Person 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 Authorised Support Coordination Agency for reassessment/review;

c. ensuring first aid kit and civil defence/emergency supplies are stocked and updated as necessary; and

d. emergency management and evacuation plans.

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. Disabled 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.

7.20 The Provider must:

a. support the Disabled Person to be the ultimate decision-maker about their life by giving them the assistance they need to make decisions for themselves; and

b. develop and/or adopt effective supported decision-making processes[2].

[2] Supported decision-making - Ministry of Social Development

8 Exit Criteria

Voluntary Exit

8.1 If a Disabled Person voluntarily exits the Services, the Provider must notify:

a. Immediately, the Disabled Person's family/whānau/guardian/advocate (as appropriate);

b. MSD Work and Income Residential Support Subsidy unit within 24 hours;

c. the Authorised Support Coordination Agency within 48 hours; and

d. the Purchasing Agency (for payment processing purposes) through the next information reporting (invoicing) cycle.

Involuntary Exit

8.2 The Purchasing Agency does not support the involuntary exit of a Disabled Person from a residential support service and views this as contrary to the terms and conditions of the Provider's Panel Agreement, except in exceptional circumstances as described in the Purchasing Agency's operational policy "Exceptional Circumstances when a Community Residential Support Service Provider requests the Exit of a Service User": dss_operational_policy_exit_of_a_service_user-11.doc **(Exit Policy)**.[BF1]

8.3 The Provider must ensure that a Disabled Person does not involuntary exit from a home and the Services provided by the Provider except in accordance with the Exit Policy.

Moving homes

8.4 Clauses 8.5 to 8.8 apply if a Disabled Person moves from their existing home to another home with the same Provider.

8.5 The Provider must inform the Authorised Support Coordination Agency within 48 hours of a Disabled Person moving from their existing home to another home with the same Provider. This will result in a review of the funding provided for Services provided to the Disabled Person.

8.6 In addition to the requirements set out in section '7.10 Exit from Service' of the Tier One Service Specification, any decision that a Disabled Person moves from one home to another must be based on the needs of the Disabled Person, not the needs of the Provider. Unless otherwise agreed by an Authorised Support Coordination Agency before the move takes place, the Provider must not move a Disabled Person to another home except with the agreement of the Disabled Person, and/or the family/whānau/guardian and or advocate (with the permission of the Disabled Person), which must be recorded in writing.

8.7 The Provider must ensure that the Authorised Support Coordination Agency is

involved in decisions where a Disabled Person is changing providers, service type or region.

8.8 The Provider will ensure that the Disabled Person is not moved from their home unless:

a. requested by the Disabled Person, their family/whānau/guardian and or advocate (if appropriate);

b. assessed by the Authorised Support Coordination Agency prior to being moved and with the involvement of any appropriate specialist support services; or

c. as agreed by the Purchasing Agency.

Admission to a Specialist Service

8.9 Where a Disabled Person requires admission to a mental health service or to a specialist provider, input from the relevant specialist e.g. Psychiatrist or Behaviour Support team will be required. The Provider will inform the Authorised Support Coordination Agency and involve the Authorised Support Coordination Agency if they consider that there might be a change in the Disabled Person's needs.

Death

8.10 In the event of the death of a Disabled Person, the Provider must:

a. follow the process outlined in the Purchasing Agency's operational policy "Reporting of critical incidents and deaths" (https://www.disabilitysupport.govt.nz/providers/reporting-of-critical-incidents-and-deaths); and

b. complete the following forms within the following timeframes:

- if the death relates to a critical incident (ie. is unexpected or suspicious) a Critical Incident Reporting Form must be completed and emailed to the Purchasing Agency within 24 hours (if the death was due to natural causes or disease progression a Critical Incident Reporting Form is not required); and
- an Initial Death Review (IDR) Form must be completed within 15 working days of the death and emailed to the Purchasing Agency (quality@msd.govt.nz).

8.11 The Purchasing Agency will review the information provided about the death and determine if further investigation, by it or another agency, is required.

8.12 If the death of a Disabled Person is unexpected or suspicious, the Provider must treat the death as being a Critical Incident. The Provider must notify that death in the manner specified by the Purchasing Agency:

a. immediately to the family/whānau of the Disabled Person;

b. within 24 hours to the Purchasing Agency;

c. within 24 hours to the MSD Work and Income Residential Support Subsidy unit;

d. within 48 hours to the Authorised Support Coordination Agency; and

e. if the death meets the Te Tāhū Hauora criteria for SAC 1 harm events, within the timeframes specified by Te Tāhū Hauora in its Te Tāhū Hauora Healing, Learning and Improving from Harm Policy.

Critical incident notification process

8.13 If there is a Critical Incident, the Provider must:

a. complete the DSS Critical Incident Reporting Form;

b. email the completed form to quality@msd.govt.nz;

c. if the Provider's service and the incident site are certified by HealthCert, the Provider must also send the form to certification@health.govt.nz; and

d. if the incident involves someone receiving services under the ID(CC&R) Act, the Provider must also send the form to IDCCR@health.govt.nz.

8.14 The Purchasing Agency will review the incident and determine if further investigation, by it or another agency, is required.

8.15 If in doubt as to whether a Critical Incident should be reported, the Provider will submit a report, as the possibility of over-reporting is better than under-reporting.

Guidelines, Policies and Legislation

Legislation

9.1 The Provider must comply with all relevant legislative and regulatory requirements, including the requirement for Certification for homes of five or more Disabled People as required under the Health and Disability Services (Safety) Act 2001.

9.2 For homes of less than five Disabled People, the Provider must meet the Ngā Paerewa Health & Disability Services Standard NZS 8134:2021.

