



# Home and Community Support Service

## Implementation Guide August 2008

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# Home and Community Support Services

## IMPLEMENTATION GUIDE

### PART A: PRACTICE GUIDE

#### 1. Introduction

The following information is designed to assist you in the interpretation and implementation of the Home and Community Support Services Service Specification, introduced in July, 2007.

The new specifications were a combination of existing service specifications for both providers and NASCs, with provision for additional flexibility, and an outcomes focus for people added. Changes were made due to feedback and requests from the sector. The sector indicated that flexibility was being requested and had been provided for, but was not evident in the specifications.

This guideline was written by the Implementation Reference Group in response to requests from providers for clarification on the issues that had caused some confusion under the new specification. It is a living document and updated versions will be made available as necessary.

Accident Compensation Corporation (ACC) and Disability Support Services (DSS) at the Ministry of Health have developed one service specification for a group of people that have similar needs. All these people need long-term Home and Community Support Services. Both ACC and DSS contract with the same providers for Home and Community Support Services. This service specification is seen as an opportunity to align service requirements and reduce duplication of reporting, monitoring and audit requirements.

To access Services the person must be referred to the service provider by an ACC staff member or a Needs Assessment Service Coordination (NASC) organisation.

#### 2. Service philosophy

ACC and the Ministry of Health (MOH) purchase Home and Community Support Services to provide individualised support for people with physical, intellectual and/or, sensory disabilities.

The Service provides household management and/or personal care as identified, with the disabled person, by the NASC or ACC staff member. The Services align and contribute to the achievement of a person's goals.

ACC Services also include childcare and registered nursing.

Underpinning the Home and Community Support Services Service is the New Zealand Disability Strategy vision of *"a society that values the lives of people with disabilities and enhances their full participation in society"*.

## Assumptions

- There is no additional funding, or current funding proposals attached to the new service specifications, therefore costs related to implementation of the new service specification are assumed to be neutral. All costs of service provision need to be covered by current allocations and resources.
- It is **critical** to the success of this service that all naturally existing social supports for a disabled person be investigated first before a Carer/provider is requested to deliver it.
- The disabled person and their family remain responsible for all personal and social costs which are not covered by any other funding source.
- The current (pre-existing) provider, NASC, and funder processes, protocols, systems and frameworks will remain unchanged (for example, employment agreements, assessment and support allocations) – this work is to provide direction within current contexts.
- The provider reserves the right to define which Services they may or may not deliver within the terms of their contractual responsibilities.
- Ongoing dialogue and discussion between NASC/ACC Assessors and Service Coordinators will occur to ensure mutual understanding of people's expectations, provider capability, and service delivery principles.

## 3. Target population

This Service will assist people who:

- a) Have been profiled into the ACC Serious Injury Portfolio. Serious Injuries include spinal injury, brain injury or conditions with comparable severity, examples are multiple amputation, burns to at least 50% of the body, blindness or neurotoxicity OR
- b) Are eligible for MOH funded disability support services:

“people with a physical, intellectual or sensory impairment or disability (or a combination of these), which is likely to continue for a minimum of six months and result in the reduction of independent function to the extent that ongoing support is required”.

**Note:** These services are usually for people who are under 65 years of age. People with an age related disability or those with mental health needs are usually funded by the DHB's.

## 4. Service setting

Services will be provided in the person's home, in their community, and in the workplace when these supports are not funded by any other government or local organisation.

## **5. Rationale for setting up a Home and Community Support Service specifically for ACC clients with a Serious Injury**

ACC are currently working with around 4,000 people with serious injuries. This group requires specialist support, to support their ability to live an active and full life. Although many individuals have positive outcomes, they recognise that there is more that they can do to achieve more sustainable outcomes for their clients.

ACC has recognised the need to refocus efforts in the support of seriously injured people. The main goal of this service will be *“to work with people who have been disabled through injury to rebuild their lives and participate to the maximum practicable extent in the social and working life of the community”*. See Appendix 1: Serious Injury Profiles.

## **6. Supporting and enabling people to live an ordinary life**

Many people who sustain serious injuries, or who have long term disabilities may become socially isolated or face challenges due to their disabilities. For example, people who have experienced traumatic brain injury (TBI) present with a variety of cognitive, behavioural and emotional difficulties that impact significantly on how they live life. Resuming life within the home and the community becomes a major challenge for these people.

The change in focus under the new service specification aligns to the MOH Disability Support Services Strategic Plan. The report from the Office of Disability Issues entitled “An Ordinary Life” and the Disability Support Services Strategic Plan are all aimed at enabling disabled people, and those who fall under the “Serious Injury” category for ACC to live an ordinary life, and participate as much as possible in their family and community life.

