

Community Residential Support Services within Aged Care Facilities for Younger People with Lifelong Disabilities Tier Two Service Specification

1. Introduction

This Tier Two service specification specifies requirements for Community Residential Services within Aged Care Facilities for Younger People with Lifelong Disabilities Services (the Services) funded by Disability Support Services (DSS). It should be read in conjunction with the DSS Tier One Service Specification, which details requirements common to all services funded by DSS.

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

2. Service Definition

DSS aims to accommodate people with lifelong disabilities in home like settings tailored to meet their specific needs. When necessary DSS funds community residential services within aged care facilities, for people with a lifelong intellectual, physical or sensory disability aged 16 years or over.

This service will provide 24-hour support at the level necessary for the Person to have a safe and satisfying home life. This includes having 24-hour duty of care if a Person has to remain home from vocational services for any reason. The level of support will meet holistic needs, including physical, social, spiritual, emotional, cultural, and recreational needs and can be provided through a combination of services determined at the time of the Person's needs assessment.

2.1 Key Terms

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

Term	Definition
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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. DSS has contracted a provider of Specialist Behaviour Support Service that is accessed through NASC referral.
Care 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.
Term	Definition
Dual diagnosis	Means a condition whereby a person has two diagnoses e.g. a mental illness and a significant intellectual disability. Such people may require high levels of support and behaviour management strategies. Special expertise is needed to provide appropriate services for people with dual diagnosis.
Needs Assessment Service Co-ordination (NASC)	NASCs are services funded by DSS. 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.
People/Persons	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	Means a staff member identified by the Person to support them as a Primary Support Worker. The Primary Support Worker may be any staff member e.g. care worker, Registered Nurse. (This role may also be known by key worker or similar).

Specialist Behaviour Support Service	Means the provider contracted by the Disability Support Services group in DSS to provide these services.
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3. Service Objectives

3.1 The Provider will deliver on the following objectives:

- a) People will be encouraged and supported to maintain or increase their independence (to the capacity of the Person), self-reliance, and be provided with information that enables choice and control.
- b) People will live in an accessible, clean, homelike and safe environment that provides maximum 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 the life of 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, and his/her 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).

4. Service Performance Measures

4.1 Performance measures form part of the Results Based Accountability (RBA) Framework and specify the key service areas the Purchasing Agency and the Provider will monitor to help assess service delivery.

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 DSS priorities.

Measures are detailed in the Data Dictionary, available on the DSS website, which defines what DSS means by each data component.

	How much	How well	Better off
1.	# of personal plans completed by a registered nurse within three weeks of entry into the service and signed off by the Person	% of personal plans completed by a registered nurse within three weeks of entry into the service and signed off by the Person	#/% of goals in personal plans achieved
2.	# of personal plans reviewed and signed off by the Person at least once every 12 months	% of personal plans reviewed and signed off by the Person at least once every 12 months (or as clinically instructed)	
3.			
4.		% of frontline Staff who have obtained the Level 2 NZ / National Certificate in Health, Disability, and Aged Support	
5.		% staff turnover	
6.	# home agreements	% home agreements reviewed and signed off by the Person at least once every 12 months	

7.			#/% of Māori who are active participants in their
	How much	How well	Better off
			whānau, hapū, iwi and communities
8.			#/% of People who are active participants in their community

5. Eligibility and access

5.1 Service entry criteria

5.1.1 Access to the Services is through an authorised referral from the NASC following an individual needs assessment process. DSS must approve the placement prior to the Person entering the service.

5.1.2 The NASC will ensure that the following criteria have been met for Persons referred to the Provider:

- a) The individual is eligible - i.e. has an intellectual, physical or sensory disability and requires the level of support available in an aged care / rest home service, and a more age-appropriate residential service is not available in the Person's region.
- b) The individual, and where appropriate, their family / whānau / guardian / advocate have been involved in the selection of the Provider.
- c) A clear rationale is provided to the Person, their family / whānau / guardian / advocate (if appropriate) and DSS as to why placement in an aged care service is being recommended.
- d) DSS has approved the placement in writing. The NASC service must receive this approval from DSS and then forward this to the Provider as part of the admission process. A copy of the written approval from DSS for entry to services must be retained by the Provider on the Person's file.

