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He Whakaora.
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SERVICE SCHEDULE FOR RESIDENTIAL SUPPORT SERVICE

CONTRACT NO: _____

A. QUICK REFERENCE INFORMATION

1. TERM FOR PROVIDING RESIDENTIAL SUPPORT SERVICE

1.1 The Term for the provision of Residential Support Services is the period from date of signing ("Start Date") until the close of 30 September 2025 ("End Date") or such earlier date upon which the period is lawfully terminated or cancelled.

1.2 Prior to the End Date, the parties may agree in writing to extend the Term of this Service Schedule for a maximum of two further terms of one year each. Any decision to extend the Term of this Service Schedule will be based on:

1.2.1 The parties reaching agreement on the extension in writing prior to the End Date; and

1.2.2 ACC being satisfied with your performance and delivery of the Services; and

1.2.3 All other provisions of this Contract either continuing to apply during such extended Term(s) or being re-negotiated to the satisfaction of both parties.

1.3 There is no obligation on the part of ACC to extend the Term of this Service Schedule, even if the Supplier has satisfactorily performed all the Services.

2. SPECIFIED AREA AND SERVICE LOCATION (PART B, CLAUSE 3)

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3. SERVICE ITEMS AND PRICES (PART B, CLAUSE 5)

Table 1 - Service Items and Prices

Code	Service Item Description	Service Item Definition	Price (excl. GST)	Pricing Unit
RRC01	Residential Care Low Needs	Bed night rate - for Clients with low level care needs (refer clause 5.10.2)	$«RRC01_Residential_Care_Low_Needs_was_RR»	Per day
RRC02	Residential Care Medium Needs	Bed night rate - for Clients with medium level care needs (refer clause 5.10.3)	$«RRC02_Residential_Care_Medium_Needs_was»	Per day
RRC03	Residential Care High Needs	Bed night rate - for Clients with high and complex needs (refer clause 5.10.4)	$«RRC03_Residential_Care_High_Needs_was_R»	Per day
RRR02	Residential Rehabilitation (Slow Stream) Medium Level	Bed night rate - for Clients who require medium level Rehabilitation. Facility must meet additional IDT requirements (refer clauses 5.14)	$«RRR02_New_Residential_Rehabilitation_Sl»	Per day
RRR03	Residential Rehabilitation (Intense) for Clients with High and Complex Rehab needs	Bed night rate – for Clients who require an intensive level of Rehabilitation. Facility must meet additional IDT requirements (refer clauses 5.14)	$«RRR03_New_Residential_Rehabilitation_In»	Per day
RRS11	Residential Short Term Low Needs	Bed night rate for facilities who are providing short term and/or temporary care, carer relief, etc. for Clients with low level care needs (refer clauses 5.10.2)	$«RRS11_Residential_Short_Term_Low_Needs_»	Per day
RRS12	Residential Short Term Medium Needs	Bed night rate for facilities who are providing short term and/or temporary care, carer relief, etc. for Clients who have medium level care needs (refer clauses 5.10.3)	$«RRS12_Residential_Short_Term_Medium_Need»	Per day
RRS13	Residential Short Term High Needs	Bed night rate for facilities who are providing short term and/or temporary care, carer relief, etc. for Clients who have high and complex care needs (refer clauses 5.10.4)	$«RSS13_Residential_Short_Term_High_Needs_»	Per day
RR950	Residential Bed Retention	To hold a bed up for up six days of absences unless otherwise agreed.	$«RR950_Residential_Bed_Retention»	Per day

Code	Service Item Description	Service Item Definition	Price (excl. GST)	Pricing Unit
RRINT	Interim Care	DHB rate for duration of stay excl GST (refer clause 5.11)	$	Per day for duration of stay
RRAC1	Additional Care to meet temporary need - Nursing	Hourly Rate (refer clause 5.16)	$«RRAC1_New_Additiuonal_Care_to_meet_tempo»	Hourly
RRAC2	Additional Care to meet temporary need – Allied Health	Hourly Rate (refer clause 5.16)	$«RRAC2_New_Additional_Care_to_meet_tempor»	Hourly
RRAC3	Additional Care to meet temporary need - Care Assistant	Hourly Rate (refer clause 5.16)	$«RRAC3_New_Additional_Care_to_meeting_tem»	Hourly
RR102	Residential Services Medium Needs	Residential Rehabilitation or Care for a Client who requires a medium level of intensity service inputs	«RR102_Jul_2021_No_Change__RR102_Residen»	Per Day
RR104	Residential Support Shared Costs	Residential Rehabilitation or Care for a Client who has Shared costs with MOH	$«RR104_ONLY_FOR_OPEN_POS»	Per Day
RR106	Other Agreed Costs	Long Term Residential Support – Other Agreed Costs	$«RR106_ONLY_FOR_OPEN_POS»	Per Day

Note: Price refers to uninterrupted residential stay within the Facility, with the Client occupying a facility bed at midnight.

Price Review

ACC will review pricing when, at ACC's sole discretion, it considers a review necessary. The factors ACC may take into account during a review include, but are not limited to:

- general inflation
- changes in service component costs
- substantial changes in the market

If ACC finds that the factors it takes into account have not had a significant impact on price, the prices will remain unchanged.

If ACC provides a price increase, the Supplier must agree any adjustment in writing. The price increase will take effect from a date specified by ACC.