## **7. Consultation and collaboration in the development and implementation of the new service specification**

The new approach to service delivery incorporates feedback from ACC and MOH Staff, NASCs and Assessors, providers and the people receiving Services as well as their families/carers. It reflects requests for increased flexibility with service delivery, which was often accommodated informally, but not legitimately recognised. There is ongoing collaboration between representatives of all participant groups to implement the new service specification across New Zealand in a consistent manner, with positive outcomes.

## **8. Services offered**

Home and Community Support Services will continue to provide individualised support for a person with physical, intellectual and/or sensory disabilities that will enable them to participate in everyday living activities.

Services include hours allocated for household management and/or personal care as identified by the NASC or ACC staff member, at the time of assessment. This aspect

of service planning is unchanged. What has changed is that Services will now be aligned to the person's goals, and the actual Services delivered will contribute to the achievement of the person's goals, incorporating a greater degree of flexibility, and focused more on the person's choices and their individual circumstance.

The new service specification allows the NASC/ACC staff, and the provider to discuss what the person wants to do with the hours identified as flexible, and how they can support this in their service delivery. Flexible and Core Services are discussed in Section 16 below.

## **9. What the Service does not deliver**

There are some closely related Services that are not covered under this service specification. This information is set out under the heading "What is Not Funded" on page 5 of the service specification. Any service funded, or mandated to be funded by a separate service specification or agreement from ACC, MOH, or any other government agency is not provided for under the new service specification. Additionally, Services which can be provided through the use of natural supports, such as friends and family, are not provided for under the new service specification.

Gardening and lawn mowing are not included in the Services purchased by either ACC or DSS, as these Services may be accessed through other funding avenues e.g. Work and Income.

For DSS, advanced personal care, registered nurse Services and childcare are not included in the Services purchased under this service specification.

Services will also not include the following activities

- a) Supported Living/Supported Independent Living
- b) Training for Independence programme

For more clarity on the differences between Supported Living/Supported Independent Living, and Training for Independence compared to this service, refer to the Frequently Asked Questions on the ACC or MOH websites.

## **10. Referral to Home and Community Support Services**

A person is referred to the Service by a ACC Staff Member or NASC organisation.

The following information should be included in the referral:

- a) The person's name and address.
- b) The person's unique identifier. This is the NHI, and/or the ACC claim number.
- c) The ACC Purchase Order Number where the person is an ACC client.
- d) The person's ethnicity and any need for an interpreter (cultural or deaf interpreters).
- e) The reason for the referral
- f) Background information relevant to the person which may include advice regarding preferences, medication, any threatening or aggressive behaviour that the NASC or ACC Assessor is aware of and/or any diagnosed psychiatric conditions known which may cause the person to be aggressive or violent, including circumstances which may trigger a response e.g. coming up behind someone or high pitched laughter.

- g) A copy of the Individual Support Plan, and other relevant assessments, as agreed by the person.
- h) Details of any other funded supports the person may be receiving.
- i) Name and phone number of NASC Assessor/ACC case owner.

On receipt of the referral, the provider will, within 2 working days after meeting with the person, notify the NASC or ACC case owner that they have the capacity to accept the referral or that their Services are inappropriate for the person and they are declining the referral.

The person may also choose to decline or withdraw from Services after the initial meeting or at any time and the vendor must inform the NASC or ACC case owner within 24 hours if this is the case.

## **11. Roles and responsibilities of participants under this service specification**

Roles and responsibilities under the new service specification are not changed, although some aspects of the process have.

Under the current DSS services specifications the NASC is tasked with developing a support plan in discussion with the person and including the person's goals in that plan. The support plan will then be forwarded, with the person's agreement, to the service provider. The service provider is responsible for developing an Individual Service Plan in discussion with the person, and uses the information and goals set out in the Support Plan from the Assessor to do that. The new service specifications do not change this process; it simply ensures the goals set by the NASC/ACC Service/Support Coordinator are outcome focused for the person. It also introduces flexibility as to how those Services may be provided and allows the provider to be more innovative in their service delivery.

A detailed overview of the roles and responsibilities of the participants, and the process of service planning and delivery is as follows:

### **NASCs and ACC Assessors/Service Coordinators**

NASCs and ACC Assessors/Service Coordinators are responsible for:

- The initial and ongoing assessment of the person's needs.
- Identification of goals in collaboration with the person.
- Allocation of packages of care.
- Outlining Core and flexible hours.
- Assisting the person to maintain realistic expectations of the provider based on positive relationships and ongoing dialogue.
- Linking the above to the person's goals.
- Developing a Support Plan outlining the above.
- Sending the Support Plan to the provider.
- Regular review of the service package, and consequently the Support Plan, should occur annually, or there may be reassessment as required when needs change.