Policies

9.3 In addition to the requirements for Certification, or elsewhere specified, the Provider must 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; and

e. healthy lifestyle issues including: fostering respectful relationships, contraception and sexually transmitted disease/safe sex.

9.4 In addition to any other policies referred to, or required under this service specification, the Provider must develop policies and procedures that the Provider must follow in the event of a death of a Disabled Person including:

a. appropriate and culturally sensitive procedures for notification of next of kin;

b. any necessary certification and documentation; and

c. appropriate cultural arrangements, particularly to meet the needs of Māori, which are to be taken into account in the care of the deceased, until responsibility is accepted by the family/whānau or a duly authorised person.

Guidelines, frameworks and research

9.5 The Purchasing Agency has developed a Quality & Safeguarding Framework [How-DSS-checks-the-quality-of-disability-supports-quality-and-safeguarding-framework.docx] (**the Framework**). The Framework outlines expectations of Providers to undertake quality and safeguarding actions that:

a. Prevent - Prevent issues happening

b. Identify - Identify issues when they do happen

c. Respond - Respond to issues that are found

d. Develop – develop and improve disability supports.

9.6 The Provider will adapt their Services to respond to new quality and safeguarding research findings, best practice developments, policies and guidelines in the disability field, to improve outcomes for Disabled People.

10. Linkages

10.1 The Provider will have linkages to ensure that Disabled People have access to the following as required:

a. Primary and secondary medical services;

b. Authorised Support Coordination Agency 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; and

o. Community services, e.g. Libraries, swimming pools.

Equipment Services

10.2 Disabled 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.

10.3 If a Disabled 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 a Disabled Person living in community residential support should be undertaken by an appropriately accredited EMS Assessor.

10.4 The equipment may be primarily for the Disabled Person's individual use or may be shared with other residents. Factors for consideration are:

a. the availability or suitability of other equipment within their residential setting to meet the Disabled Person's needs;

b. equipment may have a shared use (e.g. a hoist) where other Disabled People living in the same home have similar equipment needs; and

c. the impact of the equipment not being provided, such as:

- increased level of assistance the Disabled 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.

10.5 When a Disabled 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.

10.6 The Disabled Provider will supply equipment necessary for general use by the Disabled People in the home.

10.7 Refer to the Equipment Manual for further details.

Behaviour Support

10.8 When delivering Behaviour Support the Provider must:

a. ensure implementation of Behaviour Support is consistent with this service specification and relevant Purchasing Agency's guidelines and policies;

b. ensure that challenging behavior is identified early, and a request for referral to the Specialist Behaviour Support Service is made to the Authorised Support Coordination Agency 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 Disabled Person;

d. ensure the home has and operates a policy of using positive behaviour support for managing challenging behaviour that incorporates the principle that the Disabled 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 (Behaviour Support Plan). The Behaviour Support Plan will be integrated with the Personal Plan and other planning done by the Provider to

support the Disabled 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; and

h. ensure behaviour support plans are only written by people with specialist skills in Behaviour Support. 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.

11. Excluded from funding

11.1 The following items are excluded from the funding provided by the Purchasing Agency for the Disabled Person. The Disabled 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 Disabled Person, next of kin or agent as required and that items purchased are consistent with the preferences of the Disabled Person;

b. telecommunications made by the Disabled Person;

c. services such as community dentists, opticians, hairdressers and solicitors. If the costs of these services fall beyond their ability to pay, the Disabled 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; and

e. transport costs to family/whānau/guardian visits outside their local community.

11.2 The following items for the Disabled Person are generally funded by the Purchasing Agency through a separate service agreement or by another funder. However, the Provider will ensure the Disabled 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 by Health New Zealand or directly with dental practitioners for specialist dental services requiring general anaesthetic;

c. incontinence supplies (these are funded by Health New Zealand);

d. Specialist Behaviour Support Service;

e. Day programmes/Vocational Services; and

f. other personal health services such as District Nursing.

11.3 The Provider will support, as required, the implementation of plans or strategies developed by these other services, such as implementation of a Behaviour Support Plan.

12. Complaints Resolution

12.1 The Provider must manage complaints according to section 1.8 (I have the right to complain) of Ngā Paerewa Health and Disability Services Standard, which includes the requirement to resolve complaints in accordance with the Code of Health and Disability Services Consumers' Rights.

12.2 To maintain a harmonious and friendly environment, the Provider must ensure that:

a. it has a process to raise and resolve the complaints, concerns or feedback either between Disabled People or between the Provider and other person(s), family/whānau and other people significant to the Disabled Person;

b. each Disabled Person, and their family/whānau/guardian/advocate are aware and know how to access the Provider's complaints process;

c. there is mediation support available if the parties are unable to resolve the complaint through the above process. The mediator should be agreeable to both parties. As part of the complaints process each Disabled Person, family/whānau/guardians/advocates must be made aware of other avenues they can approach with their concern should a satisfactory resolution be unable to be reached;

d. each Disabled Person has support to access independent Advocacy services. Each Disabled Person must be informed that 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 Disabled 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;

e. it provides a range of safe ways that each Disabled Person and their family/whānau/guardians/advocates can share their feedback, concerns or complaints with the Provider, including face to face approaches, without fear of retribution; and

f. it takes action to ensure that all feedback and complaints are managed in a manner that each Disabled Person can be confident that:

- there will be someone they can talk with about their concerns using their preferred method of communication;
- if they make a complaint, it will not negatively affect the care they receive;
- their concerns will be taken seriously;
- they will be treated with respect;
- their privacy and confidentiality will be respected;
- their concerns will be resolved as quickly as possible;
- they will know the outcome of your complaint; and
- there are other options if they are unsatisfied with the outcome of their complaint.

13 Purchase Units

13.1 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.

14 Reporting Requirements

14.1 Reporting Requirements are included in the Panel Agreement.