4. RELATIONSHIP MANAGEMENT

Table 2 - Relationship Management

Level	ACC	Supplier
Client	Recovery Team / Recovery Team Member	Individual staff or operational contact
Relationship and performance management	Engagement and Performance Manager	Operational contact/ National Manager
Service management	Portfolio Team or equivalent	National Manager

5. ADDRESSES FOR NOTICES (STANDARD TERMS AND CONDITIONS, CLAUSE 23)

NOTICES FOR ACC TO:

ACC Service Strategy & Commissioning
Justice Centre (for deliveries)
19 Aitken Street
Wellington 6011
P O Box 242 (for mail)
Wellington 6140
Marked: Attention: Procurement Partner
Phone: 0800 400 503
Email: health.procurement@acc.co.nz

NOTICES FOR SUPPLIER TO:

_____
_____
_____ (for deliveries)
_____
_____
_____ (for mail)
_____
_____ _____
Marked: “Attention: _____ _____, _____“
Phone: _____
Mobile: _____
Email: _____

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B. SERVICE SPECIFICATIONS FOR RESIDENTIAL SUPPORT SERVICE

1. PURPOSE

1.1 The purpose of the Residential Support Service is to provide residential care for Clients who are unable to live independently in the community or are unable to live in their usual place of dwelling due to their covered physical injury including a Traumatic Brain Injury.

1.2 The Residential Support Service supports Clients who require residential care for varying durations including:

1.2.1 Short Term Care for Clients who require short term residential care, Transitional Care or Carer Relief care;

1.2.2 Clients who can maintain a degree of independence but require Long Term Care with supervision and supports;

1.2.3 Care for Clients who require slow stream Rehabilitation or a more intense level of Rehabilitation;

1.2.4 Long Term Care for Clients with high medical and/or Rehabilitation needs and who require Long Term Care.

1.3 ACC wishes to purchase Residential Support Services from the Supplier on the terms and conditions set out in this Service Schedule.

2. SERVICE OBJECTIVES

2.1 Success of this Service will be based on the following outcomes:

2.1.1 Clients are provided with safe and high quality, clinically appropriate residential care;

2.1.2 The Client's medical, Rehabilitation, cultural, social and emotional needs are identified and services are delivered to meet those needs;

2.1.3 Services delivered to the Client are targeted towards achieving and maintaining the Client’s optimum level of rehabilitation;

2.1.4 The Client achieves and maintains their optimum level of independence where possible;

2.1.5 The Client and their family/whānau are satisfied with this Service;

2.1.6 The provision of care is efficient, cost effective and delivered in a timely manner.

3. SPECIFIED AREA AND SERVICE LOCATION (PART A, CLAUSE 2)

3.1 The Supplier will maintain residential facilities in the area and location specified in Part A, clause 2.

4. SERVICE COMMENCEMENT

4.1 The Supplier must ensure that they meet the following minimum standards:

4.1.1 Is certified against the Health and Disability Services Standards NZS 8134:2021;

4.1.2 Has a Residential facility which meets all required building compliance codes for a residential care facility;

4.1.3 Has a Governance body;

4.1.4 Has a Manager (of the facility, or a member of the senior Management team) who has the overall responsibility for the clinical care and welfare of Clients and this manager is a registered Health Care professional and holds an Annual Practising Certificate;

4.1.5 Has capacity for five or more Clients;

4.1.6 Has an Interdisciplinary Team as specified in this Service Schedule;

4.1.7 Provides 24 hour care 7 days per week;

4.1.8 Provides all medical equipment and consumables as specified in this Service Schedule;

4.1.9 Provides all nursing care and support services;

4.1.10 Has the capacity to provide best practice quality care and Rehabilitation services to meet each individual Client's needs;

4.1.11 Provides a home like environment as much as practicable.

4.2 Eligibility for Service

4.2.1 A Client is eligible for the Service if they meet all of the following criteria:

4.2.1.1 Has an injury that has been accepted for cover by ACC;

4.2.1.2 Is assessed as requiring residential services primarily due to the covered physical injury, including a Traumatic Brain Injury;

4.2.1.3 Is unable to live independently and safely in their own home or usual place of dwelling and needs support and supervision for their health and wellbeing due to their covered injury.

4.3 Access Exclusion

4.3.1 Excluded from services under this Service Schedule are:

4.3.1.1 Services for individuals that are funded by, or the responsibility of, another funder (for example, primary care services that are funded by the Ministry of Social Development, or Ministry of Health);

4.3.1.2 Individuals whose needs arise solely as a result of a mental health or addiction condition;

4.3.1.3 Individuals whose needs are solely for housing;

4.3.1.4 Any individual where this service is not considered appropriate to meet the individual's identified support needs.

4.4 Referral Process

4.4.1 Clients may be referred to the Supplier by public health services, a specialist rehabilitation facility, the community, or ACC.

4.4.2 ACC will refer eligible Clients to the Supplier using the referral form provided by ACC.

4.4.3 Prior to ACC sending a referral, the parties will discuss and agree the following:

4.4.3.1 The Client's service needs and level of care required;

4.4.3.2 The duration of the Client's length of stay;

4.4.3.3 The Supplier's capacity and availability.

4.4.4 The Supplier will only admit a Client if ACC provides a purchase order or confirms to the Supplier that the purchase order has been approved. If the referral is for a fixed period, the timeframe will be identified in writing when the purchase order is provided to the Supplier.

4.5 Determining Level of Care

4.5.1 The type and level of service are determined by the referrer based on information about the Client's needs at the time the services are being arranged.

4.5.2 The Client's funding package is determined based on the level of care the Client requires (see clauses 5.10.2-5.14.5).

4.5.3 If clarification of the funding package is required, ACC will arrange an assessment of the Client, which will determine the Client's care and/or rehabilitation needs.

4.6 Dual Funding

4.6.1 On occasion, the responsibility for funding may be deemed the responsibility of more than one funder. Funders may include but are not exclusive to: ACC, MoH, MSD, Health New Zealand - Te Whatu Ora or Client and/or their family/whānau self-funding. To avoid doubt, as set out in clause 4.3.1.1, ACC will not fund services for individuals that are funded by or the responsibility of another funder.

4.6.2 ACC will determine the level of funding required via an assessment to identify the injury related need. The funding level will equate to the percentage of incapacity or the inputs of care required for the covered injury as identified in the needs assessment.

4.7 Service Entitlement

4.7.1 The Supplier must provide 24 hours a day, 7 days a week residential support for the period specified in the ACC purchase order.

4.7.2 The Service will commence for a Client on the day the Client is admitted and is in the Supplier's facility at midnight.