5.2 Residential Support Subsidy

5.2.1 People receiving residential support services who are also receiving a Main benefit from 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 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 Work and Income to pay the subsidy directly to the provider.

5.2.3 The provider is required to notify 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 are:

- a) Individuals who are admitted to the rest home because of short-term acute illness
- b) Individuals who are specifically funded for residential care under the Accident Compensation Act 2001
- c) Individuals for whom funding is provided for their primary care needs under another DSS contract or notice, including arrangements relating to palliative care and convalescent care
- d) Individuals whose needs arise solely as a result of a mental health or addiction condition
- e) Any individual where this service is not considered appropriate to meet the individual's identified support needs as identified by DSS.

6. Service Components

The following requirements are in addition to those specified in the Tier One specification, Outcome Agreement and/or Ngā Paerewa Health and Disability Services Standard NZS 8134:2021:

6.1 Care Planning

Guidance:

People living in aged care 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 Care 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, selfdirection, 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.

DSS 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, with the approval of the Person
- 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 will ensure:

- a) Development of a care plan (CP) by a registered nurse within 3 weeks of entry to the service.
- b) Ensuring the CP is developed collaboratively with the Person, other relevant support service providers and, where approved by the Person, with their family / whānau / guardian / advocate. The Person or their authorized representative must be invited to sign off the CP when they approve it.
- c) Ensuring the CP is available to all staff so that it is used to guide the support provided according to the relevant staff member's level of responsibility.
- d) Ensuring that each Person's CP is evaluated, reviewed and amended by a registered nurse when clinically indicated or when there is a change in the Person's needs or at least every six months, whichever is earlier.
- e) Notifying the Person's family / whānau / guardian / advocate (with the Person's consent) as soon as possible if the Person's needs change significantly.
- f) Ensuring different levels of complexity and support need are reflected in the Person's Care Plan.

6.1.2 The Provider will ensure that the CP covers all aspects of the Person's support needs and timeframes for achievement including:

- a) The Person's short- and long-term goals (including goals relating to any therapeutic programmes that have been put in place by allied health professionals); the services, activities and inputs which will be required to achieve those goals
- b) The means by which goals of increasing access, participation and integration in the community will be achieved
- c) How family / whānau / guardian / advocate involvement will be supported
- d) How Māori and other cultural aspects such as emotional, physical and spiritual aspects will be acknowledged and provided for
- e) The name of the person(s) responsible for seeing each goal is achieved.

6.1.3 The provider will ensure that the CP specifically addresses the Person's:

- a) Current abilities, level of independence, identified needs and take in to account as far as practicable their personal preferences and individual habits, routines and idiosyncrasies
- b) Personal care needs
- c) Health care needs
- d) Rehabilitation/habilitation needs
- e) Assessed physical needs
- f) Developmental learning needs
- g) Psychosocial, emotional and spiritual needs
- h) Behavioural support needs (where appropriate).

6.2 Clinical Record System and Shift Handover

6.2.1 The Provider will ensure that:

- a) Every caregiver, primary support worker and registered nurse maintains a record of progress for each Person who is under their care.
- b) If a General Practitioner (GP) or other health professional has cause to visit the Person, the Provider will ensure that the GP or other health professional enters findings and any treatment given to or ordered for the Person into the relevant clinical record maintained on site at the time of attendance.

- c) All entries into the clinical records are legible, dated and signed by the relevant caregiver, nurse, GP or other health professional indicating their designation.
- d) At the commencement of a shift, each nurse or caregiver who will be responsible for providing care to the Person receives a report on the status of and care required for that Person.

