SERVICE SPECIFICATION

PURCHASE UNIT CODE: DSS1034
PURCHASE UNIT DESCRIPTION: Community Residential Services within Aged Care Facilities for Younger People with Lifelong Disabilities

DSD Philosophy Statement

The aim of Disability Services Directorate (DSD) 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 "the service user/s" should be understood as referring to a person/people with impairment(s).

1 DEFINITION

The Disability Services Directorate aims to accommodate people with lifelong disabilities in home like settings tailored to meet their specific needs. However when necessary the Ministry of Health (the Ministry) is required to fund 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 service user 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 services for any reason. The level of support will meet holistic needs, including social, spiritual, emotional, culture, recreational and can be provided through a combination of services determined at the time of needs assessment for each individual service user.

Contracted providers are expected to comply with the local body safety and relevant statutory requirements.

2 SERVICE OBJECTIVES

2.1 General

The services will:

- Be relevant to the health, support and care needs of each service user recognising their cultural and/or spiritual values, individual preferences and chosen lifestyles;
- Provide accessible, homelike and safe environment that provides maximum privacy and autonomy for the service user;
- Facilitate and assist the service user's social, spiritual, cultural and recreational needs:
- Provide the opportunity for each service user wherever possible, or the service user's family/whanau/advocate to be involved in decisions affecting the service users life;
- Acknowledge the significance of each service users family/whanau/advocate and chosen support networks; and
- Support the service users integration into community life, in accordance with each person's needs and wishes.

2.2 Maori Health and Disability

The Maori Health Policy and requirements are outlined in the General Terms and Conditions and Provider Quality Specifications of this agreement and in the Health & Disability Sector Standards.

3. SERVICE USERS

Support services, as described in this specification, are for people with an intellectual, physical or sensory disability who have been referred to the Provider for service by a contracted Needs Assessment Service Co-ordination Agency (NASC). The Ministry must have approved the placement prior to the service user entering the service.

4. ACCESS

4.1 Entry

Access to residential services described is by an authorised referral from the NASC service that has been approved by the Ministry following an individual needs assessment process.

NASC services 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, physical or sensory disability (as assessed by a Ministry authorised specialised needs assessor/professional

as recognised by the NASC, not the Provider)

b. The individual, their family/whanau/advocate have been involved in the selection of the Provider
c. Any Maori service user/whanau/family/guardian/advocate accepts the Provider's cultural competence
d. The NASC service indicates that there is not a more appropriate residential facility available in the service users region; and
e. A clear rationale is provided to the service user, their family/whanau/advocate (if appropriate) and the Ministry as to why placement in an aged care facility is being recommended; and
f. The Service Manager of the relevant Ministry locality has approved the placement in writing. The NASC service must receive this approval from the Ministry and then forward this to the Provider as part of the admissions process. A copy of the written approval from the Ministry for entry to services must be retained by the Provider on the client's on-site file.

4.2. Exit Criteria

The Provider must ensure that the service user is not shifted from the facility 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 specialist provider (such as a mental health setting), this change will involve input from a relevant "specialist" e.g. Psychiatrist. The relevant NASC may be involved to assess change in the service user's needs.

Voluntary Exit

In a situation where the service user voluntarily exits the home the Provider will notify the following:

- Family/whanau/guardian or advocate immediately,
- The NASC Agency within 48 hours, and
- The Ministry through the next information reporting (invoicing) cycle
- The Service Manager of the relevant Ministry area within 48 hours

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 Service Manager of the relevant Ministry area within 48 hours

5 SERVICE COMPONENTS

5.1 Processes

5.1.1 Clinical record System

The Provider must ensure that every caregiver, primary support worker and registered nurse maintains a record of progress for each service user who is under the care of that caregiver or registered nurse. The provider must ensure that all entries in to the clinical records are legible, dated and signed by the relevant caregiver, or nurse, indicating their designation.

5.1.2 Attendance by General Practitioner or other Health Professional

If a General Practitioner (GP) or other heath professional has cause to visit the service user, the Provider will ensure that the GP or other health professional enters findings and any treatment given to or ordered for the service user into the relevant clinical record maintained on site at the time of attendance. The provider must ensure that all such entries are legible, dated and signed by the GP or other health professional, indicating their designation.

5.1.3 Handover Report

The Provider must ensure that at the commencement of a shift, each nurse or other caregiver who will be responsible for providing care to the service user, receives a report on the status of and care required for that service user.