5. SERVICE PROVISION REQUIREMENTS

5.1 The Supplier will provide the following Residential Care Services as per the Client's identified need, as per Part A, clause 3.

5.2 The Supplier will ensure the Service is delivered flexibly to fit within the Client's normal daily routine as far as practicable, and to facilitate achievement of the Client's Rehabilitation and life goals.

5.3 The Supplier will ensure that the Client and/or their family/whānau are involved in planning and discussions concerning:

5.3.1 Services delivered to the Client;

5.3.2 How the Services contribute towards the Client's goals;

5.3.3 Understanding what is important and meaningful to the Client;

5.3.4 The Client's engagement in social and community activities;

5.3.5 The amount of funding which will be contributed by the Client and the purpose of their contribution;

5.3.6 ACC's funding contribution and the Supplier will also set reasonable expectations when this might cease (ie when the Client's need for residential care is no longer due to their covered injury);

5.3.7 How the family/whānau will be involved in service planning to the extent that is appropriate for the Client.

5.4 The Supplier will provide all or part of the following service elements to meet the Client's residential care needs:

5.4.1 A pre-admission visit to the Client, if required;

5.4.2 Hotel Services;

5.4.3 Nutrition;

5.4.4 Hydration;

5.4.5 Personal care services;

5.4.6 Personal Supervision;

5.4.7 Day activities including recreational activities;

5.4.8 Access to a General Medical Practitioner;

5.4.9 Access to emergency care;

5.4.10 Medication;

5.4.11 Medical consumables in accordance with Appendix A;

5.4.12 Referral to other types of Specialists and health professionals related to the Client's personal injury as required;

5.4.13 All incidental services which a reasonable and responsible supplier of similar services would provide to meet the physiological, cultural, spiritual and social needs of the Client while in the care of the Supplier;

5.4.14 Interpreter and advocacy services;

5.4.15 Māori health and Pacific Island liaison workers;

5.4.16 Monitoring of the service delivery;

5.4.17 All equipment, appropriate to the Service being provided, where that equipment is generally available to all Clients (this includes but is not limited to beds, hoists, manual handling equipment, and environmental controls such as sensor mats, etc). Note: ACC will only provide equipment that is customised to and/or only used by the Client such as seating and sleeping systems;

5.4.18 Technical support to maintain equipment;

5.4.19 Any necessary administrative matters required by this Service Schedule including such administrative matters as would normally be required to allow the Supplier or ACC to evaluate the Service.

5.5 The Supplier must maintain up to date clinical care notes for each Client that specify details of the Client's:

5.5.1 Medicine regime;

5.5.2 Falls and Pressure Injury prevention;

5.5.3 Care Plan;

5.5.4 Rehabilitation Plan and/or Maintenance Plan to ensure that the Client is able to attain or maintain their maximum level of independence and functioning;

5.5.5 Social activities, interests and community participation.

5.6 Initial Care Plan

5.6.1 The Supplier must submit an initial Care Plan to ACC on an ACC1155 form within three calendar weeks of the Client's admission.

5.6.2 The initial Care Plan must include the Client's:

5.6.2.1 Date of admission;

5.6.2.2 Reason for admission;

5.6.2.3 Rehabilitation goals;

5.6.2.4 Planned date of discharge;

5.6.2.5 Destination where the Client will be discharged to eg: home, Rehabilitation facility, Long Term Care.

5.7 Ongoing Care Plans

5.7.1 The Supplier must ensure that all Clients have a Care Plan for the duration of their stay in the facility, which is updated regularly with the Client and their family/whānau.

5.7.2 The Client's Care Plan will, at a minimum, include all of the following:

5.7.2.1 A summary of the injuries and other relevant medical conditions;

5.7.2.2 Identification of specific risks and mitigation strategies;

5.7.2.3 The medication regime (if appropriate);

5.7.2.4 The activity/Rehabilitation schedule;

5.7.2.5 Social enrichment and community integration activities;

5.7.2.6 Client specific goals and outcomes;

5.7.2.7 The Client's concerns and stated wishes;

5.7.2.8 Discharge planning where appropriate.

5.8 The Supplier must work with other Rehabilitation or care providers contracted by ACC to provide specific Rehabilitation and/or support services to the Client and will ensure that all Rehabilitation activities, targets, goals are integrated into the Client's Care Plan.

5.9 Review of Client's service needs

5.9.1 The Supplier must ensure that the Care Plan is updated and reviewed whenever the Client's service needs change.

5.9.2 If the Client's planned service is for two years or less, the Supplier will review and update the Care Plan and send a copy to ACC every six months.

5.9.3 If the Client's planned service is for longer than two years, the Supplier will review and update the Care Plan and send a copy to ACC every twelve months.

5.9.4 In exceptional cases, ACC may request an updated individualised Rehabilitation or Care Plan on an ad hoc basis at no cost to ACC.

5.10 Service Provision to meet each Client's level of care needs

5.10.1 The Supplier must provide services which meet the Client's level of residential care needs (clauses 5.10.2-5.14.5).

5.10.2 Service Provision for Clients who have Low Needs

5.10.2.1 Clients who require low level residential care must be supported to maintain their optimum level of function and independence.

5.10.2.2 A Client is eligible for residential care with low level care needs if the Client requires:

5.10.2.2.1 Prompting with Activities of Daily Living eg: medication management, prompting to undertake tasks assistance, daily care routines, fatigue management;

5.10.2.2.2 Low level support for social integration and daily routines and facilitation of social activities;

5.10.2.2.3 Daily structured routines, attendant care and support to a minimal level;

5.10.2.2.4 A safe environment and quality medical and nursing care that meets their long-term needs including social enrichment, involvement with their family/whānau and maintenance of links with their community wherever possible;

5.10.2.2.5 Oversight to ensure risks are managed to ensure Client safety;

5.10.2.2.6 Maintenance of social integration and personal care skills, including structured routines.

5.10.2.3 The Supplier must ensure that the staffing criteria as set out in Table 3 is met.

5.10.3 Service Provision for Clients who have Medium Needs

5.10.3.1 Clients who require medium level residential care must be supported to maintain their optimum level of function and independence.