Information around assessment, goal setting and Core and flexible hours is provided in Section 13 and Section 16 below.

## Home and Community Support providers

Providers are responsible for:

- Reviewing the Support Plan.
- Meeting with the person to develop an Individual Service Plan (ISP) which implements the Support Plan and is designed to meet the persons goals.
- Developing an ISP that considers the use of identified flexible hours and outlines the tasks associated with the compulsory delivery of Core hours to ensure the person's safety.
- Sending a copy to the referring NASC or ACC Assessor within 3 weeks.
- Delivering Services which meet minimum standards as outlined in the Home and Community Support Sector Standard NZS8158:2003. This needs to remain the provider's responsibility even when Services are subcontracted or purchased elsewhere by the provider.
- Communicating to the NASC organisation or ACC Assessor when the person's needs change, requiring a reassessment or review.

## Disabled persons and family/whanau

Disabled persons and/or their family/whanau are responsible for:

- Ensuring that they participate in assessment and goal setting as much as possible.
- Identifying clearly what their goals and support needs are, including those that could be accommodated with the increased flexibility.
- Identifying, sourcing and providing all natural supports as could be reasonably expected and within their capacity to provide.
- Ensuring that the Core functions of family and support networks, such as meal preparation, child care, transportation, social support and the like are provided within their capability to do so.
- Maintaining realistic expectations of the provider based on positive relationships and ongoing dialogue.

The parts of the process which have changed are the focus on the disabled person's outcomes, the formal requirement for goals, and the identification of Core and flexible hours to ensure the opportunity for increased flexibility for people.

A process map is diagrammed in **Appendix 2:** Home and Community Support Services process.

## 12. Assessment and goal setting for NASCs and ACC Service/Support Coordinators

The NASC or ACC Support Needs Assessor undertakes the initial assessment of needs with the person and their family/whanau. The focus under the new service specification is on the goals and outcomes for the person receiving the service. This is based on what it is that the person would like to be able to do to live an ordinary life, not just the support task. The specifics of the service are not prescribed, this will vary for each person, and will be discussed between the person and their service provider.

**The assessment process is not intended to change** – it remains needs based (as opposed to entitlement based) and is intended to address the individual needs of that particular person. It should take into account their social environment and community

needs. This obviously will be different for every person. The following guidelines apply:

- a) **Allocations should not change.** The ability to trade off hours for activities/tasks that meet the persons goals and addresses some of the other, less immediate needs such as community participation should be considered with a view to a flexible approach.
- b) Natural and community supports should be investigated in the first instance and all family and social supports should be taken into account and utilised, so as to be able to support the person's goals as much as possible.
- c) Services which are funded elsewhere (i.e. MSD funded community activities) should not be accommodated within the flexible hours under this service specification. **It is critical that activities undertaken using flexible hours are not formally funded elsewhere or otherwise available to the person in any other way.**
- d) Ongoing dialogue between NASCs, Assessors and providers must occur to ensure the person expectations are managed and provider capability is considered at the assessment stage.

Services are allocated by the ACC staff member or the NASC service co-ordinator, in discussion with the person, to meet the person's goals, and written into the person's support plan.

The NASC or ACC Assessor will, in collaboration with the person, identify Core Services and any Services required to meet the person's goals. Hours which can be flexed to meet other needs outside those identified as Core will be identified in the support plan, and linked to the person's goals. The person's expectations will need to be managed based on the provider's capability, and time allocated. **Additional time will not be allocated to support increased flexibility.**

### 13. Service exit

If the person is to exit the Home and Community Support Services Service the provider will work in partnership with them, the NASC or ACC case owner and significant others (where appropriate), to ensure the safe and appropriate transfer of supports.

The provider will notify the NASC or ACC case owner within 2 working days, and others as agreed, as soon as practicable of the changes. In the event of death the provider will notify the NASC or ACC case owner immediately.

### 14. Core and flexible hours

Once the initial assessment and allocation of hours of support is completed, service coordination will include a conversation with the person about the division of Core and flexible hours and how these may be used. It is important to emphasise that this conversation occurs **after** the allocation of hours, **which is unchanged from previous practice.**

## Core hours

Core Services are those that will keep the person free from health or safety risks and support their wellbeing; for example:

- safe living environment
- freedom from infection
- skin integrity maintained
- effective bowel and bladder management
- assistance to get up every day and returned to bed at night
- assistance with nutritional needs.

Core Services are essential activities of daily living. These are agreed to when the Support Plan is being developed, and must be delivered by the provider. The Core Services will be described and written into the person's support plan by the ACC staff member or NASC.

