

SERVICE SPECIFICATION

PURCHASE UNIT CODE: DSS1031

SERVICE DESCRIPTION: Community Residential Support Services – Intellectual Disability

Philosophy Statement

The aim of Disability Services (DS) is to build on the vision contained in the New Zealand Disability Strategy (NZDS) of a fully inclusive society. New Zealand will be inclusive when people with impairments can say they live in:

‘A society that highly values our lives and continually enhances our full participation.’

With this vision in mind, disability support services aim to promote a person’s quality of life and enable community participation and maximum independence. Services should create linkages that allow a person’s needs to be addressed holistically, in an environment most appropriate to the person with a disability.

Disability support services should ensure that people with impairments have control over their own lives. Support options must be flexible, responsive and needs based. They must focus on the person and where relevant, their family and whanau, and enable people to make real decisions about their own lives.

Note: Subsequent references in this document to “service user/s” should be understood as referring to a person/people with impairment(s).

1. DEFINITION

The Ministry of Health (the Ministry) wishes to purchase community residential services, for people with an intellectual disability aged 16 years and over. This service provides 24-hour support at the level necessary for people to have a safe and satisfying home life. This includes having 24-hour duty of care if a service user has to remain home from vocational or day services for any reason. The level of support can be provided through a combination of services determined at the time of needs assessment for each individual service user.

2. SERVICE OBJECTIVES

2.1 General

The services will have the following outcomes:

- a. Support in an accessible homelike environment that provides maximum privacy and autonomy for people
- b. A safe and clean living environment
- c. Enhancement of personal growth and development

- d. Enhancement of the service users autonomy, control and self reliance
- e. Integration of the service user into community life, in accordance with each service user's needs and wishes.

2.2 Maori Health and Disability

The Provider is required to develop a plan that demonstrates their ability to meet the requirements outlined in the Health and Disability Sector Standards. This plan will outline how the Provider will ensure Maori participation and service integration at all levels of service delivery and contribute to Maori health gains. This plan needs to be initiated within an agreed timeframe between us.

3. SERVICE USERS

Support services, as described in this specification, are for people with intellectual disabilities who have been referred to the Provider for service by a contracted Needs Assessment Service Co-ordination Agency (NASC).

If a person with an intellectual disability living in a community residential home turns 65 years, it is expected that they will continue to reside there (as it is their home) and continue to receive a residential support subsidy. If however their need for disability support changes and is assessed as relating primarily to age-related condition then it is expected that person will be referred to NASC for a reassessment of their support requirements.

4. ACCESS

4.1 Entry

Access to residential services described is by authorised referral from the NASC Service following an individual needs assessment process.

NASC have the role of assessing need, prioritising and allocating resources for people with disabilities living in their area. The assessment and service co-ordination processes followed by the NASC Service will ensure that the following criteria have been met for clients referred to the Provider:

- a. The individual is eligible - i.e. has an intellectual disability (as assessed by an appropriate specialised needs assessor/professional as recognised by the NASC not the Provider)
- b. NASC indicate the individual requires the level of care and support provided by the Provider
- c. The individual, their family/whanau/guardian/advocate have been involved in the selection of the Provider
- d. Any Maori service user/whanau/family/guardian/advocate accepts the Provider's cultural competence

4.2. Exit Criteria

Moving homes

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

In addition to the Discharge Planning Provisions in the Provider Quality Specifications and the Health & Disability Sector Standards, any decision that a service user moves from one home to another must be based on the needs of the service user, not the needs of the Provider. Any variation to this must have agreement from the NASC agency prior to the move taking place. The service user, or the family/whanau/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.

The Provider must ensure that the service user is not shifted from the home unless:

- a. Requested by the service user, their family/whanau/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 the Ministry

Admission to a Specialist Service

Where a service user requires admission to a mental health setting or specialist provider, this change will involve input from a relevant “specialist” e.g. Psychiatrist, Behaviour Support team. The relevant NASC may be involved to assess change in the service user’s needs.