5.10.3.2 A Client is eligible for residential care with medium level care needs if the Client requires:

5.10.3.2.1 Support and prompting for: Activities of Daily Living, social integration, a programme of activities which is monitored weekly;

5.10.3.2.2 Frequent training and coaching interventions to assist the Client to transition to independence where the goal is to live independently in the community;

5.10.3.2.3 Daily structured routines, daily attendant care and support;

5.10.3.2.4 Supervision by carers to ensure risks are managed to ensure Client safety;

5.10.3.2.5 Encouragement for social integration and daily routines including prompting and support for facilitation of social activities.

5.10.3.3 The Supplier must ensure that the staffing criteria as set out in Table 3 is met.

5.10.4 Service Provision for Clients who have High Needs

5.10.4.1 Clients who require residential care with high level care inputs include Clients who have significant behaviour support needs and/or complex medical conditions which require medical oversight.

5.10.4.2 A Client is eligible for high level care inputs if the Client requires:

5.10.4.2.1 Clinical therapy inputs from therapy professionals. on an at least weekly basis for cognitive and physical care needs;

5.10.4.2.2 Frequent 1:1 or 2 persons to assist and specialised equipment;

5.10.4.2.3 Daily supervision of support care staff by clinical professionals (eg Registered Nurse, or Physiotherapist, or Occupational Therapist) or support care staff who has a Level 4 qualification) to ensure risks are managed and the Client is safe;

5.10.4.2.4 Daily coaching to help Clients manage their behaviour appropriately;

5.10.4.2.5 Weekly therapy inputs to maintain function;

5.10.4.2.6 Encouragement and support to maintain social integration;

5.10.4.2.7 Assistance with all Activities of Daily Living and may require 1:1 or 2 persons to assist;

5.10.4.2.8 Specialist equipment.

5.10.4.3 The Supplier must ensure that the staffing criteria, including the additional staffing criteria as set out in Table 3, is met.

5.10.4.4 Clients with behavioural or more complex medical needs will require confirmation of those needs via a Support Needs Assessment or equivalent. ACC will arrange the necessary assessments.

5.11 Service Provision for Clients who require Interim Care

5.11.1 The Supplier will deliver residential care for Clients who have been discharged from a District Health Board and who require a period of convalescence for usually up to six weeks before returning to the District Health Board for ACC funded Rehabilitation.

5.11.2 To be eligible for Interim Care, the Client must be medically well and not need acute services.

5.11.3 A Client who receives Interim Care can access medical care of a General Practitioner in the community, if required.

5.11.4 The Supplier must ensure that the Client has a Rehabilitation Plan that increases or maintains the Client's level of function to ensure that the Client does not decondition during their stay.

5.12 Service Provision for Clients who require Transitional Care

5.12.1 The Supplier will deliver short term Residential Care for Clients who require Transitional Care until further arrangements are made eg: the Client is waiting for home modifications, or further medical intervention.

5.12.2 The Supplier will, if required, ensure a Client's long-term support carers can continue to provide support in the Supplier's facility.

5.13 Service Provision for Clients who require Carer Relief Care

5.13.1 The Supplier will deliver residential care for Clients to provide Relief Care for the Client's usual caregivers for a limited period of time.

5.13.2 The Supplier will work with the usual carers (prior to the Client's admission) to identify the Client's care needs and establish a Care Plan so that the Client's needs are consistently met.

5.13.3 The Supplier may amend the Care Plan on agreement with at least one of the following: the Client, family/carer and ACC depending on the Client's needs.

5.13.4 The Supplier will consult with the ACC and the usual caregivers to determine if the length of stay is of sufficient duration to allow the usual carers to have sufficient respite from caring.

5.14 Service Provision for Clients who require moderate level (slow stream) or high and complex level Rehabilitation

5.14.1 The goal for moderate level (slow stream) or high and complex level Rehabilitation service is to improve the Client's function, independence and community participation to the maximum extent practicable. The Supplier must provide the Client with high level Rehabilitation if there is a clear expectation that the Client will be able to improve their level of independent function and return to independence and reside in the community or their usual place of dwelling.

5.14.2 If a Client requires moderate level (slow stream) or high and complex level Rehabilitation, the Supplier must provide:

5.14.2.1 Moderate or high level Rehabilitation inputs from Rehabilitation health professionals on a daily basis with the goal of increasing the Client's level of function and independence to the maximum extent practicable;

5.14.2.2 A programme of activities that is monitored by therapy staff on a weekly basis to measure functional gains.

5.14.2.3 To be eligible for moderate level (slow stream) or high and complex level Rehabilitation, the Client must meet all of the following:

5.14.2.3.1 Need and be ready for Rehabilitation;

5.14.2.3.2 Be capable and willing to actively participate in Rehabilitation;

5.14.2.3.3 Have return to independence as their Rehabilitation goal.

5.14.3 If the Supplier provides moderate level (slow stream) or high and complex level Rehabilitation, the Supplier will ensure that:

5.14.3.1 They use Rehabilitation principles and evidence based best practice;

5.14.3.2 They follow the principles of community focussed Rehabilitation, with linkages to community based services to promote integration of Client;

5.14.3.3 They provide goal directed, outcome focussed and time framed Rehabilitation;

5.14.3.4 Care Plans incorporate the goals and activities set by Rehabilitation clinicians;

5.14.3.5 The Client and their family/whānau are involved in the Rehabilitation planning;

5.14.3.6 Education is provided to the Client and their caregivers and/or whānau, to enable them to support and care for the Client on discharge or during home leave.

5.14.4 If the Supplier provides moderate level (slow stream) or high and complex level rehabilitation, the Supplier must employ an interdisciplinary team which meets the qualifications criteria as specified in Table 3 in this Service Schedule who have a shared philosophy of outcome-centred goals.