6.3 Accommodation and Household Support Services

6.3.1 The provider will ensure:

- a) 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.
- b) 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.
- c) Buildings and facilities meet the accommodation needs of the Person and include the use of all furniture, fittings, fixtures, bedding and utensils, except to the extent that the Person chooses, with the Provider's agreement, to use their own furniture and possessions where they can be reasonably accommodated.
- d) Furnishings reflect age-appropriate living environments. Where possible and appropriate, Persons will be encouraged to have personal belongings.
- e) Secure, physically safe internal and external environments that meet the particular mobility and safety requirements of the Person group.
- f) The necessary housing modifications are made to the rest home to ensure appropriate access, bathroom modifications such as wet area showers, adaptations to kitchens to enable participation in meal preparation, adaptations to telephones or other modifications as needed.
- g) The outside/recreational area incorporates sheltered seating and is accessible to the Persons.

- h) There is sufficient and safe storage for equipment, aids and supplies including the required storage facilities for all types of medications as required by relevant legislation and standards.
- i) Procedures are in place that ensure the security and safety of the Person and enable Persons to enter and leave the rest home as appropriate to their level of care.
- j) Provision of a food service of adequate and nutritious meals, and refreshments and snacks at morning and afternoon tea and supper times, which as much as possible take into account personal likes/ dislikes of the Person, address medical/ cultural and religious restrictions and are provided at times that reflect community norms.
- k) Provision of cleaning services and supplies that maintain the rest home in a clean, hygienic and tidy state.
- l) Provision of laundry services. The Provider will take all reasonable care to minimise damage to or loss of personal clothing caused by laundering.

6.4 Support services

6.4.1 The Provider will ensure:

- a) Ongoing assessment and responsiveness to the functioning, abilities, wellbeing and support needs of the Person.
- b) Support and care provided are focused on the Person and delivered in a timely and competent manner. The Provider's routines within the rest home must reflect as much as possible community norms, encourage the Person's autonomy and respect their dignity.
- c) The Person is referred to the appropriate service when there is a need for specialist assessment – some services may require the referral to be made by a GP or NASC.
- d) 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.
- e) The Person has access to services such as community dentists, opticians, audiologist's hairdressers, solicitors and banking/financial services.
- f) The Person holds a current Community Services Card and or High Health Users Card, as distributed by Ministry of Social Development (MSD) Work and Income and that the card number is correctly referenced at the Person's GP/Medical Specialist and Pharmacy.
- g) Supervision, assistance, encouragement, and support to complement and reinforce interventions and rehabilitation strategies to improve or maintain

communication, behaviour, mobility, continence and activities of daily living for the Person.

- h) Provision of supervision, oversight and/or assistance with activities of daily living and personal care as required by the Person, including using the toilet, bathing, hair washing, teeth cleaning, nail care, eating and mobility.
- i) The Person has access to planning, education and counselling requirements, including requirements for sexuality education, gender identity counselling, relationship counselling and personal development.
- j) Provision of staff support as required to assist the Person to develop skills and increase their ability to be independent.
- k) People are 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.
- l) People understand their rights, including their right to access an independent advocate, and how they can access such a person.
- m) Privacy for the Person in the form of, but not limited to:
 - Access to private telephone (including for toll calls, although the cost of this may be charged to the person).
 - Access to private space for social and other reasons.
 - Respect for personal communications (including electronic communication), for example, the ability to open letters and read in private unless assistance is required by the Person.
 - Use of bathroom and toilet.
- n) Support to maintain and strengthen the Person's relationships with family / whānau / guardian / advocate / friends/ partners.
- o) Vocational, educational, social, recreational and other interests are actively supported and encouraged.
- p) Where the Person is not involved in structured day time support, that the Person has access to a range of appropriate activities, at the rest home and outside of the rest home
- q) That feedback is sought regularly and at least annually from the People using the service, and where appropriate their family / whānau / guardian / advocate that the service is meeting their needs, is of good quality and identifying any areas for improvement.

6.4.2 As part of the service the Provider will:

- a) Use best endeavours to ensure that the Person is accompanied to personal appointments by an appropriate relative or friend;

- b) If a relative or friend is not available, provide staff to accompany the Person to appointments for which the Person reasonably requires an accompanying person.
- c) Ensure staff are available at all times to meet the needs of the Person, as identified in the Person's Care Plans and when necessary.

6.5 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.