5.2 Settings

The buildings and facilities must meet the accommodation needs of the service user.

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

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 modifications to the facility to ensure appropriate access, bathroom modifications such as wet area showers, adaptations to kitchens to enable participation in meal preparation, adaptations to telephones etc.

The outside/recreational area must incorporate sheltered seating and must be accessible to the service user.

5.3 Service Levels

Clients will present with different levels of complexity and support need. This will be reflected in the service user's Care Plan.

5.4 Equipment

Service users with lifelong disabilities in Community Residential Services contracted by the Ministry of Health, including residential homes and other similar residential services, are eligible for the provision of environment support services where it is for the sole use of the person and they meet Disability Support Services (DSS) access and eligibility criteria. To access funding for this service a person must be assessed by an Accredited Assessor. Accredited Assessors can be accessed by contacting a NASC agency or through District Health Board (DHB) community services.

The Provider must provide communal aids and equipment (which are not considered for individual use) for personal care or the general mobility needs of the service users who require them.

The provider must at all times have available sufficient clinical equipment for general use to meet the needs of the service users including, but not limited to:

- Scissors and forceps for basic wound care;
- Thermometers;
- Sphygmomanometers;
- Stethoscopes;
- Weighing scales; and
- Blood glucose testing equipment

5.5 Support services

The provider will be responsible for:

a. The ongoing assessment and being responsive to the functioning, abilities, well-being and support needs of the service user;

b. Referral to the appropriate service when there is a need for specialist assessment – some services 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. Ensure access to services such as, community dentists, opticians, audiologists hairdressers, solicitors and banking/financial services;

e. Ensure the service user holds a current Community Services Card and or High Health Users Card, as distributed by Work and Income NZ and that the card number is correctly referenced at the service users GP/Medical Specialist and Pharmacy;

f. 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;

g. Supervision, oversight and/or assistance with activities of daily living and personal care as required by the individual, including using the toilet, bathing, hair washing, teeth cleaning, nail care, eating and mobility;

h. Ensure access to planning education and counselling requirements, including requirements for sexuality education, gender identity counselling, relationship counselling and personal development;

i. Staff support as required to ensure the service user is assisted to develop skills and increase their ability to be independent

j. 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

k. Support to maintain and strengthen relationships with family/whanau/guardians, friends and partners

l. Vocational, educational, social, recreational and other interests are actively supported and encouraged

m. 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 the facility and outside of the facility

5.5.1 Care 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 a care plan (CP), developed collaboratively with other relevant, available support service providers and in conjunction with the service user and their family/whanau/guardian and or advocate. A registered nurse must develop a CP within 3 weeks of entry to the service.

The CP will cover all aspects of the individual's support needs and timeframes for achievement including:

a. The service users 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; and
b. The means by which goals of increasing access, participation and integration in the community will be achieved
c. How family/whanau/guardian and or advocate involvement will be supported
d. How Maori and other cultural aspects such as emotional, physical and spiritual aspects will be acknowledged and provided for.
e. The name of the person responsible for seeing the goal is achieved

The CP must specifically address the service users:

a. Current abilities, level of independence, identified needs/deficits 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)

The CP must be available to all staff so that it is used to guide the care provided according to the relevant staff member's level of responsibility.

5.5.2 Evaluation

The Provider must ensure that each service users CP is evaluated, reviewed and amended either when clinically indicated or by a change in the service users needs or at least every six months, whichever is earlier.

A registered nurse will responsible for reviewing and amending the CP for the service user.

The Provider must notify the service user's family/whanau/guardian (with service users consent, if appropriate) as soon as possible if the service user's needs change significantly.

5.5.3 Primary Support Worker

The Provider will be responsible to ensure that the service user has an identified person as a Primary Support Worker. The person could be a staff member such as a care worker or registered nurse. The service user will (where appropriate) be actively involved in nominating the Primary Support Worker. The Primary Support Worker will be responsible for the following functions:

- Act as primary contact for the service user in liaison with other support care workers and services.
- Participate in the development, implementation and review of the care plan.
- Assist and facilitate advocates as required.

5.5.4 Support & Care Intervention

Support and care provided by the Provider must be focused on the service user and delivered in a timely and competent manner. The Provider's routines and practices within the facility must reflect as much as possible community norms, encourage each service user's autonomy, respect their dignity and privacy and meet their cultural requirements, and be documented in the Care Plan.