Death

The Provider will notify the following on the death of any service user:

- Family/whanau/guardian or advocate immediately;
- The NASC Agency within 48 hours;
- The Ministry through the next information reporting (invoicing) cycle; and
- The DS Contract Relationship Manager

5 SERVICE COMPONENTS

5.1 Processes

(i) Individual Plans

The following requirements are in addition to those specified in the Provider Quality Specifications and Health & Disability Sector Standards:

The Provider is responsible for the development of an individual plan (IP), collaboratively with other relevant, available support service providers and in conjunction with the service user and their family/whanau/guardian and or advocate. An IP is to be developed within 2 months of entry to the service, and reviewed and developed for each service user when there is a significant

change in the needs of the service user or at least 6 monthly or at the request of the service user.

An Individual Plan should cover all aspects of the individual's support needs and timeframes for achievement including:

- a. The service users short and long term goals (including any therapeutic programmes that have been put in place by allied health professionals) are in place; and the services, activities and inputs which will be required to achieve those goals; and
- b. The means by which these goals of increasing access and participation in and integration in the community are achieved
- c. Family/whanau/guardian/advocate/friend involvement
- d. Skills attainment
- e. Minimising potential harm for individuals, staff and others in the community
- f. Recognition of Maori and other cultural aspects such as emotional, physical and spiritual aspects.
- g. The name of the person responsible for seeing the goal is achieved

(ii) Risk Management

The Provider is required to meet the requirements of the Provider Quality Specifications/Health & Disability Sector Standards. The Providers Risk Management Plan shall address matters such as:

- a. The safety and security of service users and staff while at home and away from 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. Documentation should differentiate between situations where the Behaviour Support Team/Dual Diagnosis services have been involved, and where they have not. This includes review and implementation of corrective actions
- d. Relationships and communication in crisis situations with family/whanau/guardian/advocate, neighbours/ other household members including staff
- e. Development and maintenance of positive relationships with the immediate neighbouring community.

(iii) Behavioural Support

The Provider will:

- a. Ensure that behavioural support is addressed in each service user's IP where appropriate
- b. The Provider is required to work cooperatively, support and implement the contracted Behaviour Support Service or Dual Diagnosis/Assessment Treatment & Rehabilitation Service to develop and implement any Behavioural Support or Treatment Plan for a service user

- c. The Provider is required to participate in training provided by the Behaviour Support team
- d. The Provider will incorporate strategies of individual behavioural support plans to form the basis of upskilling of all staff
- e. The home has and operates a non-aversive policy for managing challenging behaviour that adopts the principle that a person's freedom should be restricted only for safety reasons.

5.2 Settings

Services will be provided in a range of community settings such as small home large home, group of small homes or group flats etc.

The Provider will provide a comfortable, accessible, and well-maintained home and grounds for service users to live in. The home will include aids and equipment for general use to enable service users to access their environment. There will be no identifying features (signage) on the house or vehicles to denote the house/vehicle as different from others.

Furnishings will reflect age appropriate living environments, particularly in the lounge and living areas. Where possible and appropriate, service users will be encouraged to have personal belongings that reflect age and gender appropriateness.

The location of the home will provide access to community facilities, leisure activities and opportunities for socialisation.

Each service user is to have their own bedroom unless it is their clear choice and preference not to do so.

Each house will generally accommodate groups of 4 – 6 service users per house. This service specification also includes situations where service users are fully supported in groups less than 4 - 6 people. Variation to the number of service users per house (above 6) is to be approved on a situation-by-situation basis with the NASC.

The Provider will ensure secure, physically safe internal and external environments that meet the particular mobility and safety requirements of the service user group. This will include the necessary housing modifications to the home to ensure appropriate access, bathroom modifications such as wet area showers, adaptations to kitchens to enable participation in meal preparation, adaptations to telephones etc. Staffing levels, behavioural management techniques and alternative activities are considered primary means for providing physical safety of service users rather than security gates and fencing.