6.5.1 The Provider will ensure the 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.

6.5.2 The Primary Support Worker will be responsible for the following functions:

- Acting as primary contact for the Person in liaison with other support care workers and services
- Participating in the development, implementation and review of the care plan
- Assisting and facilitating advocates as required.

6.6 Primary Medical Treatment 6.6.1

The Provider will ensure that:

- a) Each Person is examined by a medical practitioner within 2 working days of admission, except where the Person has been examined not more than 2 days prior to admission, and there is a summary of the medical practitioner's examination notes.
- b) After the initial examination, the Person must be examined not less than once a month and as clinically indicated (as assessed by a Registered Nurse) except where the Person's medical condition is stable as assessed by the General Practitioner, in which case the Person may be examined by a General Practitioner less frequently than monthly, but at least every three months. This

- exception must be noted and signed in the Person's medical records by the General Practitioner.
- c) The General Practitioner reviews each Person's medication at least every three months. The Person's medication chart must be noted and signed by the General Practitioner at each review.
 - d) On-call emergency medical services are available to all Persons at all times. All costs of such emergency medical services must be covered by the Provider.
 - e) If a Person chooses to be attended by a General Practitioner of their own choice, the General Practitioner must agree to maintain the rest home's medical records for that Person as prescribed in this contract. If a Person retains his or her own General Practitioner, that Person is responsible for any cost over and above that which the Provider pays per Person for the General Practitioner contracted by them.
 - f) If a Person initiates a visit from a General Practitioner without the prior approval of the Registered Nurse or Manager, the Provider may require the Person to bear the full cost of the visit if such a visit is not in accordance with a) above.
 - g) The treatment programme prescribed by a General Practitioner to assist the Person is carried out. This may include treatments such as physiotherapy, occupational therapy, speech-language therapy, dietetics and podiatry. This treatment programme shall be reviewed at such regular intervals as are specified by a General Practitioner, Registered Nurse, or applicable health professional involved in the treatment.
 - h) The Person accesses specialist assessment services referred by the General Practitioner e.g. rehabilitation services, specialist allied health services available through community health providers.

6.6.2 Although the Provider is not required to provide the above services, the Provider must ensure that the Person has access to the services. If the Provider chooses to refer the Persons to private therapists, the Provider must meet the costs of such private therapists.

6.7 Staffing

The Provider must ensure it provides the staff for the following roles and duties in every Rest Home delivering the Services.

6.7.1 Rest home services

The provider must ensure that: a) When there are:

- (i) 10 or fewer Persons, there must be a care staff member on duty at all times
 - (ii) Up to 29 Persons, there must be one care staff member on duty and one Care staff member On-call at all times
 - (iii) More than 30 Persons, at least two care staff members shall be on duty at all times
 - (iv) More than 60 Persons, at least three care staff members shall be on duty at all times.
- b) Despite clause a), where (having regard to the layout of the rest home, the health and personal care needs of Person and the ease with which the Person can be supervised) the Registered Nurse or Manager at any time considers that additional staff are required to meet the needs of all Persons, the Provider shall ensure that those extra staff are on duty for the period of time that the Registered Nurse or Manager recommends.
- c) Where the Provider provides more than one category of services at the rest home, one of the staff members may, if qualified, provide on-call assistance in respect of another category of service, provided that the Provider continues to meet the obligations to provide sufficient staff to meet the health and personal care needs of all Persons at all times.
- d) Every rest home has a Manager who:
- i) Holds a current qualification or has experience relevant to both management and the health and personal care of people with life-long disabilities, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a rest home; and
 - ii) The role of the Manager includes, but is not limited to, ensuring the Persons of the Home are adequately cared for in respect of their everyday needs, and that services provided to Persons are consistent with obligations under legislation and the terms of this Agreement.
- e) At least one Registered Nurse is employed / contracted (excluding a registered psychiatric nurse) who will be responsible for working with staff and (where that Registered Nurse is not the Manager) the Manager to:
- Assess Persons:
 - On admission
 - When the Person's health status changes
 - When the Person's level of dependency changes
 - At each 6 month review date identified in the Care Plan