## Flexibility

In discussion and agreement with the person, service coordination will identify the household management and or personal care hours that may be used flexibly to support the person to achieve their goals. **The Core Services may not be traded for other activities – they have been identified as essential activities that keep the person safe and healthy and must be provided.** Flexible hours can be traded off/utilised to assist the person to do other things to meet their goals. The Service provider writes the agreed flexibility into the person's individual service plan.

*As an example:*

One of the person's goals, identified at the assessment, is to be able to go to the library occasionally. This person has been allocated 10 hours Personal Care (PC) and 2 hours Household Management (HM) a week. To enable the person to meet their identified goal they wish to trade 1 hour PC (forgo a shower on one day) and 1 hour HM to enable them to be assisted to go to the Library when they wish to do so (2 hours). On the week of the library visit, the provider will still claim the 12 hours of Services provided as 10 hours PC and 2 hours HM as allocated by ACC or NASC.

The service provider ensures that the goals, agreed with the person during service coordination are the focus of the Services delivered by their support workers and other staff members.

There may be occasions when a person may wish to spontaneously be involved in a community activity and flexibility around service delivery is needed. On such occasions providers are expected to have a process in place to enable support workers to seek the advice of their coordinators to discuss the change.

The provider has the right to override the activity decision where the safety of the person and the staff may be compromised, or where, due to short notice, appropriately skilled support workers are not available. If there is doubt around the type of activity requested by the person, the provider must discuss this with the person and a review by the NASC/Assessor must be arranged

Allocations should not change or reduce if the needs and goals of the person or their available supports have not changed.

Traded hours does not mean that the person needs fewer service hours – it means that they are willing to be flexible as to how those hours may be provided/received.

## 15. Community participation

One of the main differences in the new service specification is the ability to allow flexibility, with a view to enabling the person to “live an everyday life”. For some people, this may mean taking part in community or family life outside the home. The service specification encourages the service provider to support the person in line with their goals.

In the first instance the person should use their natural and community support networks such as family, whanau and friends to do this. Where there are no natural or community supports to assist the individual to achieve this and the provider is able to deliver the service, the flexibility in the Individual Service Plan can make these provisions. The implications for the provider in delivering these Services could be related to how they manage support worker roles in this context.

The provider as the support worker’s employer can choose to manage the role of the support worker in this context as they see appropriate. However the support worker should not be held personally responsible for costs incurred while assisting the person to engage in community activity. The following options could be considered:

- a) Allowing support workers to participate in the activity the person is engaging in (going for coffee for example), and ensuring that the support worker does not have to pay – this cost should be carried by the person receiving service.
- b) Creating operational policy which outlines “place of work” behavioural standards for this service delivery component specific to settings, if this is not already in place,
- c) Delivery of the service, with clear expectations of professional “workplace” behaviour regardless of the setting.

## 16. Minimum Standards of Service delivery

The provider must provide Services in accordance with:

- a) The NZS Home and Community Sector Standards NZS 8158:2003.
- b) The Code of Health and Disability Services Consumers’ Rights 1996.
- c) The Health Act 1956.
- d) The Health Information Privacy Code 1994.
- e) The New Zealand Disability Strategy 2001.
- f) The Ministry of Health Directorate of Disability Services Principles (DSS Clients).
- g) The Code of ACC Clients’ Rights (ACC Client).

All other relevant legislation relating to employment, health and safety, and privacy matters.

## PART B: CONTRACTUAL RESPONSIBILITIES

### 1. Staff training and human resource requirements

In accordance with the Home and Community Support Sector Standard, the provider and NASC/ACC Assessor will ensure that all staff have an understanding of and be able to demonstrate:

Marsha Marshall (MOH) and Mary Leighton (ACC), 25 September 08  
This document will be reviewed and update regularly

- a) The principles of Home and Community Support Services.
- b) Understanding of the person and their individual needs, including awareness and understanding of any specific health or medication needs.
- c) How to empower the person to enable their self involvement in activities of everyday living.
- d) An ability to build positive partnering relationships with the person.
- e) Knowledge of disability philosophies and the barriers faced in day to day lives by those with disability.
- f) Knowledge of the New Zealand Disability Strategy.

They will also need to know:

- a) When to call in a health or disability professional.
- b) When to seek emergency assistance.

The provider will ensure that all staff have appropriate levels of training including:

- a) A planned orientation to their role and responsibilities, including scope of practice and limitations.
- b) A planned orientation to the Service which covers:
  - areas of service philosophy and values
  - policy and procedures relevant to the role and the service
  - knowledge and skills required for the role
  - cultural appropriateness
  - privacy and confidentiality
  - health and safety and safe working practice.
- c) Escalation process to ensure that staff are aware of when and from whom they need to seek assistance should situations arise with which they are unfamiliar.