5.3 Service Levels

Clients will present with different levels of complexity and support need. This will be reflected in the service users Individual Plan.

5.4 Equipment Service

Users of Community Residential services (under 65) contracted by the Ministry of Health, including residential homes and other similar residential services, are eligible for the provision of environment support services under the following circumstances:

- The equipment is for the sole use of the service user and
- The service user meets the Disability Support Services (DSS) access and eligibility criteria. (Refer to the Enable NZ and AccessAble Manual for details)

To access funding for this service a person must be assessed by a Specialised Assessor. Specialised Assessors can be accessed by contacting a NASC agency or District Health Board (DHB).

The Provider will supply equipment necessary for general use by the residents. Refer to the Enable NZ and AccessAble Manual for details.

5.5 Support services

The provider will be responsible for:

Individual Support Services

- a. The ongoing assessment and being responsive to the functioning, abilities, well being and support needs of the service users
- b. Referral to the appropriate service when there is a need for specialist assessment – some service may require the referral to be made by GP or NASC
- c. Ensure and oversee the procurement, administration and safe storage of prescribed pharmaceuticals. Where medication cannot be managed by the service user then it must be administered by a competent employee
- d. First aid
- e. Ensure access to the services of a general medical practitioner on a regular or as required basis. Every effort is made to enable people to access the GP of their choice including emergency/on call access to the services of a general medical practitioner 24 hours/day, 7 days/week
- f. Ensure access to provision of appropriate use of dressings and incontinence supplies/aids.
- g. Ensure access to services such as, community dentists, opticians, audiologists hairdressers, solicitors and banking/financial services.
- h. Ensure service users hold a current Community Services Card and or High Health Users Card, as distributed by Work and Income New Zealand and that the card number is correctly referenced at the service users GP/Medical Specialist and Pharmacy
- i. 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
- j. Supervision, oversight and/or assistance with activities of daily living and personal care as required, including using the toilet, bathing, hair washing, teeth cleaning, toe and finger nail care, eating and mobility

- k. Ensure access to planning education and counselling requirements, including requirements for sexuality education, gender identity counselling, relationship counselling and personal development
- l. Staff support as required to ensure service users are assisted by staff to develop skills and increase their ability to be independent
- m. Privacy 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 mail, for example, the ability to open letters and read in private unless assistance is required by the service user
 - Use of bathroom and toilet
- n. Support to maintain and strengthen relationships with family/whanau/guardians, friends and partners
- o. Vocational, educational, social, recreational and other interests are actively supported and encouraged
- p. Transport to attend vocational (if not funded by Work and Income), educational (if not funded by the Ministry of Education), social, recreational and other interests to develop and maintain community links and networks
- q. Where the service user is not involved in structured day time support the Provider will ensure that the service user has access to a range of appropriate activities, at home and outside of home
- r. Where an external day programme is not provided, or the person is not able to participate the Provider is required to provide meaningful daytime activities for the service user.

The provider will be responsible for:

Accommodation and Household Support Services

- a. Support is provided as required to ensure efficient running of the household. Service users are encouraged to do as much for themselves and others as is appropriate to their ability and or the arrangements that have been made with others living in the house.
- b. Service users take as much responsibility (including partial participation) as they can for domestic work such as laundry, cooking, cleaning, and are supported to develop skills and their level of self-reliance.
- c. A home agreement is drawn up for each service user stating 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 service user’s Work and Income benefit will be paid to the Provider, the amount that is left, which will be retained by the service user, and what goods and services (as outlined in 7.2) that are the service users responsibility to fund with that portion of their Work and Income benefit
- d. Service users are assisted to independently manage their finances as far as is possible. If service users require assistance with managing their finances then a clear and auditable system for management must be established (as outlined in 8.5). This system must be understood by the service user and/or their family/whanau/guardian or advocate and staff involved

