He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

Residential Support Services

Operational Guidelines

Current as at 1 October 2025

This document is a living document and will be reviewed and updated as necessary.

He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

Table of Contents

Useful contacts and telephone numbers

You may need to contact ACC when delivering Residential Support Services. Depending on your issue or question you may need to contact a different person or team, here are the contact details you may need:

Table 1: ACC contact details

ACC Provider Helpline	Ph: 0800 222 070	Email: Providerhelp@acc.co.nz
ACC Client/ Patient Helpline	Ph: 0800 101 996	
Provider Registration	Ph: 04 560 5211	Email: registrations@acc.co.nz
	Fax: 04 560 5213	Post: ACC, PO Box 30823, Lower Hutt 5040
ACC eBusiness	Ph: 0800 222 994, Option 1	Email: ebusinessinfo@acc.co.nz
Contracts Administration and Health Procurement	If you have a question about your contract or need to update your details, please contact the ACC Health Procurement team: Email: health.procurement@acc.co.nz Ph: 0800 400 503	
Engagement and Performance Managers	Engagement and Performance Managers can help you to provide the services outlined in your contract. Contact the Provider Helpline or acc.co.nz /for Providers for details of the Engagement and Performance Manager in your region.	
ACC Portfolio	Contact the Provider Helpline for details of the Advisor/ Manager for Residential Support Services or email RSS@acc.co.nz.	

The ACC website can provide you with a lot of information, especially our "for Providers" section. Please visit www.acc.co.nz. For Residential Support Services specific information see Residential Support Services.

Please report all health, safety and security risks or incidents in writing using the procedure on our website https://www.acc.co.nz/for-providers/report-health-safety-incidents

Introduction

The overarching contractual documents for Residential Support Service (RSS) are the Standard Terms and Conditions for Health Contracts and the Service Schedule also known as "the contract". Together the Standard Terms and Conditions and the Service Schedule form the whole Contract.

These Operational Guidelines are intended to provide you with the detailed information and context you need to deliver Residential Support Services.

The Operational Guidelines should be read in conjunction with the Service Schedule. If there is any inconsistency or conflict between the Service Specification and the Operational Guidelines, then the provisions of the Service Schedule will take precedence.

Overview

The Residential Support Service provides a homelike environment for clients who have sustained a physical injury, including Traumatic Brain Injury, and who are unable to live independently, requiring placement in a residential setting, either short term or long term, due to that covered injury. The goal is to provide these clients with safe, high quality residential support.

Types of Residential Care facilities

Residential care facilities can vary depending on the type of clients they service. Types of residential care facilities include:

- **Aged Residential Care facilities** which are primarily funded by the Ministry of Health, and generally support older clients in rest home or hospital-level care environments
- **Shared community living facilities and smaller group homes** which offer shared living arrangements in the community for smaller groups.
- **Specialised care and rehabilitation facilities** which offer specialised rehabilitation to specific groups of clients, such as those who are more medically complex, or have a brain injury.

Types of Residential Care service

ACC primarily purchases two key types of residential service based on the expected duration of support a client is expected to need. A client may enter under one service and then may transition to the other at some stage during their stay.

Short Term Residential Care

Short Term Residential Care is for clients whose intended length of stay at a facility is less than 6 months. This could be because they:

- have been discharged from a hospital and require a period of convalescence or rehabilitation before returning to the hospital for further rehabilitation, or further medical or rehabilitation intervention
- have been discharged from a hospital and need further support or rehabilitation before returning to their usual place of residence
- require care for a temporary period until further arrangements are made, such as Home Modifications
- require Relief Care for their usual caregivers.

Short Term Residential Care is purchased under service codes (see below for further information on Levels of Care):

- RRS11 – for low needs clients
- RRS12 – for medium needs clients
- RRS13 – for high needs clients

Long-Term Residential Care

Long-Term Residential Care is for clients whose intended length of stay at a facility is longer than 6 months or permanent. This could be because they:

- require an extended stay whilst they receive rehabilitation to enable them to return to their usual place of residence
- are not currently suitable to live in the community with support, but may achieve this in the future; or
- are no longer able to live independently without substantial support or medical oversight, and/ or have been assessed as requiring long term residential support.

Long-Term Residential Care is purchased under service codes (see below for further information on Levels of Care):

- RRC01 – for low needs clients
- RRC02 – for medium needs clients
- RRC03 – for high needs clients

Service objectives

The objectives of Residential Support Services are:

- **Clients receive suitable care for their needs** – Clients in a Residential Care facility are expected to be provided with safe, high quality and clinically appropriate care.
- **Clients' needs are met** – A client's medical, rehabilitation, cultural, social, environmental and emotional needs are considered by the supplier, included in their Care Plan and services delivered to meet these needs.
- **Clients achieve and maintain their optimal level of independence** – Clients should be discharged to their usual place of residence in a timely manner or, for clients who require Long-Term Residential Care, be supported to maximise their participation in their daily activities and local community.
- **Clients are satisfied with their service** – Clients and those important to them, including their family/whānau should be happy with the support they are receiving.
- **Care provision is cost effective and efficient** – Clients should be receiving the appropriate level of support to meet their assessed needs in a timely manner.
- **Clients have a reduced risk of further injury** – Clients should receive care, support and education to reduce the risk of a further injury, including pressure injury.

Service Entry

This section details how a client is determined to be eligible for Residential Support Services, and how the appropriate level of support is confirmed.

Service eligibility

A client is eligible for the service if they:

- have an injury with accepted ACC cover, including a traumatic brain injury; and
- are assessed as requiring residential services primarily due to the covered physical injury; and
- are unable to live independently and safely in their own home or usual place of dwelling and needs support/supervision for their health and wellbeing due to their covered injury.

This includes if their home or usual place of dwelling is temporarily unsafe until the client receives further rehabilitation or other intervention, such as assessment for equipment to enable them to return home, or if the client cannot remain safe in their home due to the availability of their usual caregivers, e.g. carer relief care.

Service exclusions

A client is **not** eligible for the service if they:

- require residential support, which is the responsibility of another funder, e.g. Ministry of Health or Ministry of Social Development
- require residential support solely due to a mental health or addiction condition
- require residential support solely due to a need for housing, or to prevent homelessness; or
- where it is determined that this service is not appropriate to meet the individual's support needs.

Where it is identified that a client meets one of these categories, the supplier and/or ACC should consider alternative options for funding support for the client, including engaging appropriate agencies.

Referral process

A client may be referred to the service by public health services, e.g. a hospital, a specialist rehabilitation facility, a Traumatic Brain Injury Residential Rehabilitation supplier, spinal unit, or ACC.