- Develop and/or review Care Plans in consultation with the Person and family / whānau / guardian / advocate and primary support worker
 - Advise on care and administration of medication, possible side effects and reported errors/incidents
 - Provide and supervise care
 - Act as a resource person and fulfil an education role
 - Monitor the competence of other nursing and care staff (including the Primary Support Worker) to ensure safe practice
 - Advise management of the staff's training needs
 - Assist in the development of policies and procedures.
- f) Where there is more than one Registered Nurse in the Rest home, the duties and responsibilities assigned to the Registered Nurse may be shared between the Registered Nurses on duty over a 24 hour period.
- g) Records are maintained that document the hours worked by care staff in the rest home. The hours documented in the records must list only the actual hours worked by Care staff in providing the services at the rest home for which payment is claimed under this Agreement. For the avoidance of doubt, staff hours spent working in flats or apartments associated with the rest home do not qualify as hours spent working in the rest home.

6.7.2 Hospital services

The Provider must ensure that in every hospital:

There shall at all times be on duty at least one Registered Nurse (excluding a registered psychiatric nurse) and:

- i) The distribution of care staff over a 24 hour period shall be in accordance with the needs of the Persons as determined by a Registered Nurse. A minimum of 2 care staff are required to be on duty at all times
 - ii) The lay out of the rest home must also be taken into consideration when determining the number and the distribution of care staff required to meet the needs of the Persons in addition to clause (i) above.
- b) There is a Manager:
- i) Who is either a General Practitioner or a Registered Nurse (excluding a registered psychiatric nurse) and holds a current New Zealand practising Certificate. The Manager must hold a current qualification or have experience relevant to both management and the health and personal care of people with lifelong disabilities, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a Hospital;
 - ii) Whose role includes ensuring the Persons in the Hospital are adequately cared for in respect of their everyday needs, and that services provided to the user are consistent with obligations under legislation and the terms of this Agreement.
- c) Registered Nurses are employed, contracted or otherwise engaged and are responsible for:
- i) the development of an initial Care Plan within 24 hours of admission ii) the co-ordination and documentation of a comprehensive Care Plan within three weeks of admission
 - iii) ensuring that the Care Plan reflects the assessments and the recommendation/s of other health professionals where their input is required
 - iv) on-going re-assessment and review of care v) implementation/delegation of nursing tasks vi) supervision and provision of care according to each Person's Care Plan vii) acting as a resource person and fulfilling an education role viii) monitoring the competence of nursing and care staff to ensure safe practice
 - i) providing advice and assistance to management regarding the staff's training needs.

6.7.3 Manager of a Rest Home providing Services in more than one category

Where the Provider provides both rest home and hospital care at the same facility, the Manager may act as Manager of both these services so long as they are being delivered at a single site and they meet the requirements for a Manager of Hospital service contained in clause 6.7.2 b)) above.

6.7.4 Orientation and Competency of New Staff

The Provider will ensure that:

- a) All newly engaged staff receive a planned orientation programme that includes the organisation's philosophy and vision, physical layout of the facility, their job description, policies, procedures, protocols and guidelines relevant to their engagement and non-clinical and clinical emergency protocols.
- b) All staff in direct contact with the Persons have completed education that is related to their care. Those staff who have not completed the training at the time of their appointment must complete appropriate training within six months of appointment. This education must be provided at a suitable location and address:
 - Understanding of Persons' rights.
 - Support and care of people with physical, sensory, intellectual or dual diagnosis disability needs;
 - Practical care skills;
 - Awareness of cultural issues;
 - Communication, including sensory and cognitive loss and other barriers to communication, communication aids;
 - Observation and reporting;
 - Promotion of independence and recognition of individuality
 - Rehabilitation/ habilitation concepts.
- c) Any staff member carrying out tasks, procedures, or treatment will have demonstrated they are competent at performing the task, procedure or treatment, and follow documented policies / protocols developed by the Provider to ensure safe practice.

6.7.5 Staff Support and Guidance

The Provider will ensure that:

Any Registered Nurse or health professional carrying out a delegated medical task or a specialised procedure or treatment must have demonstrated prior competency in the task, procedure or treatment, and follow documented policies and protocols developed by the Services to ensure safe practice and compliance with accepted ethical and professional standards.