- e. Adequate meals that meet generally accepted principles of good nutrition and cater to the needs of service users on special diets including dietary supplements and equipment for special requirements for eating/feeding
- f. Emergency access to supplies of toothpaste, shaving equipment, sanitary supplies, and other toiletries which are not included in normal household supplies for occasions when a service user's own supply is not available
- g. Laundry, including personal laundry and care and maintenance of clothing
- h. Cleaning services and supplies
- i. All furniture, furnishings, bedding and utensils. However service users are encouraged to bring in their own furniture and furnishings if they wish and these are cared for appropriately. The Provider must list all personal items that belong to the service user and keep this list on the service user's file.

Complaints Resolution Support Service

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

- There is a regular forum to resolve the complaints or air any grievances either between the service users or Provider and the service user.
- 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.
- A Complaint register is maintained and all the complaints written or verbal are logged on the register by the provider.
- There is access to independent advocacy services.

5.6 Facilities

The Provider will meet the requirements as set in the Provider Quality Specifications or Health & Disability Sector Standards.

5.7 Key inputs

Staffing

The Provider will be responsible for employing competent staff for adequate hours for the needs of the service user group to ensure 24-hour service provision (as per definition). The Provider will have sufficient experienced staff to provide a level of service relative to the service user's assessed needs such as risk management, dual diagnosis, physical disability, intellectual disability, high medical needs, personal cares and social functioning.

Staff are expected to work in a collaborative way to best meet the ongoing needs of all people with an intellectual disability.

The Provider will recruit and orient staff to meet the core staff competence components but will also be responsible to ensure the particular needs of service users are also addressed in the orientation and ongoing training programmes.

Core staff competence should include, but not be limited to the areas of: disability knowledge, values (inclusion, least restrictive alternatives, the right to live in the community, knowledge about the Human Rights Act (1993) and the New Zealand Disability Strategy (NZDS)), client-centred services, physical

care of people, communication skills and behavioural management, understanding health and disability as they relate to Maori and other cultures and as appropriate, particular needs of service users as they change.

The Provider will actively encourage, promote and develop Maori health and disability workers to be employed at all levels of the service to reflect the service user population.

6. SERVICE LINKAGES

Providers of services for people with an intellectual disability must achieve their purpose by establishing and maintaining co-operative working relationships with all other relevant service providers. Whilst the provider of care may not be responsible for providing these services, they must ensure timely access to them. The Provider is required to demonstrate links where appropriate with:

- a. Primary medical services
- b. Day activity/vocational/educational services
- c. Needs Assessment and Service Coordination (NASC) services
- d. Independent advocates
- e. Client/carer community support services
- f. Equipment Management Services (EMS)
- g. Specialised assessment services
- h. Mental Health Services
- i. Behavioural Support Services
- j. Assessment Treatment & Rehabilitation Services
- k. Secondary medical and surgical services
- l. Appropriate ethnic and cultural groups
- m. Disability consumer groups
- n. Government departments such as IRD etc
- o. Advocacy Services
- p. Maori co-ordinate/adviser: iwi social and community services, support groups, and social service organisations e.g. local Kaumatua, marae, whanau groups, counselling, budget and family support services;
- q. Supported work and other employment programmes

In addition, links with Work and Income is required. Provider links with Work and Income include agreeing to notify Work and Income of a person's entrance or exit from the service within 24 hours.

7. EXCLUSIONS

Excluded from services under this specification will be any individual or individuals entitled to the support under the Injury Prevention, Rehabilitation and Compensation Act (2001) or where this service is not considered appropriate to meet the individuals identified support needs as identified by NASC and negotiated with the Provider.