Where a referral comes from ACC, it should be sent at least 3 business days prior to admission, and should include, at a minimum:

- the client's name, gender, date of birth and contact details
- if it is not the client, their preferred contact person and relationship to the client
- the ACC claim number
- the details of the client's injury; and
- any health and safety, behavioural, complex medical or other risk factors which may impact the delivery of the service.

If the supplier requires more information to determine if they can accept the referral, they should contact ACC directly to discuss and request this prior to commencing the service.

Where a referral comes from a source other than ACC, the supplier should work with the referrer to ensure that they have enough information to confirm they can accept the client and consider the appropriate level of service.

The supplier must notify ACC of their ability to accept or decline the referral, or request further information, within 1 business day of receiving the referral.

Appropriateness of facility to meet client's needs

Clients should be placed in a residential care home which best aligns to their needs, taking into consideration:

- Whether the facility can meet the client's care needs
- The wishes of the client and their whānau
- The match between the client's cultural, social, emotional, intellectual and spiritual needs and what the residential care home has to offer
- The ability of the client's whānau to visit and support the client
- Age appropriateness of other clients in the residential care home - Clients over 65 years would usually be placed in an Aged Residential Care facility.
- The facility/house has the appropriate level of certification to provide the level of care to meet the client's assessed needs.

Sometimes it may not be possible to place a client in a residential care home which is the best match for all the client's needs. At times one of the above factors takes precedence over other factors. E.g., a client may be best placed in a residential care home which is near their whānau even though that facility may not usually cater for that client's age group.

Determining client's funding package

Clients can have a variety of different needs and complexities depending on their injury and the reason they are requiring residential support. The level required will be determined by either medical notes available, or an assessment to determine whether the client's need for residential support is due to their covered injury and the type and level of residential support required.

Assessments may include:

- Support Needs Assessment (SNA)
- Social Rehabilitation Needs Assessment (SRNA)
- Other Specialist Assessments, e.g. Geriatrician
- Health NZ – Te Whatu Ora notes, other medical notes.

Levels of care

The client's level of care needs may be identified as low, medium or high. The level of need is based on a combination of factors that will determine the level of support required.

The described levels of care are a guideline which don't reflect all clients' unique combinations needs and circumstances. When determining the appropriate level of support for a client, it's important to note a client doesn't need to meet all the requirements under a level to be eligible for that level of support, and meeting one of the requirements does not immediately mean that they are eligible for that level of support.

It's also important to recognise that the level and type of support provided in an Aged Residential Care facility is different in nature to the level and type of support provided in a shared community living facility or house.

The level of care needs to be agreed between the facility and referrer when confirming a placement, and care needs to be tailored to the client's individual needs as opposed to strictly following the criteria described in the levels of care.

Client Example	Presentation
Example 1 Low Level of Care	• A client requires low or no physical assistance to manage their activities of daily living, and the daily structured routines of the facility are sufficient for them to maintain their wellbeing alongside the clinical oversight. • The client also has another complex health need, e.g. insulin dependent diabetes, which needs to be included in their Care Plan, and the management of which is important for maintaining their injury-related needs. • Although some of the client's needs are features of the high level of care, this client is likely still appropriate to be managed as a low needs client.
Example 2 Medium Level of Care	• A client requires no physical assistance but has cognitive and infrequent behavioural needs. The daily structured routines and safe environment with oversight meet the majority of their needs.

Client Example	Presentation
	• The client is under 65 but is staying in an Aged Residential Care facility due to the desire to be near their whānau taking priority over being with clients their own age. As a result, some tailored activities and community activities are required to ensure that they remain stimulated. • Behavioural support strategies have been provided to the facility, and staff need to respond based on the client's behavioural support plan when these needs present. • Although the majority of the client's needs are features of the low level of care, the fact that the supplier is tailoring support to a client with different needs to their usual residents, this client is likely to meet a medium level of care.
Example 3 High Level of Care	• A client has high medical needs because of their injury and comorbidities. • They need a high level of input from therapy professionals to manage their medical needs and to maximise their participation in daily living. • They require 2 people to assist with transfers and personal care using specialised equipment, and their complex medical needs require them to have availability of 24/7 Oversight with a high degree of Supervision. • They have no behavioural or communication needs and actively participate in their care where they are able. • This client is likely still appropriate to be managed as a high needs client.

For a more comprehensive summary of the differences between levels of care, please see Appendix 1.

Service planning

This section describes how the client's individual Care Plan should be developed and reviewed to meet the client's unique needs.

Care Plans document:

- the level of care provided to the client to manage and treat the client's injury-related needs and any medical conditions; and
- the type and amount of support provided to the client to enable the client to be as independent as possible; and
- how the client's health and wellbeing will be promoted; and
- how the client's spiritual, emotional and cultural needs will be met.

The supplier must engage the client and anyone the client identifies as important to them, including their whānau, in discussions around how their care will be delivered. This includes:

- the services the client will receive
- the client's goals, and how the services will support them to achieve these
- the things that are important and meaningful to the client, including their cultural needs
- how the client will be supported to engage in social and community activities that are important to them
- how the client would like their whānau to continue to be involved in their service planning and reviews
- the duration of the client's stay, and when and for how long ACC is likely to contribute to this, e.g. if their stay is likely to continue for longer than ACC's contribution to funding
- the contribution the client or other funders will be making to their stay, and
- the client will be supported to allow dignity of risk.

The supplier must ensure that, where relevant, any other rehabilitation or care providers involved in support for the client, including those arranged by other funders, are engaged to ensure that their input (rehabilitation activities and specific targets and goals) are integrated into the client's Care Plan.

Initial care plan

All clients must have an Initial Care Plan completed within 15 business days of the client's admission to the facility. This ensures that the appropriate services have been considered and tailored to the client's unique needs.

The Initial Care Plan does not need to be submitted to ACC unless requested.

The initial care plan must include:

- the date of the client's admission to the facility
- the client's goals, and the strategies in place to support the client to meet these goals, including those which are the responsibility of the supplier and other providers, such as external rehabilitation or treatment input, and
- a risk management plan including Oversight to ensure client safety, allow dignity of risk, promote well-being.

For clients who are receiving Short-Term Residential Care, it must also include:

- planned date of discharge, and the strategies in plan to meet these, including those which are the responsibility of the supplier and other providers, such as external rehabilitation or treatment input; and
- destination the client will be discharged to, e.g. home, alternative rehabilitation facility, or Long-Term Residential Care.

Where the intention is for the client to be transferred from Short-Term Residential Care to Long-Term Residential Care, it should be noted whether this is expected to be funded by a party other than ACC, such as Ministry of Health, Private Funding, or a combination of these.

Where it is recommended that a client currently receiving ACC funded Short-Term Residential Care requires ACC funded Long-Term Residential Care, the supplier should complete a request to ACC to transfer the client to Long-Term Residential Care immediately (see Change in level of care required in these guidelines).