- b) Where certification is required to carry out a particular task or specialised procedure (for example an I.V. Certificate), care staff must have such certification.
- c) Strategies and/or protocols shall be operational to ensure that advice and/or support is available to on duty staff at all times, should the need arise.
- d) Protocols are developed and made known to staff, to guide staff when managing clinical and non-clinical emergencies.
- e) Plan and undertake ongoing staff performance appraisals. Such appraisals must be documented at least annually.

6.7.6 Ongoing Programme of Staff Development

The Provider will:

- a) Ensure that all staff are aware of DSS's zero tolerance of abuse and neglect, and know how to identify, report and manage abuse, as well as how to support the Person who has been abused.
- b) Undertake a planned, documented programme of staff development or inservice education, with at least 8 hours of programmes being provided annually, including courses attended other than at the Rest home. The Provider must keep a written record of staff attendance at such programmes.
- c) The Provider will actively encourage, promote and develop Māori health and disability workers to be employed at all levels of the service to reflect the Person population.

6.8 Supplies

6.8.1 Provision of Supplies

The Provider will:

- a) Provide emergency supplies of toothpaste, toothbrush, disposable razors, shampoo, sanitary supplies, soap and other toiletries on those occasions when the Person's own supply is not available.
- b) Provide all standard (non-specialist) dressings and supplies used in treatments.
These must be of an appropriate standard, as determined by a Registered Nurse, to meet the needs of the Person. Specialist dressings can be accessed through the DHB.
- c) Provide continence management products that are of an appropriate standard to meet the assessed needs of the Person, as set out in the Care Plan.
- d) Obtain appropriate continence management advice for those Persons identified as requiring specialist continence advice and support. This may be (but is not required to be) from the continence advisory service of the DHB community support services.

6.8.2 Provision of Pharmaceuticals

The Provider will:

- a) Discuss with the Person's General Practitioner the prescription of medications for the Person
- b) Encourage the General Practitioner to prescribe generic medications to lessen the occasions when a manufacturer's surcharge applies
- c) Pay the Government's prescription charge, any manufacturer's surcharge and any package and delivery charge by the Pharmacist.
- d) Inform the Person in writing that they may be required to pay the cost of any pharmaceutical over and above the charges stated above.

6.9 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 clear documented and agreed process for how this works, including the organisation's oversight to prevent abuse of trust.

6.9.1 The Provider will:

- 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 / 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 rest 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.

6.10 Risk Management

6.10.1 The Provider's Risk Management Plan shall address matters such as:

- a) The safety and security of Persons and staff while at the rest home and away from the rest home. There will be times when responsibility transfers to another funded provider e.g. day programme. Such transfers must be clearly documented and agreed in advance.
- b) Dealing with challenging behaviours – when and how to access support services and when to access NASC for reassessment/review.
- c) Management of crises and incidents - incidents and crisis situations should be documented, which includes an Incident Register. This includes review and implementation of corrective actions.
- d) Relationships and communication in crisis situations with family/ whānau/ guardian/ advocate, neighbours, other Persons, and staff.

6.10.2 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.

7. Legislation / Guidelines

7.1 Legislation

7.1.1 The Provider will meet all relevant legislative and regulatory requirements, including the requirement for Certification for facilities of five or more People as required under the Health and Disability Services (Safety) Act 2001.

- 7.1.2 For facilities of less than five People, the Provider will meet the Home and Community Support Services Standards.

7.2 Guidelines, frameworks and research

- 7.2.1 DSS 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 DSS Website.
- 7.2.2 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>
- 7.2.3 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.

8. Exit Criteria

8.1 General

The Provider must ensure that the Person is not shifted from the rest home unless:

- a) Requested by the Person, their family/ whānau/ guardian/ advocate (if appropriate), or
- b) Assessed prior to being shifted by the NASC and with the involvement of any appropriate specialist support services, or
- c) As agreed by DSS.

8.2 Voluntary Exit

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) DSS (for payment processing purposes) through the next information reporting (invoicing) cycle.