All staff will have had a Police check and have sufficient and ongoing training as required to meet the person's individual support requirements. They will also have a supervisory relationship with a senior person as a training resource for them and as a quality management tool for the Service.

## **2. Other considerations of Service Delivery will include:**

### **Safety**

The provider will have a set of documented policies/protocols as part of their Risk and Quality Management framework including, but not limited to:

- a) Code of Conduct, including professional boundaries.
- b) Conflict of interest.
- c) Complaints policy and processes.
- d) An abuse policy that covers recognising and reporting physical or sexual abuse from others and preventing abuse (physical, sexual, financial and psychological) from staff.
- e) Privacy and Confidentiality.
- f) Protocols, or a guide for support workers related to supporting flexibility and goals within organisational parameters.
- g) Positive behavioural approaches.
- h) Escalation process to ensure that staff are aware of when and from whom they need to seek assistance should situations arise with which they are unfamiliar.

## Contingency planning

If for some reason the usual Services cannot be delivered then the provider must arrange alternative Services as part of contingency planning for the person. This includes:

- a) When the support worker is on leave.
- b) On public holidays.
- c) In case of a natural disaster.

There is provision in the new service specification for the provider to deliver additional Services to a person who requires them urgently, to protect their health and safety, outside normal business hours. In the service specification, this is termed “urgent care”, but has in past been termed differently. Some of the terms used in past include emergency, or discretionary. When additional care outside the allocated hours is delivered by the provider, they must notify the relevant NASC or ACC staff on the next business day.

## Stopping Services

The Service will cease when the person:

- a) Voluntarily exits the particular Home and Community Support Services provider/option they have chosen. The provider will notify the ACC case owner and significant others within 24 hours of this occurring.
- b) The person no longer needs the Service because their goals and independence have been achieved<sup>1</sup>.
- c) The provider can no longer safely provide the type or level of service required.
- d) Dies. The provider will notify the NASC/ACC case owner immediately.

## 3. Outcomes expected from Service delivery

The primary outcome for Home and Community Support Services is that which enables the person to meet their goals. This incorporates the delivery of appropriate supports to enable a person a greater opportunity for an ordinary life.

Successful Services occur when:

- a) A person has increased personal knowledge and self determination.
- b) A person holds the central role in all planning and decisions about their life.
- c) A person is satisfied with the service.
- d) The home environment is safe and meets the person's preferences.
- e) There is a partnering and collaborative relationship between the person, the NASC or ACC case owner and the provider.

## 4. Quality Performance Requirements

The joint service specifications require that providers operate in accordance with the Home and Community Sector Service Standards: NZS 8158:. As outlined in the Standard, the success of this Service will be measured on the following.

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<sup>1</sup> To the maximum extent practicable

### **Mission and philosophy**

The Service has a clearly defined mission and philosophy which expresses a commitment to the values and practices which underpin Home and Community Support Services.

### **Service planning**

The Service demonstrates:

- a) A comprehensive approach to planning with the person being the centre of the ongoing decision-making process.
- b) The ability of the provider to identify barriers for each person referred to their Service.
- c) The plan clearly identifies the person's goals, preferences and all support needs.

### **Cultural appropriateness**

The Service implements strategies that actively incorporate the place of the Treaty of Waitangi within service provision and recognises the cultural diversity of peoples.

### **Ongoing support**

- a) Service provision adopts a "whatever it takes" approach that achieves a strong commitment to achieving the goals identified for the person.
- b) Identification and resolution of non-participation, or dissatisfaction among people receiving service referred to the provider. ?Non-participation in achieving goals or dissatisfaction among people receiving Services are identified and referred to the Service provider for resolution. Or ? Identification and resolution of issues such as non-participation, or dissatisfaction with Services.

### **Community relationships**

Service provision should have a high profile in the community for the achievement of successful outcomes for people as well as effective ongoing partnerships with a variety of different agencies.

### **Management and administration**

The Service has a clearly defined organisational structure where governance and management have the capacity to offer all key components of Service delivery.

### **Consumer rights and accountability**

The service ensures that the person is actively supported to participate in the ongoing refinement of the Service as well as included in Service monitoring and evaluation.

### **Human resources**

The provider will ensure a calibre of staff that will have the knowledge and competencies required to deliver quality Home and Community Support Services.

### **Concern for quality**

The Service has a documented systematic approach to ensure service quality. Key components for consideration by the provider will include:

- a) All support needs of the person receiving service are met.
- b) Satisfaction with the Service provider and overall Service. This will be measured using customer satisfaction surveys.