5.14.4.1 The Supplier's interdisciplinary team will:

5.14.4.1.1 Provide frequent training and Rehabilitation interventions to improve the Client's level of function appropriate to the Client's individual needs and ability;

5.14.4.1.2 Work closely with the Client and their family/whānau to develop an individualised Rehabilitation Plan;

5.14.4.1.3 Use appropriate clinical assessment and outcome measurement tools to monitor the progress of the Client;

5.14.4.1.4 Meet as a team at least monthly, to review the Client's progress and to update the Rehabilitation Plan with all the providers listed in Table 3 represented;

5.14.4.1.5 Provide Rehabilitation as specified in the Client's Rehabilitation Plan.

5.14.5 Rehabilitation Plan for Clients who require moderate level (slow stream) or high and complex level Rehabilitation:

5.14.5.1 The Supplier must ensure that a Client's Rehabilitation Plan:

5.14.5.1.1 Sets out the Client's Rehabilitation goals;

5.14.5.1.2 Sets out the frequency and type of Rehabilitation inputs;

5.14.5.1.3 Is outcome-focused;

5.14.5.1.4 Has short and long term goals;

5.14.5.1.5 Includes recreation and outings with associated transport;

5.14.5.1.6 Sets out the plan for the Client's discharge or transition.

5.14.5.2 The Supplier must regularly review the Client's Rehabilitation Plan.

5.14.5.3 The Supplier must submit an ACC1155 Report to ACC once the Rehabilitation Plan is agreed or amended with the Client and keep ACC updated on the Client's progress.

5.15 Change in Level of Care required

5.15.1 If a Client's care needs have changed (for example due to a deterioration or an improvement in the Client's level of function, medical needs or well-being), the Supplier may ask ACC to review the Client's level of care needs.

5.15.2 To instigate a review, the Supplier must submit an ACC1156 Variation Report to ACC.

5.15.3 ACC will require confirmation of the Client's need via a Support Needs Assessment or equivalent to approve an increase in the level of care and/or to approve additional care to meet the Client's behavioural or medical needs This could include a determination whether the Client's requirement for Residential Care is primarily due to their covered injury.

5.15.4 If ACC is reviewing a change to a Client's level of care needs, the Supplier will continue to invoice ACC at the negotiated rate until the health assessment or Geriatrician report has been received and ACC has agreed to change the level of care needs. Retrospective adjustments may be made by ACC.

5.16 Purchasing Additional Care for Temporary period of time.

5.16.1 At times, Clients who have been assessed as having High and Complex Needs may require additional Registered Nursing, Allied Health, or Support Care Worker hours for a temporary period of time. Such instances could include:

5.16.1.1 Management of behavioural issues;

5.16.1.2 Additional therapy support;

5.16.1.3 Additional medical care.

5.16.2 If the Supplier considers that additional care of a temporary period is required, the Supplier should contact ACC in the first instance and update the Care Plan with a request for additional support. The request must state: the number of hours of support the Client is currently receiving; how many additional hours are required; and the rationale of why additional care is required.

5.16.3 ACC will consider each request on a case by case basis and may issue a purchase order for the appropriate period of time up to a maximum of four weeks to support the Supplier to manage the Client's behavioural issues, Rehabilitation or medical needs.

5.17 Provision of Services outside of this Service Schedule

5.17.1 On occasion, a Client may require services outside of the support purchased under this Service Schedule. In order to fund any services outside of this Service Schedule, ACC needs to ensure both of the following:

5.17.1.1 That those services are not covered by provisions within this Service Schedule;

5.17.1.2 The need is directly linked to the Client's covered injury;

5.17.1.3 The provision of the service will directly lead to the Client's transition to independence or is directly linked to the Client achieving measurable goals as stated in their rehabilitation and/or care plan.

5.17.2 ACC may require an assessment to gather further information. The type of assessment will depend on what type of services are being requested. ACC may make any necessary referrals.

5.17.3 If it is determined that the need for this additional service is not relating to the covered injury, it is expected the Supplier will ensure an appropriate referral is made to access necessary supports.

5.18 Prices Payable During Client Absences

5.18.1 The Client may be absent from the facility either at short notice or planned (eg: to attend to family/whānau responsibilities, undertake a home trial, or take a holiday). No prior approval is required. ACC will fund up to fourteen nights per year at the full applicable bed night rate and the remaining nights at the bed retention rate.

5.18.2 If a Client returns home for a short period and requires support, the Supplier must contact ACC to ensure that all supports are set up and are in place to support the Client and their family/whānau.

5.18.3 If a Client returns to Acute Care due to significant complications, ACC will continue to fund the full bed night rate for the time the Client is in Acute Care.

5.18.4 If the Client is absent from the facility without authorisation, the Supplier will:

5.18.4.1 Notify the relevant authorities immediately if there is a risk to the safety of the Client or the public;

5.18.4.2 Take the appropriate actions to return the Client to the facility;

5.18.4.3 Notify ACC via email within 24 hours.

5.18.5 If the Client is absent from the facility without authorisation, ACC will fund the usual bed day rate for two nights and then subsequent nights will be paid at the bed retention rate until it is determined that the Client has been discharged.

5.19 Discharge planning

5.19.1 For Clients for whom the goal is that they will be discharged, the Supplier must ensure that discharge planning commences when the Client enters the facility.

5.19.2 The Supplier must ensure that a Discharge Plan includes all of the following:

5.19.2.1 The date the Client will be discharged;

5.19.2.2 The destination where the Client will be discharged;

5.19.2.3 What supports the Client will require on discharge.

5.19.3 To enable ACC to organise the appropriate supports on discharge, the Supplier will provide ACC with the Discharge Plan four weeks before the Client's expected discharge date.

5.19.4 The Supplier must notify ACC when the Client has been discharged.

6. SERVICE EXIT

6.1 Clients are discharged when the service is completed. The Supplier will work with ACC to ensure that each Client transitions smoothly and safely out of the Supplier's facility to their next place of residence. In particular, the Supplier must provide documentation on the Client's ongoing support and care needs.