Staff must be available at all times to meet the needs of the service users, as identified in the service users' Care Plans and when necessary.

5.5.5 Primary Medical Treatment

If required the Provider must ensure that:

a. Each service user is examined by a medical practitioner within 2 Working Days of admission, except where the service user has been examined not more than 2 days prior to admission, and there is a summary of the medical practitioner's examination notes. After the initial examination, the service user must be examined not less than once a month and as clinically indicated (as assessed by a Registered Nurse) ***except*** where the service user's medical condition is stable as assessed by the General Practitioner, in which case the service user 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 service user's medical records by the General Practitioner;

b. The General Practitioner reviews each service user's medication at least every three months. The service user's medication chart must be noted and signed by the General Practitioner at each review; and

c. On-call emergency medical services are available to all service users at all times. All costs of such emergency medical services must be covered by the provider;

d. A service user may choose to be attended by a General Practitioner of their own choice who agrees to visit the facility and maintain the facility's medical records as prescribed in this contract. If a service user retains his or her own General Practitioner, that service user is responsible for any cost over and above that which the Provider pays per service user for the General Practitioner contracted by them;

e. If a service user initiates a visit from a General Practitioner without the prior approval of the Registered Nurse or Manager, the Provider may require the service user to bear the full cost of the visit if such a visit is not in accordance with point one above.

f. The Provider must provide the treatment programme prescribed by a General Practitioner to assist the service user to develop and maintain functional ability. This may include such goal and outcome orientated treatment 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;

g. Where a service user requires specialist assessment services (for example, where there has been a marked deterioration in the service user's functionality or health status) and a General Practitioner refers a service user to either:

   - rehabilitation services (for example, assessment, treatment and rehabilitation services); or
   - specialist allied health services available through community health providers,

   The Provider is not required to provide such services, but must ensure that the service user has access to such services; and

   If the Provider chooses to refer the service users to private therapists, the Provider must meet the costs of such private therapists.

5.5.6 Accommodation and Household Support Services

The provider will be responsible for:

a. Lodging with the use of all furniture, fittings, fixtures, bedding and utensils, expect to the extent that service user choose, with the Provider's agreement, to use their own furniture and possessions where they can be reasonably accommodated;

b. A food service of adequate and nutritious meals and refreshments and snacks at morning/afternoon tea and supper times, which as much as possible take into account personal likes/dislikes of the service user, address medical/cultural and religious restrictions and are provided at times that reflect community norms

c. An 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, 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 7.4) are the service user's responsibility to fund with that residual portion of their Work and Income benefit

d. Service users are assisted to independently manage their finances as far as is possible (also see Clause 8.6). If the service user requires assistance with managing their finances then a clear and auditable system for management must be established. This system must be understood by the service user and/or their family/whanau/guardian or advocate and staff involved;
e. Cleaning services and supplies that maintain the facility in a clean, hygienic and tidy state;
f. Laundry services. The Provider will take all reasonable care to minimise damage to or loss of personal clothing caused by laundering.

5.5.7 Complaints Resolution Support Service

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

- There is a process to resolve the complaints or air any grievances either between the service users or the 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 the Provider logs all the complaints written or verbal on the register.
- There is access to independent advocacy services.

5.6 Facilities

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

The Provider must have sufficient and safe storage facilities for equipment, aids and supplies including the required storage facilities for all types of medications as required by relevant legislation and standards

The Provider must have procedures in place that ensure the security and safety of the service user and enable service users to enter and leave the facility as appropriate to their level of care.

5.7 Key inputs

5.7.1 Rest Homes

a. In every Facility where there are:

(i) 10 or fewer service users, there must be a Care Staff member On Duty at all times;
(ii) up to 29 service users, there must be one Care Staff member On Duty and one Care Staff member On-call at all times;
(iii) more than 30 service users, at least two Care Staff members shall be On Duty at all times;
(iv) more than 60 service users, 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 Facility, the health and personal care needs of service user and the ease with which the service

user can be supervised) the Registered Nurse or Manager at any time considers that additional staff are required to meet the needs of all service users, 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 Facility, 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 service users at all times.

d. Manager

(i) Every Rest Home must engage a Manager who 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 service users of the Home are adequately cared for in respect of their everyday needs, and that services provided to service users are consistent with obligations under legislation and the terms of this Agreement.