8.3 Involuntary exit

8.3.1 DSS 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.

8.3.2 Where the provider wishes to exit a Person from their service, this must be discussed fully with the NASC and a planned approach taken to ensure the best outcomes for the Person. The provider must inform the Contract Relationship Manager if this circumstance arises.

8.4 Death

8.4.1 The Provider will notify the following on the death of any Person:

- Family / whānau / guardian / advocate immediately
- MSD Work and Income Residential Support Subsidy unit within 24 hours
- The NASC within 48 hours
- DSS (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 DSS must be within the time frame specified for a critical incident in the Outcome Agreement.

- The DSS Contract Manager as soon as is reasonably practicable.

8.5 Moving homes

8.5.1 (This section refers to a service user moving from their existing rest home to another rest home with the same Provider or moving to a new rest home with a different provider.)

8.5.2 In addition to the requirements set out in section '7.10 Exit from Service' of the Tier 1 Service Specification, any decision that a service user moves from one rest 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.

- 8.5.3 The Provider will ensure that the service user is not shifted from the rest home unless:
- a) Requested by the service user, their family / whānau / guardian and or advocate (if appropriate), or
 - b) Assessed prior to being shifted by the NASC and with the involvement of any appropriate specialist support services; or
 - c) As agreed by DSS.

8.6 Admission to a Specialist Service

- 8.6.1 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.

9. Linkages

- 9.1 The Provider will ensure that each Person has access to the services, listed in this clause, as required by the assessed need of each Subsidised Person:

- a) Needs Assessment and Service Co-ordination Services
- b) Assessment, treatment and rehabilitation services contracted by us
- c) Primary care & district nursing services for advice and information sharing
- d) Laboratory services
- e) Radiological services
- f) Mental health services
- g) Dental services
- h) Specialist medical services
- i) Podiatry services (not prescribed by General Practitioner)
- j) DSS funded Specialist Behaviour Support Service
- k) Māori provider organisations
- l) Government departments such as MSD Work and Income
- m) Social workers
- n) Independent Advocacy services
- o) Supporting voluntary organisations such as People First
- p) Socialisation outside the rest home
- q) Person/carer community support services
- r) Vocational services and or day services.

9.2 The Provider must meet the costs of transport, including specialised transport required, to the services in clause 9 a) – j) but are not required to meet the cost of transport to the services listed in clause 9 k) – r).

9.3 The Provider must inform each Person about any specialist travel and accommodation funding to which the Person may be entitled and refer them to DSS or Work and Income for information about this funding as appropriate.

10. Equipment

10.1 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 rest home / hospital. Any other equipment should be returned to the Equipment Management Services (EMS) provider. Refer to the Equipment Manual for further details:
<http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/519>

- 10.2 If a Person needs new personal equipment while living in the Services, they will need to be assessed by an accredited EMS Assessor who can be contacted through the NASC or DHB.
- 10.3 When a Person leaves or shifts to another service, they can take their equipment to their new service.
- 10.4 The provider will provide communal aids and equipment (which are not considered for individual use) for personal care or the general mobility needs of the People who require them.
- 10.5 The Provider must at all times have available sufficient clinical equipment for general use to meet the needs of the Persons including, but not limited to:
- Scissors and forceps for basic wound care
 - Thermometers
 - Sphygmomanometers
 - Stethoscopes
 - Weighing scales
 - Blood glucose testing equipment.

11. Behaviour Support

- 11.1 When delivering behaviour support the Provider will:
- a) Ensure implementation of behavioural management is consistent with relevant DSS guidelines and policies.
 - b) Ensure that challenging behaviour is identified early and, where the provider requires support to manage the behaviour effectively, a referral is initiated via the NASC to the Specialist Behaviour Support Service. 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 rest 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) Any behaviour support provided must be managed 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 other planning done by the provider to support the Person.

- f) The behaviour support plan has the following component:
- g) Assessment (including measurement and quantification of the behaviours of concern)
- h) Implementation planning (including training of support people)
- i) Implementation
- j) Review of progress
- k) Maintenance.
- l) When a behaviour support plan is implemented progress must be measured by gathering the appropriate data (advised by the behaviour support specialist) on the frequency, duration and impact of the behaviours being managed.
- m) All people assisting with the behaviour support plan must be trained in how to use the techniques specified in the plan prior to the plan implementation. The provider is required to support training delivered by the Specialist Behaviour Support Service and support staff to apply the skills learned.
- n) Behaviour support plans must only be 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.