Long-term Care Plans

The Supplier is responsible for ensuring that all clients have a Care Plan, which is updated regularly with the Client and their whānau, for the duration of their stay in the facility,. This includes updating whenever the client's situation or needs change, or when the client identifies new goals or achieves existing goals.

A Long-term Care Plan is only required for clients who are receiving Long-Term Residential Care (e.g. services are funded as service codes RRC01, RRC02 or RRC03). The supplier should begin to develop the Long-term Care Plan immediately upon commencing Long-Term Residential Care. This could be either:

- when the client changes from Short-Term Residential Care to Long-Term Residential Care funding; or
- on admission to the Supplier's facility, where it has been identified that the client requires Long-Term Residential Care prior to commencing services.

The first Long-term Care Plan must be submitted to ACC within 3 months of the client commencing Long-Term Residential Care.

The Long-term Care Plan can be completed using an ACC1155 form, or on a template of the Supplier's choice. It must contain at a minimum:

- the client's identifying information, including a summary of their injuries and other relevant medical conditions
- the client's date of admission to the facility
- recognition of the client's physical, psychosocial, spiritual and cultural abilities, deficits and needs
- the client's concerns and stated wishes
- identification of specific risks and mitigation strategies, such as programmes and/ or education in place to manage these
- the medication regime (if appropriate)
- the activity/ rehabilitation schedule
- social enrichment activity and community integration schedule
- client specific goals and outcomes, and required strategies to meet these, and
- discharge planning (wherever relevant).

Review of a client's needs

A client's care plan should be updated with the client and their whānau whenever their needs change.

For Long-term Care Plans, they must be reviewed and updated at a minimum of every 12 months, with a copy sent to ACC within that timeframe.

For the Long-term Care Plan review, alongside ensuring all the information is updated, the supplier must comment on the client's goals and their progress toward these since the last review.

ACC can also request an updated Long-term Care Plan at any time if required, at no cost to ACC. This may be:

- due to concerns about the client's progress
- as supporting information for a referral or assessment, or
- to verify the level of support a client is currently receiving.

Service extension or variation

This section describes situations when the Supplier needs to request changes or variations to the client's stay.

Extension of care

ACC approves care for set periods at a time. No more than 6 months for Short-Term Residential Care and no more than 12 months for Long-Term Residential Care.

Short-Term Residential Care extensions

When a client receiving Short-Term Residential Care requires an extension, the supplier can request this by submitting an ACC1156 variation report. The report must be submitted to ACC no less than 10 business days prior to the expiry of the service and must be signed off by a Registered Health Professional.

The report will detail:

- the reason for the extension
- the new planned discharge date
- the planned interventions to support the client to achieve their goals, including who will provide this, and
- any changes to the client's needs.

It is expected that clients receiving Short-Term Residential Care should require only one extension of their service. This is because on admission to the facility, the referrer (usually a hospital or ACC) will have determined the likely period that a client will require support prior to their return home but allows for a variation to this based on the client's actual progress.

If the supplier believes the client receiving Short-Term Residential Care is going to need support for more than 6 months, they should use this extension request and ACC1156 variation report to request a change to a Long-Term Residential Care approval. This will enable ACC to consider early what assessments and support will be required to either support the client to discharge, to confirm support for funding for a long-term placement, or to arrange for alternative funding options to be considered (such as dual funding with the Ministry of Health).

Long-Term Residential Care extensions

For clients receiving Long-Term Residential Care, ACC may renew the funding on an annual basis without the need for an ACC1156 variation report to be submitted where the ACC Recovery Team Member has already planned for this extension to occur. If the supplier has not received an approval for an extension, the supplier must still submit the ACC1156 variation report no less than 10 business days prior to the expiry of the service.

Change in level of care required

Where a supplier is delivering support for a client and identifies that the level of care currently funded is not correct, they should notify ACC using an ACC1156 variation report recommending a change to the appropriate alternative level of funding. This may be due to either a deterioration or an improvement in the client's medical or behavioural needs, meaning that they no longer need the same amount of support.

On receipt of the ACC1156 variation report, ACC will consider the information available and whether further assessment is needed to agree to the recommended change.

Potential outcomes could be that:

- ACC agrees to the recommended change and issues a new approval at the recommended level of care
- ACC declines the recommended change, as information indicates the current level of care is still appropriate
- ACC arranges for an independent assessment (e.g. a Support Needs Assessment) to better understand the client's level of need and provide support for the recommended change, or
- ACC arranges an independent medical assessment (e.g. with a Geriatrician) to determine if the change in needs is still linked to the client's injury.

ACC may agree a temporary change in the level of support during this process, or else the supplier will continue to invoice ACC at the current rate until the review of the client's needs has been completed.

If ACC does subsequently agree to increase the level of support for a client, ACC may retrospectively approve the increase in support for the client.

Purchase of temporary additional care

When a client receiving support needs additional temporary care, the supplier should contact ACC by submitting a care plan highlighting the additional need. The support can be either for:

- Registered Nursing
- Allied Health or
- Support Care Workers.

All of this support is available under the standard levels of care (low/ medium/ high), so the supplier will need to demonstrate why this is exceptional and what specific temporary need it is intended to address. This could include:

- interventions (additional support) to support management of behaviours that impact service delivery, to allow time for targeted interventions to support the client with longer term strategies, e.g. Behavioural Support Services program
- additional therapeutic support, such as to return the client to their previous level of independence following an illness or new accident, or
- additional medical care, such as to support the client with managing a minor wound which doesn't require Nursing Services.

Because the support is intended to be temporary, it can only be requested and approved for up to 4 weeks at a time. If support continues to be required beyond this, the supplier will need to make a new request to ACC for consideration. When reviewing a request for an extension of the support, ACC will also consider if this may result in a transition to a long term need which requires an increase in the level of care or allocated funding for the client.

Likewise, if the supplier is aware that the need is expected to be permanent, these codes should not be requested, and the supplier should request a change in the level of care instead.

Changes to approved support

Where ACC determines that a change to the approved support is needed, they will advise the supplier of the date this is to take effect.

This includes when:-

- ACC has determined a change in level of care is appropriate
- Dual-funding is determined to be appropriate
- The client is no longer eligible for the support.

A reasonable notification period should be provided, such as 4 weeks, although this may vary depending on factors like the reason for the change, the potential impact on the client or capacity issues (including due to time of year and so on). This is to account for the possibility that the supplier may need to make changes to how services are delivered, or the client may need to be supported to consider additional funding options, including obtaining a needs assessment.

See sections Levels of care, Dual funding and Ending the service of these guidelines for more information.