e. Registered Nurse

The Provider must employ, contract or otherwise engage at least one Registered Nurse, 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:

(i) Assess service users:

a. On admission;

b. When the service user's health status changes;

c. When the service user's level of dependency changes; and

d. At each 6 month review date identified in the Care Plan;

e. Develop and/or review Care Plans in consultation with the service user and family/whanau and primary support worker;
f. Advise on care and administration of medication, possible side effects and reported errors/incidents;
g. Provide and supervise care;
h. Act as a resource person and fulfill an education role;
i. Monitor the competence of other nursing and Care Staff (including the Primary Support Worker) to ensure safe practice;
j. Advise management of the staff's training needs;
k. Assist in the development of policies and procedures.

f. Where there is more than one Registered Nurse in the Facility, the duties and responsibilities assigned to the Registered Nurse may be shared between the Registered Nurses On Duty over a 24 hour period.

g. Care Staff for Rest Homes

(i). The Provider must maintain records that document the hours worked by Care Staff in the Facility. The hours documented in the records must list

only the actual hours worked by Care Staff in providing the services at the Facility for which payment is claimed under this Agreement. For the avoidance of doubt, staff hours spent working in flats or apartments associated with the Facility do not qualify as hours spent working in the Facility.

5.7.2 Hospitals

a. In every Hospital:

There shall at all times be On Duty at least one Registered Nurse, excluding a registered psychiatric nurse;

(i) The distribution of Care Staff over a 24 hour period shall be in accordance with the needs of the service users 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 Facility must also be taken into consideration when determining the number and the distribution of Care Staff required to meet the needs of the service users under clause(ii) above.

b. Manager

i. The Provider must engage a Manager who is either a General Practitioner or a Registered Nurse (excluding a registered psychiatric nurse) and holds a current 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 life long disabilities, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a Hospital;

ii. The role of the Manager includes ensuring the service users of 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 Nurse

Registered Nurses must be employed, contracted or otherwise engaged by the Provider 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 3 weeks of admission;

iii. ensuring that the Care Plan reflects the assessments and the recommendation 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 Subsidised Resident'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;

ix. providing advice and assistance to management on the staff's training needs.

5.7.3 Manager of a Facility providing Services in more than one category

Where the Provider provides both Rest Home and Hospital care at the same Facility the Manager, if holding a nursing qualification recognised by the Nursing Council of New Zealand that is relevant to care of people with life long disabilities, may act as Manager of both these services so long as they are being delivered at a single Facility.

5.7.4 Orientation and Competency of Newly Engaged Staff

The provider must ensure that all newly engaged staff receive a planned orientation programme that familiarises them with the 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.

The Provider shall ensure all staff that will be in direct contact with the service users have completed education that is related to their care. Those staff that have not completed the training at the time of their appointment must complete appropriate training within six months of appointment. The training must address:

- 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; and
- Understanding of service users' rights.

The Provider may arrange the education referred to above at the Facility or externally. Any staff member carrying out tasks, procedures, or treatment must have demonstrated they are competent at performing the task, procedure and treatment, and follow documented policies, and protocols developed by the Provider to ensure safe practice.

5.7.5 Staff Support and Guidance

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 facility to ensure safe practice.

Tasks specified above shall be carried out in accordance with the relevant accepted ethical and professional standards.

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.

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.

The Provider must implement protocols to guide staff managing clinical and non-clinical emergencies.

The Provider must plan and undertake ongoing staff performance appraisals. Such appraisals must be documented at least annually.

5.7.6 Ongoing Programme of Staff Development

The Provider must undertake a planned, documented programme of staff development or in-service education, with at least 8 hours of programmes being provided annually, including courses attended other than at the Facility. The Provider must keep a written record of staff attendance at such programmes.

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.

5.7.7 Supplies

5.7.7.1 Emergency Provision of Personal Supplies

The Provider must provide emergency supplies of toothpaste, toothbrush, disposable razors, shampoo, sanitary supplies, soap and other toiletries on those occasions when the service users own supply is not available.

5.7.7.2 Provision of Pharmaceuticals

The Provider's liability for payment of prescribed medication is limited to the payment of the Government's prescription charge, any manufacturer's surcharge and any package and delivery charge by the Pharmacist.