## **5. Reporting requirements of the Service**

The provider will provide a six monthly report to ACC and MoH that will include:

- a) Demographics and number of service plans with goals and flexibility.
- b) Satisfaction with the Service.
- c) Number and type of complaints and number of persons involved including the percentage of those complaints resolved and action plan to address any issues.
- d) Report on any emerging trends or innovative approaches taken, and conversely, any systemic or Service delivery issues.

The provider will attend and participate in meetings with the funder at agreed times to discuss Service performance and development. This will occur at least yearly.

## **6. Monitoring of the Service**

ACC and the MoH will work closely with the provider to ensure the satisfactory delivery of Services.

### **Potential problems with the provision of Services**

If ACC or MoH identifies an issue with service provision, the provider will be contacted by an ACC or MOH Contract Relationship Manager. The Relationship Manager will outline the problem and work with the provider to seek a resolution within an agreed timeframe. For example if service development and training is identified as a problem, ACC or MOH would assist the provider with this activity.

### **Inability to agree a resolution to the problem**

If ACC or the MoH and the provider cannot seek resolution in accordance with timeframes provided, ACC will issue the vendor with a Notice of Breach. ACC or MOH will allow the provider a time frame to resolve the issue (if it is capable of resolution).

## Glossary of Terms

ACC Case Owner	The staff member engaged by ACC as the case manager or life time rehabilitation planner for the Claimant and located in an ACC branch for the purposes of the IPRC Act, and may also include a claims manager or other authorised ACC personnel.
Approved ACC Claimant	A person who has been accepted by ACC as eligible for cover in respect of personal injury under the IPRC Act, or is likely in the referrer's experience to be accepted and who has been referred to the Service provider by the ACC Case Owner.
Approved Assessor	DSS: An assessor employed or contracted by a Needs Assessment Service Coordination Service (NASC) organisation.  ACC: An assessor engaged or employed by ACC in accordance with clause 84(2) of the Injury Prevention, Rehabilitation, and Compensation Act 2001 (the IPRC Act).
Approved DSS client	A person who has been referred from the NASC organisation and is identified as having significant unmet support needs.
Child Care Services	Involve providing support to an approved ACC Claimant by caring for the Claimant's child or children. Child care primarily includes provision of the following:  (a) Personal assistance to each child with bathing, dressing, feeding and toileting.  (b) Supervisory care, which involves overseeing the child/children when no-one else is available to do so, to ensure the child/children is/are safe.  (c) After school activities/homework.  (d) Any other needs that are essential to the child/children.
Claimant Training Programme	The programmes which involve the participation of the support worker and include:  a) Training for Independence Services.  b) Maximum Abilities Programmes Individual Programme.  c) Rehabilitation Retraining Sessions.
Competent	The combination of skills, knowledge, attitudes, values and abilities that underpin effective performance.
Community participation	Engagement in activities outside the home which are, or have been a component of an ordinary, everyday life for the person receiving service.
Core Services	Personal support activities of daily living assessed as essential activities given health or safety risks. These activities must be delivered by the Service provider to the person.
Flexible hours	Hours which are not consistently vital to the person's safety and wellbeing and can occasionally be traded for other activities to meet the persons identified goals.

Goal	An aspiration or target or future condition that the person wishes to achieve in relation to the person leading an everyday life. Goals can serve more than one purpose.
Home	<p>Home means residential premises in New Zealand in which the Claimant lives and which are owned, rented, or otherwise lawfully occupied by the person or his or her parent, guardian, or spouse [or partner]</p> <p>Home includes residential premises in New Zealand in which the person proposes to live after they are built and which will be owned, rented, or otherwise lawfully occupied by the person or his or her parent, guardian, or spouse [or partner]</p> <p>Home does not include any hospital, hostel, hotel, motel, rest home, or other institution.</p> <p>Note: Where a contractual arrangement exists whereby the resident pays for, or the facility owner is obliged to provide Home and Community Support Services usually purchased by the Ministry of Health or ACC, then this definition does not apply.</p>
Household Support or Household Management	<p>Services which assist a person with a disability to maintain, organise and control their household/home environment, enabling them to continue living within their own environment. This includes but is not limited to:</p> <ul style="list-style-type: none"> <li>• meal preparation including shopping, cooking, dishes and kitchen cleaning</li> <li>• laundry including washing, drying and ironing</li> <li>• cleaning including vacuuming, dusting, cleaning bathroom and toilet, rubbish and bed making.</li> </ul>
Individual Service Plan	A plan agreed with the person that specifies how specific support/services will meet the goals identified in the Support Plan.
NASC organisations	Needs Assessment and Service Co-ordination. These organisations are funded by the Ministry of Health. Their roles are first to assess the person's needs, and then to coordinate Services to meet these needs, including allocation of DSS funded Services.
Person/People	The Approved DSS client or Approved ACC Claimant receiving support.
Personal Support	<p>For ACC: Personal care defined in Schedule 1 Clause12 of the IPRC Act 2001 means physical assistance to move around and to take care of basic personal needs such as bathing, dressing, feeding, and toileting.</p> <p>Personal Support includes Services delivered as Attendant Care as defined in the IPRC Act 2001.</p> <p>For DSS: Assistance with activities of daily living that enable a disabled person to maintain their functional ability at an optimal level.</p>