Dual funding

Where a client has a combination of injury- and non-injury related needs which require Residential Support Services, ACC is only responsible for funding injury-related needs. This is usually identified in one of two ways.

Client already in a residential care facility

Where a client is already living in a residential care facility prior to their accident and due to the accident requires an increase in their level of support, ACC will usually pay for the difference between the existing arrangement and the new level of care.

In some cases, ACC may consider funding the full cost of the higher level of care, e.g. if a bed retention rate is needed to hold the client's usual accommodation whilst they temporarily receive a higher level of care elsewhere. This would be agreed on a case-by-case basis.

If the client requires the increased level of support long-term or permanently, ACC will follow the below process to consider long-term funding responsibility.

Client moving to residential care following their accident

It is recognised that a client may require residential care following an accident due to a combination of injury and non-injury related need, but because most injuries are not permanent, clients are expected to return to their previous level of independence at some point. Where a client requires long-term residential care following an accident, this is usually considered to be due to a combination of injury and non-injury related factors.

Situation	Funding arrangement	Rationale
Client needs residential care following an accident but expects to return home following their recovery.	• ACC will fund the residential care placement under short-term care. • The supplier will advise ACC of any changes to the expected discharge timeframes, and any additional support the client needs to return home.	The need for residential care is largely accident-related, and the client will not need this long term.
Following their accident client and whānau identify that the client has been struggling at	• ACC will usually not contribute to residential care funding but may support with funding for	The need for residential care pre-dates the accident. Although the accident may have triggered the client

home for a while, and residential care is recommended.	rehabilitation in the facility to recover from the injury. • Supplier will support the client to consider and apply for alternative funding options (e.g. Residential Care Subsidy),	entering residential care, ensuring funding comes from the correct source upfront reduces delays in having needs assessment completed.
Client and whānau expect the client to return home after admission to the facility, but client's return to independence plateaus.	• ACC will fund the residential care placement under short-term care. • The supplier notifies ACC of the need for long-term care following the Extension of Care process detailed in these guidelines to request a change to a long-term service code. • If there is enough information, ACC will approve the change to a long-term service code. ACC may arrange an assessment to verify the need is related to their injury. • If the need is not purely injury-related, ACC will notify the supplier of the percentage of funding ACC will cover and the date this will take effect. The supplier will support the client to consider and apply for alternative funding options (e.g. Residential Care Subsidy).	The need was expected to be short-term, so it is appropriate for ACC to fund this in full. When it's identified the need is long-term, it is likely a combination of reasons for this, and dual funding arrangements need to be considered. See the Dual Funding section of these guidelines for more information.

Client absence

Approved absences

Although it is expected that a client receiving Residential Support Services needs to be present in the facility the majority of the time due to their health needs, clients may sometimes be absent from the facility for short periods. This could be:

- to attend to whānau responsibilities
- to undertake a home trial, or
- to take a holiday.

Prior approval is not required, but the supplier must notify ACC so that required supports can be arranged for the client and their whānau. ACC will approve up to 14 nights per year at the full bed rate, and any remaining days at the bed retention rate.

If there are substantial numbers of absences over an extended period, e.g. bed retention rate payments, it may be a prompt for ACC to consider if the residential care placement is appropriate or if the client is able to be discharged to be supported in the community.

Hospital admissions

If the client needs to be admitted to hospital, ACC will fund up to 14 nights per admission at the full rate, and the bed retention rate for any further nights absent during the same admission.

This applies for any separate admissions throughout a 12-month period, however repeated absences for this reason may be a prompt for ACC and the supplier to reconsider if the placement is appropriate or if the client's needs would be better met elsewhere.

Unplanned absences

For clients who are absent from the facility without the supplier's approval, e.g. have absconded, the supplier must notify the relevant authorities immediately if there is a risk to the safety of the client or the public.

The supplier is also responsible for taking all appropriate action to return the client to the facility. This is because the client has been assessed as needing residential care, so it is assumed that they are unsafe to be in the community.

The supplier must also notify ACC via email of the absence within 24 hours, including detailing what actions are being taken to return the client to the facility.

For these clients, ACC will pay the full rate for the first two nights of an absence, and then the bed retention rate for any further nights until either the client returns to the facility or until ACC determines that the client has been, or can be, discharged.

Once it is determined that the client has been discharged, ACC will make a new referral to the supplier, and the supplier is to accept that referral before the client can be readmitted.

Service delivery

Service requirements

Clients who are receiving support from the supplier are able to receive some or all of the following service elements to meet their needs:

- Pre-admission visit
- Hotel services
- Nutrition
- Hydration
- Personal care services
- Personal Supervision
- Day activities including recreational activities
- Programmes and/ or education on minimising risk of further injury
- Access to a General Medical Practitioner
- Access to emergency care
- Medication
- Medical consumables (except for those which are excluded from the service, see 'Consumables and Equipment' below)
- All incidental services which a reasonable and responsible support of similar services would provide to meet the physiological, cultural, spiritual and social needs of the client
- Interpreter and advocacy services
- Relevant cultural liaison workers
- Monitoring of the service delivery
- All equipment appropriate to the provision of the services which is generally available to all clients (see 'Consumables and Equipment' below)
- Technical support to maintain the equipment
- Administrative support required to deliver this service, including to enable the supplier and ACC to evaluate the service.

The supplier is expected to provide the above to the degree that other similar providers with similar clients would provide it. This does therefore differ depending on the specific facility. E.g. a facility which caters for clients who have recently discharged from acute admission following their injury and focuses on rehabilitating clients for a short period of time before their return home would be expected to have greater access to allied health oversight and nursing support, whereas an aged residential care facility which caters for clients with lower needs as a 'home for life' may not have this ready access.

Targeted rehabilitation aimed at creating or directing a rehabilitation plan to achieve specific goals is not required in the service. ACC will arrange for this separately however ACC expects that all suppliers have access to appropriate clinical oversight to deliver a client's required support, including their day to day rehabilitation needs in between visit from external rehabilitation providers.

Programmes and education on minimising risk of further injury can vary from client to client but are an important part of achieving the service objective of reducing risk of further injury. E.g. it is acknowledged that a patient who is non-weight bearing in a short-term placement at a facility will not be able to engage in active falls prevention activities, but may be able to receive education on this, and have pressure management also form a part of their care plan and education.

Consumables and Equipment

A supplier is required to meet the majority of the consumables and equipment needs of their clients. It is expected that these would generally be available for all of their clients, regardless of who is funding their stay.

This means that, for consumables, standard items like gloves, aprons, IV sets, continence pads, supplements and thickeners, basic wound dressings (eg bandages, dry dressings), wipes, creams and tapes would all be available.