Funding for services for people with an intellectual disability who choose to live in the following situations are excluded from this Specification, except by specific case by case negotiation with NASC:

- Living with own family/whanau/guardian
- Independent Supported Living
- Rehabilitation Services

7.1 Service type

The following items are excluded from the negotiated contract price. These services may be purchased by the Ministry through a separate service agreement, or another service purchaser. The Provider is required to ensure the service user has access to:

- Specialist assessment services - including assessment for individual equipment via an appropriate specialist equipment/seating service. The supply of sole use equipment is through the Equipment Management Service (EMS)
- Equipment funded by EMS where it is for the sole use of the resident and they meet DSS access and eligibility criteria (refer section 5.4).
- The provision of equipment, assistive devices, medical and incontinence supplies/aids, or services that relate to conditions covered by Personal Health which are funded through the personal health care budget except where these have been specified in the service specification. However, the service continues to be responsible for ensuring the service user has access to these services
- Educational services and travel to those services as funded through the Ministry of Education
- Specialist dental services as funded directly by the Ministry of Health through District Health Boards (DHB) or directly with Dental Practitioners for specialist dental services requiring general anaesthetic.
- Behaviour Support Services
- Day programmes funded by the Ministry
- Other personal health services such as District Nursing

7.2 Individual service user responsibility:

The following items are excluded from the negotiated contract price. They are the responsibility of the individual service user:

- Clothing and personal toiletries, other than ordinary household supplies. However, the Provider is responsible for ensuring these items are purchased by the service user, next of kin or agent as required and that items purchased are consistent with the preferences of individual service users
- Telephone call charges for toll calls made by the service user
- Services such as community dentists, opticians, hairdressers and solicitors. If the cost of these services fall beyond the service user's ability to pay the Provider will advocate or negotiate with Work and Income for access to special grants or funds that the service user is entitled to as part of their Invalids/Sickness Benefit
- Transport costs to family/whanau/guardian visits outside their local community

- e. Part user charges for pharmaceuticals and medical costs e.g. GP/Medical Specialists

8 QUALITY REQUIREMENTS

8.1 General

The Provider is required to comply with the General Contract Terms, the Provider Quality Specifications of this agreement and Health & Disability Sector Standards.

In accordance with the Provider Quality Service Specifications other quality indicators will be incorporated as part of your internal evaluation and service development plan.

These include:

- a. Adaptability of the service to respond to new research developments and policy guidelines in the intellectual disability field. It is also expected that there is development in best practice programmes for strategies to increase the inclusion of people with disabilities in the day-to-day management of their home environment.
- b. Development of professional relationships with referrers
- c. Comprehensiveness of the programme to cater for diversity amongst residents
- d. Maintenance of service user records to reflect clear, current, accurate and complete information

8.2 Service User/Family/Whanau/Guardian/Advocate Involvement

The Provider will have a number of means by which the service user and or their family/whanau/guardian/advocates can provide input into service operations and development. These should include:

- a. Input into service planning and development
- b. Involvement into internal quality monitoring
- c. Input and active participation in the development of the Individual Plan (IP)
- d. Involvement in audit of expenditure from service user trust accounts
- e. Involvement in, including planning, arranging and managing activities such as social and recreational activities
- f. Maori input and involvement in all service planning and review processes
- g. Full access to this service specification to enable the service user to fully understand the nature of the service.

In addition the Provider is required to have clear separation of governance from management roles.

8.3 Acceptability

The Provider will demonstrate how effective the service has been in achieving the goals to enable the service users to have full access to their community.

8.4 Safety and Efficiency

The Provider will have a set of documented policies/protocols for the following aspects of service delivery:

- Managing disruptive behaviour in the least restrictive way possible
- Medication administration and review
- Potential risk to service users of all types of abuse from others
- Clinical aspects of support delivery
- Healthy lifestyle issues including: fostering respectful relationships, contraception and sexually transmitted disease/safe sex

8.5 Financial Accountability

A service user has the right to control their own money unless this is removed under the Protection of Personal and Property Rights Act 1988, and a welfare guardian is appointed for them.

Occasionally a service user may choose to have their money managed for them by another person or agency. When this occurs the service user and or family/whanau/guardian and or advocate, will nominate someone as manager for his or her personal financial arrangements. A financial manager in this area will not be another service user in the home, nor someone employed by the Provider.