12. Service Exclusions

12.1 The Services do not include:

- a) Specialised assessment and rehabilitation services – including specialist assessment for, and advice on, rehabilitation and specialised assessment (by accredited assessors) for individual customised equipment via ACC or DSS funded Environmental Support Services provider.
- b) Customised equipment, accessed through services funded by the relevant DHB or through specialised accredited assessors, such as wheelchairs modified for an individual's use, seating systems for postural support, specialised communication equipment and other customised and personal care and mobility equipment.
- c) The provision of equipment, aids, medical supplies or services that relate to conditions covered by DHB funding
- d) Services such as those provided by, opticians, audiologists, chaplains, hairdressers, dry cleaners and solicitors. However, the service continues to be responsible for ensuring the Person has access to these services

- e) Clothing and personal toiletries, other than ordinary household supplies. However the Provider is responsible for ensuring that these items are purchased by the Person or their family / whānau / guardian / advocate as required and are consistent with the preferences of the individual Person.
- f) Charges for toll calls made by the Person.
- g) Insurance of the Person's personal belongings
- h) Vocational service fees and travel to vocational services as funded by Work and Income
- i) Educational services and travel to those services as funded through the Ministry of Education
- j) Specialist dental services as funded directly by DSS or with Dental Practitioners for specialist dental services requiring general anaesthetic.
- k) Specialist Behaviour Assessment Service
- l) Day programmes funded by DSS.

12.2 The following items are excluded from the contract price. They are the responsibility of the individual Person:

- a) Clothing and personal toiletries, other than ordinary household supplies. However, the Provider is responsible for ensuring these items are purchased by the Person, next of kin or agent as required and that items purchased are consistent with the preferences of individual Persons.
- b) Telephone call charges for toll calls made by the Person.
- c) Services such as community dentists, opticians, audiologists, chaplains, drycleaners, hairdressers and solicitors. If the cost of these services fall beyond their ability to pay the Person or advocate will negotiate with Work and Income for access to special funds under their entitlement as part of their Invalids/Sickness Benefit.
- d) Transport costs to vocational services (if not covered by Work and Income). Also refer to Clause 9 for Person responsibilities for travel.

13. Person/ Family / Whānau / Guardian / Advocate Involvement

13.1 The Provider will 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.

13.2 The Provider will have a number of means by which the Person, and his/her family/ whānau members/ guardians/ advocate (with the consent of the Person), can provide input into service operations and development. These should include:

- Input into care planning and financial management where approved by the Person
- Input into policies and procedures
- Input into service planning and development
- Input into staff selection/ appointment
- Involvement in internal quality monitoring
- Representation on an advisory board
- Involvement in planning, arranging and managing activities such as social and recreational activities
- Māori input and involvement in all service planning and review processes
- Full access to this service specification to enable Persons to fully understand the nature of the service
- Regular hui or facility meetings held at least monthly to cover anything they choose to discuss, including the service effectiveness and acceptability.

14. Complaints Resolution

14.1 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 of and know how to access the Provider's complaints process.
- b) A complaint register is maintained.
- c) 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, family/whānau must be made aware of other avenues they can approach with their concern should a satisfactory resolution be unable to be reached.
- d) People have access and 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.

15. Purchase Unit

- 15.1 Purchase Units are defined in the Te Whatu Ora's Nationwide Service Framework Purchase Unit Data Dictionary.

The following Purchase Unit applies to this Service.

Purchase Unit Code	Purchase Unit Description	Purchase Unit Definition	Measure
DSS1034	Residential - Younger Aged Care Facilities	Provision of short and long term care for people with a lifelong intellectual, physical or sensory disability aged 16 years or over in a privately owned or in rest homes or public hospital facility.	Occupied Bed Day

16. Reporting Requirements

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

Any delays in providing reports should be notified to your Contract Manager.