Equipment such as hospital beds, specialist mattresses, mobility aids including generic wheelchairs (including powered), walking frames and manual handling equipment including hoists and sliding sheets would all be available.

Some clients have more specialised and complex needs Equipment for these should be requested from ACC through their contracted suppliers.

This includes consumables like:

- those required for enteral feeding
- specialised bowel and bladder management including catheters and colostomy consumables
- specialised breathing equipment including oxygen tubing and masks and suctioning equipment, and
- specialised wound dressings, including negative pressure wound therapy.

For equipment, where a client requires a specially scripted item, such as an individually scripted wheelchair or positioning or sleep system, ACC should be contacted to arrange assessment of this.

For a complete list of equipment and consumables which are or aren't the responsibility of the supplier, refer to Appendix 2.

Record keeping

As well as the client's Initial and/ or Long-term Care Plans described above, the supplier is responsible for maintaining clinical care notes for the client, including:

- their medicine regime
- falls and pressure injury prevention plan
- care plan (including their daily routine)
- rehabilitation plan and/ or maintenance plan to ensure that the client is able to attain or maintain their maximum level of independence and functioning, and
- social activities, interests and community participation.

The records should include detail of any requirements for the supplier to support with externally managed rehabilitation programmes for the client, e.g. to prompt or support the client with exercise or rehabilitation programmes.

Where requested by ACC, the supplier must make these records available to ACC.

Provision of services outside of Residential Support Services

Occasionally, the supplier, the client or ACC may identify additional services which are not covered as part of Residential Support Services. Some examples of this could include:

- nursing for complex wound management
- allied health or rehabilitation services for targeted therapeutic input
- medical assessment or review
- medical treatment, or
- dental.

To determine if ACC should fund these services, ACC will consider whether the need is relatedto their injury, that it shouldn't be provided as part of Residential Support Services and that the services will support the client to maintain or increase their independence.

If ACC determines that this is not something that can be arranged by ACC, the supplier should arrange referral for the client to access the supports.

Client participation and attendance at day programmes, recreational activities

The client's level of independence, participation and engagement in activities will be appropriate to the client's ability, wishes, identified goals, needs and interests. It is important clients are supported to maintain their optimum level of function and independence as much as possible.

If the client's Care Plan states they will attend an activity outside of the Residential Care facility, then the Supplier is responsible for facilitating this to occur. Costs associated with the client's attendance at recreational activities are met by the client.

Where the client's Care Plan indicates the client is not able to attend any programmes or activities outside the facility, then the Supplier should provide appropriate day activities and recreational activities that the client is able to participate in.

Transport

Travel to enable the client's families to visit the client is arranged outside of the provisions of this contract and ACC will manage this on a case-by-case basis.

- Transport for clients to attend outpatient appointments at Health NZ – Te Whatu Ora is the responsibility of Health NZ - Te Whatu Ora if the appointment is within first six weeks following discharge from acute care. After six weeks, it is ACC's responsibility if the appointment is injury related.
- Transporting the client to any medical appointments related to their injury - costs may be met under ACC's ancillary provisions.
- Transporting clients to day programmes and activities included in Residential Support Services - cost is met by the residential care home provider.
- Transporting clients to activities outside of Residential Support Services – cost is met by the client.
- If an ambulance transfer from a residential care home to acute care is required, this is covered under Public Health Acute Services (PHAS) funding.

ACC does not cover transport where the client has their own vehicle.

Enduring Power of Attorney (EPoA) and Protection of Personal and Property Rights (PPPR)

In instances where a client is no longer able to make decisions for themselves and where they already have Enduring Power of Attorney in place this may become active. The supplier will

need to ensure that the person holding the EPoA is involved in all decisions relating to the client's care.

Where there is no existing order, whānau members or the client's representative may apply to the Family Court under the PPPR Act to make a personal or property order for the client or ask for the appointment of a welfare guardian or property manager to make decisions on behalf of the client.

ACC may consider making a financial contribution towards the costs of the application where the client and/ or their whānau are unable to finance the application and there are risks to the client's welfare and wellbeing. Consideration is made on a case-by-case basis, by contacting ACC.

It is unlikely to be appropriate for the supplier, or someone employed by the supplier to also hold welfare or property management for the client, however in some cases a court may determine this to be necessary. ACC considers this to be a conflict of interest in as per the Standard Terms and Conditions.

If the supplier or anyone employed by the supplier is requested to hold guardianship for one of their clients, or they already hold guardianship and have not yet notified ACC, this must be declared to ACC so a management plan can be established.

Service exclusions

Some services are specifically excluded from being delivered under Residential Support Services. If these services are required, the supplier must request them from ACC (as above) or arrange referral for the client to access the supports.

These services are:

- Acute and elective secondary care services
- Diagnostic imaging services
- Outpatient services and community services not covered by the Service Schedule
- Long term equipment for independence or orthotics
- Vocational Rehabilitation services
- Dentistry
- Optometrist
- Podiatry
- Audiology
- Escort or transport costs to treatment (ACC may pay under ancillary supports)

- Transport which is not part of the client's rehabilitation programme (eg whānau outings) is the responsibility of the client and/ or their whānau
- Independent external assessment services
- Services provided under other ACC contracts eg Training for Independence, Living My Life, Psychology Services
- Payment for consultation with specialists for conditions other than the client's presenting injuries; and
- Cost of Pharmaceutical items that are not required as a consequence of personal injury.

Costs which may be incurred and are not funded by ACC

The following costs may arise in delivery of the service. These cannot be funded by ACC.

- Administration costs involved where a client is declined admission into the residential care home.
- Destruction or vandalism of the supplier's property – this is covered by the supplier's own insurance.
- Destruction of client's property when the client has left Residential Support Services.

Resolving issues (escalation process)

If you have any concerns or require clarification relating to the provisions of this contract or which concern service provision to a specific client, you should contact the ACC Recovery Team Member who is directly involved with the client in the first instance. Examples include concerns about:

- the level of care or funding for a client
- the case management of a client
- communication with ACC
- you require verbal instructions to be put in writing.

If you have raised an issue which is not able to be resolved directly with the ACC Recovery Team Member, the issue should be escalated to their Team Leader.

If the issue cannot be resolved with the Team Leader, you may contact the Engagement and Performance Manager. Contact details can be found on the Contact our provider relationship team on the ACC website.

Ending the service

The service can end for a variety of reasons, which are covered in this section. These reasons can generally be grouped into the following categories:

- Discharge
- Loss of eligibility
- Client self-discharge
- Supplier initiated involuntary exit
- Death.

Discharge

Clients who can safely live in the community, with or without support, should do so to help them stay independent. Suppliers should continuously review whether a client is able to be discharged from their facility.