The appointment of a financial manager does not remove the need for access to general advocacy or independent support, however it is desirable that different people are appointed to carry out the different roles.

When service users do not control their own money, appropriate safeguards must be in place. The Manager of the home/s is to provide documentation of financial matters for audit purposes by our evaluation agency. Service users should hold copies of the documentation of their finances when these are managed on their behalf.

9 PURCHASE UNITS

Residential services will be purchased according to levels of need as assessed by the Ministry contracted Needs Assessment Service Co-ordination agency. Residential services will be purchased by occupied bed days.

Service users make a part payment through their benefit toward the cost of service provision as assessed by Work and Income.

The following purchase units apply to this service:

Purchase Unit Code	Purchase Unit	Measure	Purchase definition	Measure
DSS1031	ID Community Service user	Bed Days	Occupied bed days	

10 REPORTING REQUIREMENTS

Purchase Unit Code	Purchase Unit	Reporting Frequency	Reporting Requirements
DSS1031	Bed days	Six Monthly Annually (Financial Year)	<i>Quality/Service Development measures:</i> 1 A written narrative detailing Quality Requirements (Section 8) 2 A written narrative detailing those items listed in the service specification 10.2 <i>Maori Health:</i> 3 Organisational Policy Requirements for Maori

10.1 Quality Measures

Providers that are registered are required to comply with the Provider Quality Specification and are to immediately report to the Ministry of Health any critical incident or crisis that may result in media or political attention. Providers that are certified are required to meet section 31/5 of the Health and Disability Services (Safety) Act 2001.

In addition to the general quality requirements, the following quality requirements apply to this service:

- Assessment of effectiveness and acceptability of the service through the Hui or regular resident meetings held at least monthly and/or as required.
- Seek feedback at least annually from the Whanau/family and service users that the service is meeting the resident's needs.

10.2 Service Development

The Provider is required to report 6 monthly on the following:

- Planned service development
- Changes in the type and way in which services are delivered
- Critical incidents and events – detailing the circumstances, dates and persons involved and outcomes of incident

10.3 Registration/Certification

From 01 October 2004, homes for five or more people with disabilities must be certified under the Health and Disability Services (Safety) Act 2001. Homes with less than five people with disabilities must be registered by the Ministry of Health (sections 18-22A of the Disabled Persons Community Welfare Act).

GLOSSARY OF TERMS

Access:

Means that the service user is able to receive or obtain other services or facilities which are not provided under this contract but which are important to the person's well being. It is not the responsibility of the Provider to deliver these services within the purchase price agreed with the Ministry.

Critical incident: is any unusual event, which could:

- be life threatening for the Service user
- be dangerous – safety of the Service user at risk with grave harm
- have significant consequences such as Service user involved in criminal activity
- be a serious and grave crisis that may result in media or political attention

Disability Support Services:

The wide range of services whose purpose is to assist people with a disability. NASC agencies co-ordinate such services, but do not themselves provide support services.

Dual diagnosis:

Dual diagnosis services are for people who have both a mental illness and significant intellectual disability, and who require high levels of support and behaviour management strategies. Special expertise is needed to provide appropriate services for people with dual diagnosis

Medical fragility:

Is a combination of an intellectual or physical disability and condition(s) that result in fragility of their personal health. As a result the person may have needs related to both their disability and medical and personal care support, often needing a high level of input from multiple providers, for example pharmacy, specialist nursing, environmental support services.

Less intensive service user support provider:

Is any service user service that is not purchased specifically to address the specialist support needs of people with an intellectual disability on an ongoing basis.

Needs Assessment Service Co-ordination Agencies (NASC):

These agencies are funded by the Ministry. Their roles are first to assess client's needs, and then to co-ordinate other services to meet those needs.

Provision:

Means the act of providing and being liable for the costs incurred, unless otherwise stated.