6.2 This Service is complete for a Client and a Client is considered to have exited the service when one of the following occurs:

6.2.1 Client no longer needs the Service;

6.2.2 Supplier is no longer able to meet the needs of the Client;

6.2.3 Expected Rehabilitation outcomes/goals have been reached and the Client no longer requires residential care for their injury;

6.2.4 Client is no longer eligible for ACC funded services;

6.2.5 Client has self-discharged;

6.2.6 Approved absence has been exceeded;

6.2.7 Client has died.

6.3 ACC will pay the bed night immediately following the day of the Client's discharge, transfer to another facility, or death.

7. EXCLUSIONS

7.1 The following Services are not purchased under this Service Schedule but may be purchased under other Service Schedules:

7.1.1 Acute and elective secondary care services;

7.1.2 Diagnostic imaging services;

7.1.3 Outpatient services and community services not covered by this Service Schedule;

7.1.4 Long term equipment for independence or orthotics;

7.1.5 Vocational Rehabilitation services;

7.1.6 Dentistry;

7.1.7 Optometrist;

7.1.8 Podiatry;

7.1.9 Audiology;

7.1.10 Escort or transport costs to treatment (ACC may pay under ancillary supports);

7.1.11 Transport which is not part of the Client's Rehabilitation programme (e.g. family outings) is the responsibility of the Client and/or their family;

7.1.12 Independent external assessment services e.g. Serious Injury Assessments or Needs Confirmation Residential Report;

7.1.13 Services provided under other ACC contracts e.g. Training for Independence, Living My Life, Psychology Services;

7.1.14 Payment for consultation with Specialists for conditions other than the Client's presenting injuries;

7.1.15 Cost of Pharmaceutical items that are not required as a consequence of personal injury.

8. LINKAGES

8.1 The Supplier will ensure that linkages are maintained with the following Services:

8.1.1 Culturally appropriate groups;

8.1.2 Drug and alcohol services;

8.1.3 Mental health services;

8.1.4 Education sector;

8.1.5 Work and Income New Zealand;

8.1.6 Community Groups;

8.1.7 Ministry of Justice;

8.1.8 Police;

8.1.9 Advocacy Groups;

8.1.10 Vocational Supplier Groups;

8.1.11 Community based day programmes, independent of those that may be operated by the Supplier.

9. SERVICE SPECIFIC QUALITY REQUIREMENTS

9.1 In addition to the requirements specified in the Standard Terms and Conditions, the following Audit, Staff Qualifications, Service Timeframes, Performance Requirements will be met.

10. AUDIT REQUIREMENTS

10.1 ACC acknowledges that the Ministry of Health determines the standard and level of care for residential services in New Zealand.

10.2 The Supplier must, on request, provide ACC with evidence of any required certifications.

11. STAFF QUALIFICATIONS AND EXPERIENCE

11.1 The Supplier will have an Interdisciplinary Team which has the appropriate specialty, experience and qualifications to deliver both of the following:

11.1.1 Outcome focused, Client centred, assessment and Rehabilitation services; and/or

11.1.2 Goal oriented, Client centred, Residential Care.

11.2 Each facility must have a core Interdisciplinary Team available to meet Clients' needs which includes:

11.2.1 Registered Nurse;

11.2.2 Support/Care Assistants;

11.2.3 Supervisor/Manager;

11.2.4 A General Practitioner and Pharmacist.

11.2.4.1 The General Practitioner and Pharmacist provide input into the IDT.

11.3 The core Interdisciplinary Team must be available to the Client when needed.

11.4 There must be 24-hour back up with adequate relief available for Support/Care Assistant staff.

11.5 The wider Interdisciplinary Team may include:

11.5.1 Cultural advisors/support;

11.5.2 Physiotherapist;

11.5.3 Occupational Therapist;

11.5.4 Social Worker;

11.5.5 Rehabilitation Specialist;

11.5.6 Nurse Specialist;

11.5.7 Dietician;

11.5.8 Speech Language Therapist;

11.5.9 Key Worker

11.5.9.1 The Supplier must appoint a Key Worker. The Key Worker could be any member of the Interdisciplinary Team (eg the Key Worker could be a Care Worker, Nurse or Rehab Therapy Assistant).

11.5.9.2 The role of the Key Worker is to lead the Interdisciplinary Team meetings to develop each Client's Care Plan and to ensure that treatment and care services provided to the Client are co-ordinated. The Key Worker does not need to be employed onsite at the facility.

11.6 Supervision

11.6.1 The Supplier must keep an up to date record of the qualifications, training and experience of all Interdisciplinary Team members.

11.6.2 The Supplier must ensure that regular Supervision and oversight is provided by the IDT or Registered Nurse to staff who do not meet the experience criteria set out in this Service Schedule.

11.6.3 If a member of the Interdisciplinary Team does not meet the qualifications, training and experience criteria and are under supervision, the Supplier must keep records that demonstrate the frequency and content of supervision provided to the staff member.

11.7 Pharmacist

11.7.1 The Supplier must ensure that Residential Support Service facilities have good medicines management in place led by a Pharmacist. The Pharmacist must be part of the Interdisciplinary Team. The Pharmacist does not need to be employed onsite at the facility, but should work closely with the Interdisciplinary Team.

11.7.2 If the Pharmacist is not employed by the facility, the Supplier must ensure that the Pharmacy supplying the medicines makes the Pharmacist available to provide pharmaceutical services as part of the facility’s Interdisciplinary Team.