When a supplier identifies that a client may be able to be discharged in the future, discharge planning should commence immediately. For clients receiving Short-Term Residential Care, this should usually be on admission to the facility.

Where a supplier has identified that a client may be able to be discharge, the supplier must notify ACC of the potential for discharge using an ACC1156 Variation Report within 5 business days. The report should include the proposed timeframe and the discharge destination.

Discharge planning should include working with the client, their whānau, ACC and other external suppliers as appropriate to identify what support the client will require to discharge, and determining who will be responsible for ensuring the supports are in place.

Some examples of supports which may be required on discharge include:

- Attendant care
- Community rehabilitation
- Housing modifications
- Rehabilitation equipment.

ACC will arrange a referral for supports and services which ACC determines to be appropriate and related to the client's injury. For other supports, the supplier should arrange referrals to appropriate other services, such as Needs Assessment and Service Coordination (NASC) services.

Loss of eligibility

In some cases, ACC may determine that a client is no longer eligible for Residential Support Services. This may occur following an assessment of eligibility, such as those described in the Dual Funding section of these guidelines, or as a result of new information being received by ACC.

Where ACC determines the client is no longer eligible for ACC funded Residential Support Services, ACC will either work with the supplier to determine a suitable discharge date, where the intention is for the client to return to the community, or notify the supplier of the date that ACC funded Residential Support Services will cease. This will enable the supplier to work with the client to determine alternative funding sources for their residential care (where required).

Client self-discharge

Where the client advises they wish to return to the community and it is safe for them to do so, the process described in the Discharge section of these guidelines should be followed wherever possible.

If the client notifies the supplier or ACC they intend to return to the community before a full discharge planning process can be completed, the client, the supplier and ACC should ideally agree a date for the client's Residential Support Services to cease.

In the event the client exits the facility before the agreed date, or without notice, the process described under Unplanned absences would be followed.

Supplier initiated involuntary exit

An involuntary exit of a client from Residential Support Services is where the client wishes to remain at the facility, but the facility wishes to discontinue support for this specific client. The facility is still able to support other clients in their care, i.e. the service could otherwise continue for this client.

This could be due to:

- the medical needs of the client having increased beyond what the facility is able to provide
- the behavioural needs of the client becoming unsafe for the supplier or their staff
- the medical and/ or behavioural needs presenting a risk to the ongoing viability of the service delivery, or
- the needs of the client presenting a risk to the client should they remain in the facility.

The facility is intended to be the client's home, whether for a short- or long-term stay. Therefore, any removal of the client from the facility against their wishes, which is not led by the client or ACC as the funder, should be considered exceptional and as a last resort option.

This should be approached collaboratively between ACC and the facility to ensure that:

- opportunity has been given to consider all options to resolve the issue(s) leading to the involuntary exit of the client, and
- attempts have been made to work with the client to make this a voluntary and planned exit from the facility.

If the client presents an immediate risk to themselves, staff or other clients at the facility, the supplier should take immediate and necessary steps to safeguard their staff and clients, including and not limited to contacting:

- necessary health services (including hospitals and mental health services)
- ACC, and
- Police (where required).

Where this is not the case, the supplier should notify ACC of their request to exit the client from their services. ACC and the supplier must then work together in a timely manner to either resolve the concerns or progress the client to exiting from the facility.

The expected process for this is:

1. ACC and the supplier have a discussion to understand the scope of the concerns and actions already taken to attempt to address this.
2. ACC and the supplier meet with the client and their whānau to discuss the concerns, hear the client's point of view and agree options to move forward including an action plan with timeframes. The action plan should include beginning to identify suitable discharge locations if the issues cannot be resolved.
3. If the action plan is not effective in resolving the concerns, a further meeting should occur between all parties to agree a discharge date, location and share information that could include: risk assessment and management, client's care plan, medical needs, and medication.

The client must not be discharged from the facility until a safe discharge can take place, with a suitable supplier who can meet the needs of the person. The only exception to this would be where risk to the client or others in the facility is significant enough for police to arrest and charge the client.

If the supplier wishes to initiate an involuntary exit following the criteria in this section, and there are concerns that the process is not being treated with the required urgency, please

contact an Engagement and Performance Manager by referring to Contact our provider relationship team on the ACC website.

Death

The supplier must notify ACC within 1 business day of the client's death, including arranging an incident report (where required). The services will cease immediately, and ACC will pay the bed night immediately following the day of the client's death.

Service quality requirements

Audit requirements

The supplier is required to be certified against the Ngā Paerewa Health and Disability Services Standards NZS 8134:2021. In order to align with the purpose of the service and service exclusions, the facility must meet the criteria for one of the following:

- Aged residential care services
- Residential disability services
- Public and private overnight hospital inpatient services
- Hospice services, or
- Home and community support services (for facilities with fewer than 5 clients only).

The supplier must provide ACC evidence of their certification on request and send this to the requester within 2 business days.

Interdisciplinary team (IDT) requirements

All suppliers must have a core IDT available to clients which includes:

- Support/ Care Assistants
- General Practitioner (GP)
- Registered Nurse
- Pharmacist
- Supervisor
- Manager

'Available' means that the supplier will engage the services of these health professionals as required and this is covered in the bed night rate. The health professional is available to physically attend to the client as required to meet the client's health care needs.

The wider team may include:

- Physiotherapist
- Occupational Therapist
- Social Worker,

Most suppliers providing medium or high levels of care would be expected to have access to this allied health input to provide oversight of their clients' needs. More comprehensive leadership of a rehabilitation programme, including working toward improving function to achieve specific rehabilitation goals is not expected of this input.

Support/ Care assistants

Support/ Care assistants are also referred to as 'Care, Rehabilitation or Therapy Assistants' and manage the day-to-day requirements of supporting clients, under the guidance of the remainder of the IDT. They are required to have or be working towards NZQA in a service appropriate to the client's service need (e.g. New Zealand Certificate in Health and Wellbeing). They must have formal and direct supervision from the Registered Nurse and/ or IDT where they do not yet have the necessary qualifications.

General Practitioner (GP)

The GP manages the day-to-day medical issues which arise. The GP is not necessarily employed by the facility but works as part of the IDT team. The GP input could be directly to the client, or the input could be advice provided to members of the IDT, e.g. the registered nurse, as required to meet a client's need. For Short-Term Residential Care clients in particular, the client may prefer to continue to access their regular GP.

The purpose of this requirement is to ensure that clients have access to medical input from a GP when needed. There is no minimum requirement for the input by a GP. The GP is not required to attend monthly IDT meetings, but the GP should be linked into the IDT to provide advice and support as needed to meet the client's medical care needs. The GP may also provide guidance regarding the client's injury related needs and whether this is the primary reason the client requires residential support.