Registered Nursing Services	Registered Nursing Services delivered to a person in their home by a registered nurse. A registered nurse has a current annual practising certificate issued by the Nursing Council of New Zealand and works within the scope of practice as defined by the Health Practitioners Competence Assurance Act 2003.
Rehabilitation	A process of active change and support with the goal of restoring to the maximum practicable extent, a person's health, independence and participation in society
Service	The Services that are to be provided by the Service provider in accordance with this agreement as described in this specification
Service provider	Organisations accountable for the delivery of Services.
Sleepover care or night support	Is an attendant care Service or personal care Service where the staff member is required to sleep at the home of the person in order to provide intermittent care throughout the night.
Staff member	An individual who is responsible for delivering Services on behalf of a Service provider.
Support for Claimant Training Programmes	Assistance provided by a support worker in the implementation of those activities identified in the Claimant Training Programme to allow the Claimant to reach their maximum independence. This includes working with the key worker who manages the programme to learn what to do and how to do it.
Support Plan	A plan agreed with the NASC or ACC Case Owner and the person that specifies their overall Goals and Type or Amount of Services. For ACC Claimants this is termed an Individual Rehabilitation Plan.
Support Worker	An individual who is responsible for delivering the Service on behalf of a Service provider. This includes the provision of direct and indirect care or support service to the person and covers all staff and management who are: <ul style="list-style-type: none"> <li>(a) Employed</li> <li>(b) Contracted</li> <li>(c) Volunteer support workers accountable to the service provider.</li> </ul>
Type or amount of Services	An indication of the quantity or nature of Services approved by the NASC agency or ACC in accordance with their legislation and operational policies.

## Service Provision Enquiries – Contact Information

If you have any queries about this Service please contact the person most appropriate to your specific query. These are listed in the table below.

Query	Contact person	Role
Contract query ACC Contract query MOH	0800 400 503  Rose Hawkins Mark Powell	ACC Procurement Services  Northern Operations Southern Operations
Service Quarterly Reporting	Becky Olson	Programme Manager ACC
ACC Provider Helpline	0800 222 070	Provider Service Centre
General MOH queries	0800 MOH DSD Marsha Marshall	Development Manager – Home and Community Support Services

## Training Material and Web References

“*Back on Track*”. Verkaaik, J. (2004), New Zealand Spinal Trust.  
ACC Traumatic Brain Injury Guidelines.  
Joint ACC and MOH Home and Community Support Service Specification Refresher.  
MOH, ACC (2008).

### Web Sites

<http://www.mapl.com.au/TBI/index.htm>  
[http://www.brain-injury.org.nz/about\\_bianz.html](http://www.brain-injury.org.nz/about_bianz.html)  
<http://www.biausa.org/>  
<http://www.birf.info/home/bi-tools/tests/fam.html>  
<http://www.obia.on.ca>

## Appendix 1: ACC Serious Injury Profiles

Profile	Injury	Clinical Description
1	<b>High level tetraplegic</b>	C5 and above (includes injury at C5/6 level), ASIA scale A, B or C
2	<b>Low level tetraplegic</b>	C6 –T1, ASIA scale A, B or C
3	<b>Paraplegic</b>	T2 and below, ASIA scale A,B or C
5	<b>Severe Brain Injury</b>	Severe cognitive and / or physical injury. Includes anoxia. GCS under 9, post resuscitation, or on admission to ED. PTA more than 7 days. Brain damage or anoxia at birth.
6	<b>Severe to Moderate Brain Injury</b>	Either GCS between 9 – 13, assessed post resuscitation or on admission to the ED, or PTA between 12 hours to 7 days. Brain damage or anoxia at birth
8	<b>Comparable Injuries</b>	Conditions with comparable severity to other profiles. Examples are multiple amputation, burns to at least 50% of the body, blindness or neurotoxicity.
10	<b>Incomplete Spinal cord injuries</b>	Incomplete spinal cord injury , ASIA D (any level) including clinical syndromes e.g. cauda equine