Table 3 - Provider Qualifications

Service Provider	Qualification & Registration	Experience
Manager who holds overall clinical responsibility	Registered Health Care professional and holds a current Annual Practising Certificate.	Must have: Minimum of two years' experience working under supervision in a residential care facility. The Manager may be the Registered Nurse, or other member of the IDT.
Registered nurse	A current Annual Practising Certificate from the relevant registering authority and membership of the relevant professional body.	Must have: A minimum of two years' fulltime post qualification experience that is appropriate to the Client's need.
Care, Rehabilitation or Therapy Assistant	Have or be working towards NZQA Level 4 qualification in a service appropriate to the Client's service need. Where Care, Rehab or Therapy Assistants do not meet the required qualifications they must be working under the direct supervision of either the Registered Nurse or the IDT.	Must have: A minimum of two years' experience that is appropriate to the Client's need. Completed Careerforce Unit Standard 28737: Demonstrate knowledge of pressure injuries and pressure care. When working with Clients with TBI: New Zealand Certificate in Health and Wellbeing (Rehabilitation Support) (Level 4) with strands in Brain Injury, Spinal Cord Impairment, and Chronic Illness Where this requirement is not met, the Care, Rehabilitation or Therapy Assistant is supervised by the IDT when working with Clients with a TBI.
General Practitioner	Must have current vocational registration in general practice.	Must have: Minimum of five years' full time post vocational qualification experience.
Additional IDT requirements for delivery of moderate level (slow stream) or high and complex level Rehabilitation (RRR02 and RRR03) and/or provision of care for Clients who have high and complex medical and/or behavioural support needs (RRC03 and RRS13)		

Service Provider	Qualification & Registration	Experience
Must have available: Occupational therapists Physiotherapists Social workers Speech-language therapists Dietician.	A current Annual Practising Certificate from the relevant registering authority and membership of the relevant professional body.	Must have: A minimum of two years' full time post qualification experience that is appropriate to the Client's need; or Training and supervision by the IDT until the provider has gained two years' experience.

12. SERVICE TIMEFRAMES/TIMELINESS

12.1 The Supplier will meet the following timeframes when delivering these services. If the Supplier is not able to meet the timeframe, the Supplier must notify ACC and provide the reason the timeframe cannot be met.

Table 4 – Service Timeliness

Report or Notification	Action Required	Part B, Clause Ref.	Timeframe
Referral and Admission			
Initial Contact	ACC will contact the Supplier to discuss the Client's need for admission, service type and level of care.	4.4	At least 3 business days before admission.
ACC1154 Referral for Residential Support	ACC will email the Supplier the completed referral after the discussion and agreement.	4.4	Within 1 business day of the Supplier verbally accepting the Client.
Accept or decline	The Supplier will, on receipt of the referral form, accept or decline the referral.	4.4	Within 1 business day of receipt of the ACC1154.
Admission	The Supplier will admit the Client after accepting the referral.	4.4	Within 2 business days of the Client being ready to enter the facility.
Change in Client need and/or Service Delivery	As soon as it becomes apparent that the Supplier cannot meet the Client's Service needs the Supplier will notify ACC by phone and email.	5.15 6.1	Within 3 business days.
Rehabilitation and Care Planning			
Preparing the Plan	The Supplier will prepare the individualised Rehabilitation/Care Plan and send it to ACC using the ACC1155 form.	5.6	Within 3 calendar weeks of Client admission.

Report or Notification	Action Required	Part B, Clause Ref.	Timeframe
Changes in Client Care	The Supplier will report any changes in Client care to ACC using the ACC1156 form.	5.15	As soon as is practical
Request for additional care or support	The Supplier will contact ACC to request additional care or support for the Client	5.16	As soon as is practical
Review and update	When the Client's residential stay is expected to be shorter than 2 years the Supplier will review, update and send the individualised Rehabilitation/Care Plan to ACC using the ACC1156 form.	5.9	Every six months
Review and update	When the Client's residential stay is expected to be longer than 2 years the Supplier will review, update and send the individualised Rehabilitation/Care Plan to ACC using the ACC1156 form.	5.9	Annually on the anniversary of the Client's admission.
ACC request	At ACC's request the Supplier will send an updated individualised Rehabilitation/Care Plan to ACC using the ACC1156 form.	5.7	Within 5 business days of receiving the request.
Absences from facility			
Notification Client is absent from facility	The Supplier will notify ACC via email if Client is absent from the facility without agreement (eg: Client has self-discharged, left without notification, or their whereabouts are unknown)	5.18.4	Within 24 hours
Discharge			
Planning the Discharge	The Supplier will send ACC a comprehensive Discharge Plan.	5.19	At least 4 weeks prior to the Client's planned discharge.
Change of circumstance	The Supplier will notify ACC when the Client has been discharged, moved to another facility or deceased.	5.19	Within 5 business days
Timeliness	Clients exit services within the timeframe specified on their Care Plan	5.6 5.7	Within the timeframe specified on the Client's Care Plan

13. PERFORMANCE REQUIREMENTS

13.1 The Supplier must meet all requirements set out in this Service Schedule, including but not limited to:

13.1.1 Audit Standards (Part B, clause 10);

13.1.2 Timeliness - timeframes for service delivery (table 4);

13.1.3 Care and/or Rehabilitation Plans, Client clinical notes (Part B, clauses 5.5-5.7);

13.1.4 Review of Client's needs (Part B, clauses 5.9);

13.1.5 Interdisciplinary Team, staff qualifications, staff training (table 3);

13.1.6 Discharge planning where appropriate (Part B, clauses 5.6 and 5.7);

13.1.7 Reporting to ACC (Part B, clause 15).

14. SERVICE MONITORING

14.1 ACC may assess the Supplier's performance against any aspect of the Service Schedule.

14.2 If requested by ACC for service monitoring the Supplier will provide any documentation relevant to delivery of Services including but not limited to:

14.2.1 Client Care Plans, Rehabilitation Plans, Client clinical notes, Staffing records;

14.2.2 Audit certification and audit reports;

14.2.3 Health and Safety incident records;

14.2.4 Complaint records;

14.2.5 Client satisfaction and Client feedback records.

14.3 The Supplier's performance will be measured as shown in Table 5.

Table 5 – Performance Measurement

Objective	Performance Measure	Target	Data Source
Care and/or Rehabilitation Plans	All Clients have Care Plan and/or Rehabilitation Plan which is sent to ACC within 3 calendar weeks of admission.	100%	Supplier's annual report
Clients' needs are regularly reviewed	Care and/or Rehabilitation Plans are sent to the Recovery Team Member as per clause 5.9.	100%	Supplier's annual report