Registered Nurse

The Supplier must have a Registered Nurse available who is responsible for:

- overseeing client's health status
- reviewing Care Plans
- providing advice on care and administration of medication, possible side effects and reported errors/ incidents; and

- act as a resource person and fulfil an education role.

The Supplier must have a defined escalation process ensuring 24/7 access to a Registered Nurse or GP, including in situations where there is not a nurse onsite or on-call at all times, e.g. for smaller homes servicing clients with lower medical needs.

Pharmacist

Residential care homes must have good medicines management practices in place led by the Pharmacist. The role of the pharmacist is to focus on the medicine regime the patient is taking. The Pharmacist does not need to be employed onsite at the residential care home but the Pharmacy supplying the medicines should make the Pharmacist available to provide pharmaceutical services as part of the facility's IDT and should make the Pharmacist available to work closely with the IDT.

Supervisor

The Supervisor should provide supervision within their scope of practice. The Supervisor should have qualifications, and experience relevant to the client's needs. E.g. if the client has a Traumatic Brain Injury, the Supervisor should have relevant qualifications and experience in working with clients with a Traumatic Brain Injury.

Manager

Each Supplier must have a manager or a member of the Senior Leadership Team (or Management Team) who is a registered Health Care professional and holds an Annual Practising Certificate. This is to ensure that the caregivers looking after clients are overseen by a manager or a member of the senior management structure who has the overall responsibility for the clinical care and welfare of the clients.

Cultural safety requirements

Cultural safety requires all suppliers to critically examine and reflect on how their own identity, culture, and views, while acknowledging the inherent power dynamics and biases, and how these impact on their interactions and the care they provide. Cultural safety benefits all patients and communities and is centred around the experience of safe care and empowerment for kiritaki (clients) and their whānau. This applies across all communities, and may include communities based on indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief, and disability.

Cultural safety is the outcome of recognising and respecting cultural identities and communities, whilst safely meeting their needs to achieve positive health outcomes and experiences. While cultural safety requires ongoing reflection and is ultimately defined by

kiritaki and their whānau. cultural competency supports suppliers to deliver care with appropriate knowledge, skills and behaviour.

ACC suppliers must ensure they embed ACC's Kawa Whakaruruhau (Cultural Safety) Policy in the services they provide for each ACC clients within their whānau. Suppliers and providers must continuously and progressively understand and address cultural differences and biases to improve the quality of, and access to, services to remove inequitable outcomes. This policy is supported by Te Whānau Māori me ō mahi: Guidance on Māori Cultural Competencies for Providers, which is grounded in te ao Māori and provides practical approaches that can be applied across all cultural groups and communities.

Suppliers must ensure that kiritaki are encouraged to actively participate in the development of their Initial and Long-term Care Plans.

The supplier is responsible for:

- ensuring all service providers, including treatment providers and medical practitioners, who are employed by or on contract to the supplier apply the requirements under this policy and demonstrate continuous improvement in cultural safety practicein a manner that is consistent across the workplace
- embedding cultural safety principles across the workplace, including in service delivery and recruitment strategies, governance, policies, and practices
- increasing employment opportunities in the workforce for cultural groups that reflect the community and the ACC clients who receive the services
- performing mandatory and regular cultural safety training and development for the entire workforce employed by the supplier; and
- cultivating community linkages and programmes with cultural and community groups to improve communication, understanding and trust.

The supplier is required to demonstrate how they have supported their staff in the provision of culturally responsive services, including cultivating appropriate organisational and community linkages to support kiritaki cultural needs on an annual basis in response to a survey sent by ACC.

This could include:

- delivery of training aimed at supporting the ongoing development of their staff's cultural awareness
- enabling access to coaching and self-reflection and peer review focused on cultural awareness, capability, sensitivity, communication, power relationships and bias; or
- developing and maintaining strategies to identify and remove barriers to access and care for all cultural groups.

Reducing re-injury requirements

As part of the service objective to reduce re-injury, the supplier is expected to work with the client to ensure that programmes and/ or education on minimising risk of further injury are included in their service, and that the Long-term Care Plan includes risks and mitigation strategies.

As noted in the Service requirements section of these guidelines, it is recognised that the actual content of these education and mitigation strategies will vary significantly depending on the client's unique needs.

The supplier is also required to report to ACC on the number of adverse events/ incidents which have occurred in the past 12 months and the measures that the supplier has taken to prevent re-occurrence. This further supports the supplier's commitment to reducing re-injury in their service provision.

Service monitoring and performance

To ensure the effective delivery of the service as intended, ACC will consider how the supplier is performing against any aspect of the Service Schedule.

To support this, where requested by ACC, the supplier must provide any documentation relevant to the delivery of the service, including the following:

- client Care Plans
- client clinical notes
- staffing records
- audit certification and audit reports
- health and safety incident reports
- complaint records
- client satisfaction and feedback records

Specific performance measures

ACC will request the Supplier to submit reports annually for the reporting requirements detailed in Table 6 of the Service Schedule by sending the Supplier a survey via email.

Care Plans

As noted in the Service planning section of these guidelines, the supplier is not required to send Initial Care Plans to ACC unless requested. However, it is important that these are still completed for all clients within 15 business days. The supplier is required to monitor and

report to ACC on an annual basis the percentage of clients who have their Initial Care Plan completed within this timeframe.

Suppliers are also required to report to ACC the percentage of clients receiving Long-Term Residential Care who have had:

- their first Long-term Residential Care Plan sent to ACC within 3 months of admission or transfer to Long-Term Residential Care, and
- their Long-term Residential Care Plan reviewed within the last 12 months.

Promoting discharge for Short-Term Residential Care clients

ACC wants to ensure that care for Short-Term Residential Care clients is being planned and delivered effectively, with a focus to supporting clients to:

- return to their pre-injury level of independence at the earliest opportunity; or
- be identified as requiring Long-Term Residential Care promptly, to enable assessment and planning to support their long-term needs.

To facilitate this, for clients who are receiving Short-Term Residential Care, the supplier is expected to continuously review whether they will be able to support the client to discharge within 6 months or request their transfer to a Long-Term Residential Care service using an ACC1156 variation report. Suppliers are expected to work to ensure that no clients receive Short-Term Residential Care for more than 6 months.

To promote a timely discharge for clients who are expected to receive care for less than 6 months, the supplier has responsibilities to ensure that certain proportions of their clients are discharged within 6 and 12 weeks.

The majority of clients receiving Short-term care are expected to have been admitted following a request from a hospital, with a length of stay clinically assessed as appropriate for them to recover from their injury and return home. To enable the supplier to account for unexpected changes to the client's recovery trajectory, suppliers can request an extension to support as detailed in the Extension of care section of these guidelines.