## Appendix 1 (Contd.)

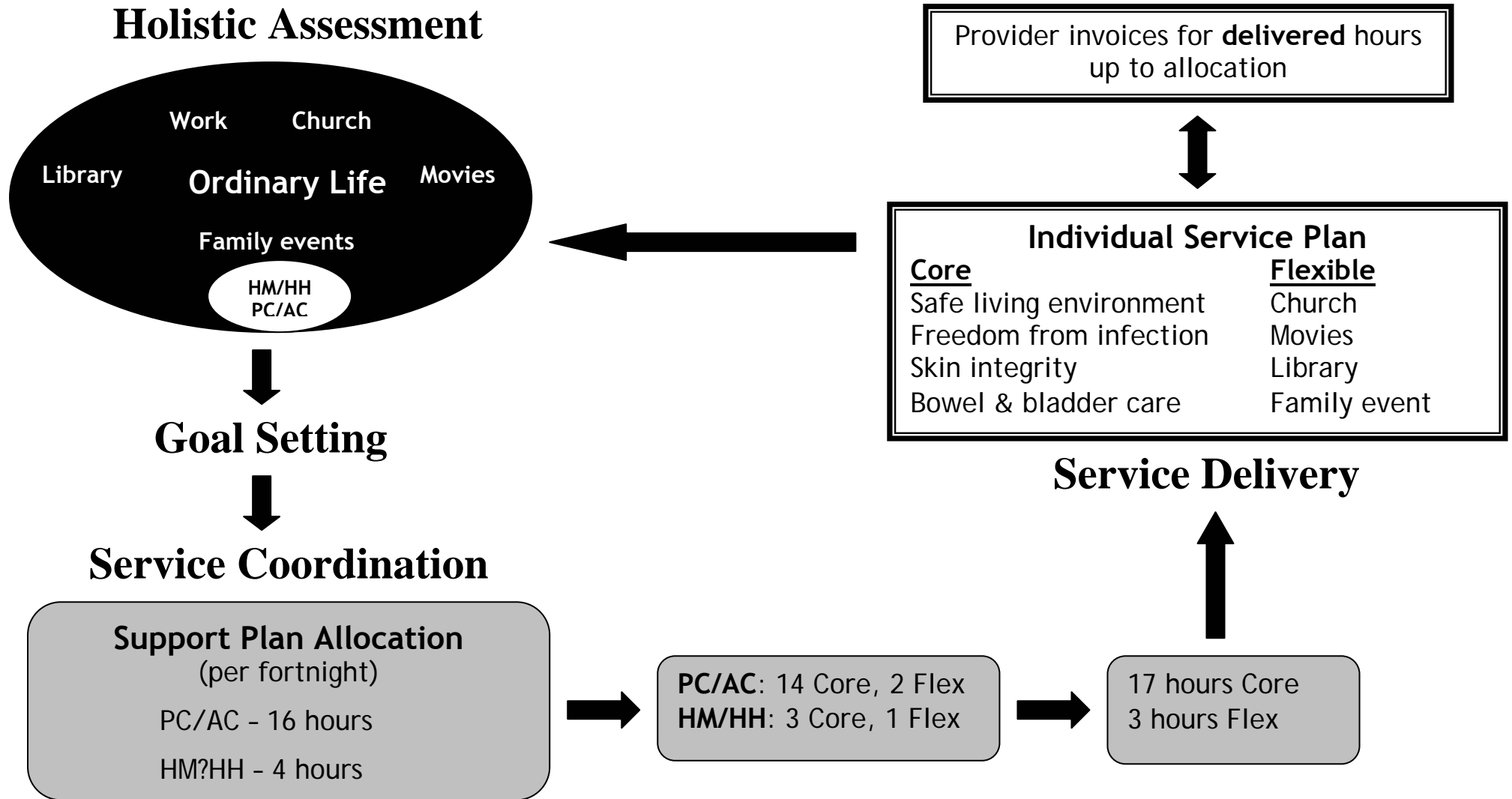
### About the ASIA scale

Internationally, spinal injuries are classified using the American Spinal Injury Association (ASIA) scale that describes a person's functional impairment from the injury.

See description of the functional elements of ASIA scale below:

ASIA Classification	Description
A	Complete motor and sensory loss.
B	Incomplete. Sensory but not motor function is preserved below the neurological level and includes sacral segments S4-S5.
C	Incomplete. Motor function is preserved below the neurological level and more than half of the key muscles below the neurological level have a muscle (strength) grade of less than 3.
D	Incomplete. Motor function is preserved below the neurological level and more than half of the key muscles below the neurological level have a muscle strength grade greater than or equal to 3.
E	Normal. Motor and sensory function is normal.

**Appendix 2: Home and Community Support Service Process and Roles**



Marsha Marshall (MOH) and Mary Leighton (ACC), 25 September 08  
This document will be reviewed and update regularly