The provider is also responsible for:

- Discussing with the service user's General Practitioner the prescribing of medications that are listed in the pharmaceutical schedule maintained and managed by Pharmac under the Act;
- Encouraging the General Practitioner to prescribe generically to lessen the occasions when a manufacturer's surcharge applies; and
- Informing the service user in writing that they may be required to pay the cost of any pharmaceutical over and above the charges stated above.

5.7.7.3 Provision of Dressing Supplies

You must provide all dressings and supplies used in treatments. These must be of an appropriate standard, as determined by a Registered Nurse, to meet the need of the service user.

5.7.7.4 Provision of Continence Supplies

- The Provider must provide continence management products that are of an appropriate standard to meet the assessed needs of the service user, as set out in the Care Plan.
- For those service users identified as requiring specialist continence advice and support, the Provider must obtain appropriate continence management advice,

which may be (but is not required to be) from the continence advisory service of the DHB community support services.

6 SERVICE LINKAGES

The Provider must ensure that each service user has access to the services, listed in this clause, as required by the assessed need of each Subsidised Resident:

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. Maori provider organisations;
k. Social workers;
l. Independent Advocacy services;
m. Supporting voluntary organisations such as People First;
n. Socialisation outside the facility;
o. Client/carer community support services; and
p. Vocational services and or day services

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 5 working days.

The Provider must meet the costs of transport, including specialised transport required, to the services in clause 6 (a) – (i) but are not required to meet the cost of transport to the services listed in clause 6 (j) – (p).

The Provider must inform each service user about any specialist travel and accommodation funding to which the service user may be entitled and refer them to the Ministry, DHB or Work and Income for information about this funding as appropriate.

6.1 Accompanying the Service User

As part of the service the Provider will:

- Use best endeavours to ensure that the service user is accompanied to such appointments by an appropriate relative or friend; or

- If a relative or friend is not available, provide staff to accompany the service user to appointments with the providers referred to in clauses 6(a) to 61(i), and any other appointments for which the service user reasonably requires an accompanying person.

7 EXCLUSIONS

7.1 General

Excluded from services under this specification will be:

- Individuals who are admitted to the facility because of short-term acute illness;
- Individuals who are specifically funded for residential care under the Injury Prevention, Rehabilitation and Compensation Act (2001);
- Individuals for whom funding is provided for their primary care needs under another Ministry contract or notice, including arrangements relating to palliative care and convalescent care;
- Individuals whose needs arise solely as a result of a mental health condition; or
- Any individual where this service is not considered appropriate to meet the individuals identified support needs as identified by Ministry.

7.2 Service Type

The Services do not include:

- 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 Ministry funded Environmental Support Services provider.
- 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.
- The provision of equipment, aids, medical supplies or services that relate to conditions covered by DHB funding
- Services such as those provided by, opticians, audiologists, chaplains, hairdressers, dry cleaners and solicitors. However, the service continues to be responsible for ensuring the service user has access to these services
- Clothing and personal toiletries, other than ordinary household supplies. However the Provider is responsible for ensuring that these items are purchased by the service user or their family or agent as required and are consistent with the preferences of the individual service user.
- Charges for toll calls made by the service user.
- Insurance of the service user's personal belongings
- Vocational service fees and travel to vocational services as funded by Work and Income

- 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 with Dental Practitioners for specialist dental services requiring general anaesthetic.
- Specialist Behaviour Assessment Service
- Day programmes funded by the Ministry

7.3 Individual service user responsibility:

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

a. 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
b. Telephone call charges for toll calls made by the service user
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 service user 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 6 for service user responsibilities for travel.

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:

8.2. Quality Improvement Programme

The Provider shall develop and implement a Quality Improvement Programme to enable a high standard of service to be provided in accordance with the Ministry Approved Standards and otherwise in accordance with this Agreement, and to ensure the Services are provided so as to achieve the best outcome for Service users.

The Provider must document a Quality Improvement Plan as part of the Quality Improvement Programme and must ensure that such a Plan is implemented, evaluated for its effectiveness, and that any necessary corrective action is taken.

The Quality Improvement Plan must include (but is not limited to):

- An explicit quality philosophy;
- Clear quality objectives;
- Quality improvement risk management systems;
- Systems for monitoring Quality Audit compliance;
- Designated organisational and staff responsibilities;
- Resident input into Services and into development of the Quality Improvement Plan;
- How the Provider will address Maori issues including recognition of:
    - the Maori Health Plan set out in clause 2.2; and
    - how the Maori Health Plan put into effect through the provision of the Services.