It is expected that the majority of clients should only require 1 extension of support during their stay and that, if the client is identified as likely to require support for more than 6 months, the request to change to Long-Term Residential Care services can be made with this extension. As a result, the Performance Measure is set at 90% of clients requiring 1 or fewer extensions of support.

Safety requirements

Maintaining the safety of all parties involved in delivering services is the highest priority. This includes, but is not limited to client, their whānau, suppliers, service providers, personnel, and ACC staff.

The Service Schedule for Residential Support Services covers the health and safety requirements for this service. The supplier, service providers and any personnel supporting clients must ensure any health and safety risks identified are appropriately managed and monitored throughout the delivery of services.

The supplier must maintain a Health and Safety Risk Management Plan relating to the delivery of the services.

Any threatening behaviour should be reported to the police immediately if it is warranted. If this occurs, the supplier should advise ACC and any other parties that are at risk as soon as possible. Please report to ACC in writing using the online form on ACC's website.

If a supplier wishes to consider withdrawing support due to Health and Safety risks presented by the client, their whānau or any other party, please refer to the Supplier initiated involuntary exit section of these guidelines.

Reporting Health and Safety incidents

Reporting any health and safety events helps us to identify areas where we can work together to improve health and safety.

There are detailed guidelines and considerations for reporting incidents on the ACC website at Reporting health and safety incidents.

These guidelines include:-

- the types of incidents which should be reported;
- how to report incidents to us; and
- information on and links to WorkSafe notifiable event reporting.

Appendix 1: Levels of Care

Area	Low Needs clients	Medium Needs clients	High Needs clients
Level of assistance	Low or no physical assistance	Moderate level of physical assistance (likely 1:1), which could include assistance with complex personal care (e.g. bowel/ bladder management) or behavioural needs	Frequent 1:1 or 2 persons to assist using specialised equipment
ADL support	Low or no physical assistance, or prompting with Activities of Daily Living, e.g. medication management, prompting to undertake tasks assistance, daily care routines, fatigue management	Support and prompting for: Activities of Daily Living, social integration, a programme of activities which is monitored weekly	Assistance with all Activities of Daily Living, including encouragement and support to maintain social integration
Additional health needs	N/A – clients may have additional needs, but these do not usually impact independence more than the injury	N/A – clients may have additional needs, but these do not usually impact independence more than the injury	A Care Plan which considers other, non-injury related complex health needs the client may have and how these affect the client's injury-related needs
Ad hoc needs	N/A – client's needs are generally predictable	Oversight, enabling timely response to occasional requests for support outside of the regular schedule	High degree of Supervision, including proactive intervention to meet needs
Daily routine	Low level support or encouragement for social integration and daily routines and facilitation of social activities	Support and/ or encouragement to engage in daily structured routines	Support and assistance for a tailored programme of activities including regular individual support

Increasing independence	N/A – primary responsibility to increase independence usually delivered externally with RSS provider supporting the recommendations	Frequent training and coaching interventions to assist the client to transition to independence where the goal is to live independently in the community	Clinical therapeutic inputs from therapy professionals. on an at least weekly basis for cognitive and physical care needs
Communication, medical and behavioural	N/A – clients may have additional needs in this area, but they do not usually significantly impact the delivery of service	N/A – clients may have additional needs in this area, but they do not usually significantly impact the delivery of service	Daily coaching to help clients manage their behaviour appropriately and/ or meet their communication needs
Allied Health and Nursing	A safe environment and quality medical and nursing care that meets their long-term needs including social enrichment, involvement with their whānau and maintenance of links with their community wherever possible	A safe environment and quality medical and nursing care that meets their long-term needs including social enrichment, involvement with their whānau and maintenance of links with their community wherever possible	Daily supervision of support care staff by clinical professionals (e.g. Registered Nurse, or Physiotherapist, or Occupational Therapist) or support care staff who has a Level 4 qualification), to ensure strategies are in place to support client to achieve their goals
Interaction with external rehabilitation providers	Clinical oversight to ensure a client's rehabilitation programme (e.g. set by hospitals or ACC funded programme such as Training for Independence) is being followed in between external therapy input.	Clinical oversight and support staff input to ensure a client's rehabilitation programme (e.g. set by hospitals or ACC funded programme such as Training for Independence) is being followed in between external therapy input.	Clinical therapeutic inputs to maintain or improve the client's function, including close collaboration with external Rehabilitation Professionals (e.g. community health or ACC funded Training for Independence providers)

Appendix 2 – Medical Consumables and Equipment

Residential Support Services - Medical Consumables and Equipment	
Standard items included in bed day rate:	**Specialist items paid outside of this service schedule:**
Fluids & irrigation products Fluids, IV sets, needles & syringes, luers, sharps containers	Enteral feeding Feeding tubes, gastronomy products, bottles and containers.
Gloves and protective garments Gloves, sterile gloves, aprons, bibs, gowns, masks	Ostomy Pouches (closed and drainable), wafers and flanges, belts and support garments.
Incontinence Pads, lubricants, children's nappies, urinal bottles, bowls, nappy wrappers, wipes, deodorants, non prescription laxatives, glycerol suppositories, uridomes, strips for uridomes, enemas, catheter change packs	Incontinence Intermittent and indwelling catheters, drainage bags, connector and leg bag accessories, enemas, irrigation equipment, suspensory garments, stoppers and plugs, disposable & non-disposable underpads, disposable and non-disposable briefs, swimmers, pull ups, fixation pants.
Nutrition Thickener and thickened fluids, nutritional supplements, fluids for enteral feeding, drinking straws (including one way), vitamin and mineral supplements, antacids	Respiratory Oxygen therapy tubing & masks, suction equipment, traches, trache accessories, filters.
Skin care & dressings Stockings, bandages, cotton wool, swabs, dry dressings, film dressings, tapes, skin cleaners, lotions, creams, antiseptics, wipes, eye pads, toothbrushes, mouthwash, mouth swabs, lip balm, sterile dressing change packs	Specialist dressings & wound care Hydrogel dressings, hydrofiber dressings, hydrocolloids dressings, alignates dressings, foam dressings, antimicrobial dressings, negative pressure wound therapy dressings.
Batteries Standard, hearing aid	Equipment Individualised wheelchairs and seating systems, specialised seating and sleeping systems.
Rehabilitation Ultrasound gel and electrodes, therapeutic putty, crutch tips, digi caps, digi sleeves	Other Haberman bottles, cast covers.
Equipment Hoists, hospital beds, mattresses including alternating air flow, sensor mats, walking frames, generic commodes, generic wheelchairs for transit, manual handling equipment such as sliding sheets, transfer belts, hoist slings.	
Other Rubbish and waste bags, blister packs, scissors, specimen containers, litmus paper, swab sticks, measuring containers, forceps.	