Objective	Performance Measure	Target	Data Source
Discharge Plans	Discharge Plans are sent to ACC four weeks prior to the Client's discharge.	100%	Supplier's annual report
Additional Performance Requirements for Clients who are funded for Residential Rehabilitation (RRR02, RRR03)			
Rehabilitation Outcomes	Client achieves measurable improvement in their cognitive and/or functional abilities as measured by standardised clinical Rehabilitation outcome measures.	90%	Supplier's annual report

15. REPORTING REQUIREMENTS

15.1 The Supplier will provide reports to ACC on the template provided by ACC in accordance with Table 6:

Table 6 – Reporting Requirements

Information	When	Method	Responsibility
Number of ACC clients the Supplier has provided Services to	Annually for the period 1 October to 30 September (report due by 14 October)	Survey sent by ACC	Supplier
Number of Care and/or Rehabilitation Plans sent to ACC within three calendar weeks of admission, and the number sent after more than three weeks	Annually for the period 1 October to 30 September (report due by 14 October)	Survey sent by ACC	Supplier
Number of Care and/or Rehabilitation Plans sent to the Recovery Team Member as per clauses 5.6 and 5.9, and the number sent outside the timeframes in clauses 5.6 and 5.9.	Annually for the period 1 October to 30 September (report due by 14 October)	Survey sent by ACC	Supplier
Number of Discharge Plans sent to ACC at least four weeks prior to the Client's discharge, and the number sent later than this timeframe.	Annually for the period 1 October to 30 September (report due by 14 October)	Survey sent by ACC	Supplier

Information	When	Method	Responsibility
Number of client goals achieved, as documented in Care and/or Rehabilitation Plans, and number of goals not achieved. (For RR02 and RR02 Clients only).	Annually for the period 1 October to 30 September (report due by 14 October)	Survey sent by ACC	Supplier
IDT Team Exception Reporting	Within two working days of the exception arising	Email to the Engagement and Performance Manager	Supplier
IDT Team Exception Reporting – Number of incidents reported where the IDT requirement has not been met in the past 12 months.	Annually for the period 1 October to 30 September (report due by 14 October)	Survey sent by ACC	Supplier
Audit outcome including any corrective actions	Within two working days of receiving audit report	Email to the Engagement and Performance Manager	Supplier

16. OPERATIONAL CONTACT

16.1 During the Term of this Service Schedule the Supplier will nominate a person (as specified in Part A, clause 5 of this Service Schedule) to be the main contact for ACC who will undertake the functions of the Relationship Manager at clause 11 of the Standard Terms and Conditions.

17. PAYMENT AND INVOICING

17.1 Services prices are defined for this Service in Part A, Table 1 – Service Items and Prices.

17.2 ACC agrees to pay the prices set out in Part A, Table 1 – Service Items and Prices.

18. OTHER SUPPLIERS

18.1 ACC reserves the right to appoint additional Suppliers, during the life of this Service Schedule, in regions where additional capacity is required. ACC will determine the most appropriate process for appointing additional Suppliers based on the specific service.

19. DEFINITIONS AND INTERPRETATION

The following definitions are for this Service alone.

"Activities of Daily Living" means personal care as required by the person including dressing, bathing and personal hygiene routines, eating and mobility.

"Acute Care" means the medical service delivered by District Health Boards in their emergency departments, intensive care, surgical and medical wards.

"Care Plan" means a plan developed by the interdisciplinary team which outlines the Client's service needs and specifies the care and activities that will be provided to meet those needs.

"Discharge Plan" means a detailed plan of where the Client is going after discharge from the service to support the coordination and arrangement of any necessary supports.

"Facility" means the residence or home like environment where the Client lives and which meets the requirements of this Service Schedule.

"Interim Care" is defined here as the Client needing accommodation while they recover sufficiently to continue their recovery journey, usually rehabilitation. The Client is usually non-weight bearing and has the expectation of returning to weight bearing and walking. They have attainable rehabilitation goals. A goal of interim care is that the Client maintains or improves their condition so their next stage of recovery is maximised.

"Long Term Care" means the Supplier's facility is the Client's home until further notice. There is no expectation that the Client will be discharged from Residential Care in the foreseeable future.

"Rehabilitation Plan" means a plan developed by the interdisciplinary team which outlines the Client's goals and the therapist's objectives and activity plan.

"Relief Care" means the Client is resident for the wellbeing of the Client and/or their carers. The stay will be short term as the Client will be returning to their usual living situation.

"Residential Care" means the Supplier is providing motel costs and all cares necessary to meet the Client's identified needs and meets the minimum requirements as set out in this document.

"Residential Rehabilitation" means the delivery of cognitive and physical rehabilitation in a live in, residential situation and meets the minimum requirements as set out in this document.

"Short to Medium Term Care" means the Client's intended length of stay as a residence is for defined period of stay, usually less than six months but it can

be longer. It can be for Relief, Transitional or Interim Care or for a fixed period during which the Client receives Rehabilitation with the goal of returning to independence.

“Support Worker” means care worker, Rehabilitation assistant or other service provider who works directly with the Client but is not a registered health professional.

“Transitional Care” means short term care provided to Clients while the Client is transitioning to their usual place of dwelling or place of permanent residence. This includes Clients waiting for housing modifications to their usual dwelling or Clients waiting for housing attainment.

APPENDIX A – MEDICAL CONSUMABLES

Residential Support Services - Medical Consumables	
Standard items included in bed day rate:	**Specialist items paid in addition to the bed day rate:**
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	Other Haberman bottles, cast covers. Individualised wheelchairs and seating systems, specialised seating and sleeping systems.
Rehabilitation Ultrasound gel and electrodes, therapeutic putty, crutch tips, digi caps, digi sleeves	
Other Rubbish and waste bags, blister packs, scissors, specimen containers, litmus paper, swab sticks, measuring containers, forceps. 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.	