The Provider is expected to monitor and evaluate the delivery of Services against the Quality Improvement Plan, including standards of service. Such quality monitoring mechanisms must include, but are not limited to, the following:

a. Service user feedback surveys;
b. Quality review procedures as a demonstrable part of service delivery; and external reviews

Policy/Protocol for:

- Managing challenging behaviour in the least restrictive way possible
- Potential risk to service user of physical or sexual abuse from others
- Healthy lifestyle issues including: fostering respectful relationships, contraception and sexually transmitted disease/safe sex

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

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

a. Input into policies and procedures
b. Input into service planning and development
c. Input into staff selection/appointment
d. Involvement in internal quality monitoring
e. Input and active participation in the development of the Care Plan
f. Representation on an advisory board
g. Involvement in audit of expenditure from service user trust accounts
h. Involvement in, including planning, arranging and managing activities such as social and recreational activities

i. Maori input and involvement in all service planning and review processes
j. Full access to this service specification to enable the service users to fully understand the nature of the service.

8.4 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.

8.5 Safety and Efficiency

8.5.1 Risk Management

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

a. The safety and security of service users and staff while at the facility and away from the facility. 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/whanau/guardian/advocate, neighbours/ other service users, and staff
e. Development and maintenance of positive relationships with the immediate neighbouring community.

The Provider must document and implement policies, processes and procedures for:

a. Identifying key risks to health and safety;
b. Evaluating and prioritising those risks based on their severity, the effectiveness of any controls the Provider has and the probability of occurrence;
c. Dealing with those risks and where possible reducing them;
d. Minimising the adverse impact of the internal emergencies and external or environmental disasters on the service users, visitors and staff;
e. Working with the organisations who have responsibility for co-ordinating internal and external (environmental) disaster services;
f. Accident and hazard management that safeguard Service users, visitors and staff from avoidable incidents, accidents and hazards.

Each policy, process, or procedure developed under clause 5.8.2 must include definitions of all incidents and accidents, and must clearly outline the responsibilities of all staff, including:

a. Taking immediate action;

b. Reporting, monitoring and corrective action to minimise incidents, accidents and hazards, and improve safety; and debriefing all staff support as necessary.

For the purposes of clause 8.2 key risks include, but are not limited to, the following:

a. Theft/burglary;
b. Fire;
c. Accidents/incidents;
d. Chemicals incidents; and
e. Disposal of waste.
f. Natural disasters such as floods and earthquakes

The Provider must maintain a record of any accidents or incidents, and must notify the Ministry and family/whanau/guardian immediately of serious accidents or incidents involving or affecting any service user.

8.6 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 facility 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 UNIT AND REPORTING REQUIREMENTS

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 must make a part payment through their benefit toward the cost of service provision as assessed and agreed with Work and Income.

The following purchase units apply to this service:

Purchase Unit Code	Purchase Unit	Measure	Payment System
DSS1034	Residential - Younger - Aged Care Facilities	Bed Days	CCPS

Reporting Requirements

You must comply with the following reporting requirements:

Purchase Unit Code	Purchase Unit	Reporting Frequency	Reporting Requirements
DSS1034	Bed days	Six Monthly	*Quality/Service Development measures:* 1 A written narrative detailing Quality Requirements (Section 8) 2 A written narrative detailing those items listed in the service specification 9.2
		Annually	*Maori Health:* 3 Organisational Policy Requirements for Maori

9.1 Quality Measures

Providers that are registered are required to comply with the Provider Quality Specification and 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 a hui or regular service user meetings held at least monthly and/or as required.
- Seek feedback at least annually from the family/whanau/guardian and service users that the service is meeting the service user's needs.

9.2 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.

9.3 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.

Definitions and Glossary of Terms

Access: means that the service user is able to utilise 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 price paid by the Ministry of Health.

Provision: means the act of providing and being liable for the costs incurred, unless otherwise stated.

Service user: means people with life long disabilities who are in receipt of residential services in aged care facilities funded by the Ministry of Health, unless expressly stated otherwise.

Primary Support Worker: is a person, who assists and facilitates as identified on the individual support plan, the process to meet the needs and goals of the Service user. In addition to this Primary Support Worker:

"performs the same functions as a key worker and has been given induction, training, information and regular supervision by the provider about the role and functions of primary support worker. "

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