

CAPITAL & COAST DHB

Home & Community Care Packages

Service Specification

Draft

Philosophy

Home and Community Care Packages are designed to align with the strategic objectives of the:

- The New Zealand Health Strategy – 2000
- New Zealand Health Of Older People Strategy 2002'
- The New Zealand Disability Strategy - 2001
- Primary Health Care Strategy - 2001
- He Korowai Oranga Maori Health Strategy - 2001
- The Pacific Health and Disability Action Plan - 2002

Taken together these Strategies emphasize the importance of developing services within the primary care and community sector. They embody the principle of consumer focused care where decision making is consumer directed and draws on the consumer's needs, goals and values.

The Home and Community Care Packages (HCPs) align with the vision of an integrated continuum of care embodied by these Strategies, whereby people, their carers, families, and whanau receive flexible, coordinated and responsive home and community care.

The HCPs will operate within the overall structure being established within the Capital & Coast DHB district to support an integrated continuum of care. In collaboration with the other services, they will use a pro-active, multidisciplinary approach to provide outcome focused health and disability services based on consumers' goals, needs and risks to enable them to remain at home and participate in their communities.

Key principles of the HCPs are that they:

- take into account a person's quality of life
- address a consumer's goals, needs and risks holistically
- value families, whanau and people providing ongoing support, and will support personal, family and whanau wellbeing.

Definition

The purpose of the Home and Community Care Packages is to allow a coordinated multidisciplinary response that is customised to meet the individual health and disability needs of people in their homes. Services must be flexible, proactive, responsive and based on consumers' goals, needs and risks. They must focus on the person and their caregiver/family/whanau, work with their strengths and

enable people to make real decisions about their own lives.

The goal is consumer driven services that assist people to achieve quality, cost-effective outcomes to enable them to live as independently as possible and participate at an optimal level in their communities.

Service Aims:

- Increase pro-active intervention to prevent or delay deterioration which results in increasing levels of care, acute admissions and premature or inappropriate residential care admissions
- facilitate the ability of consumers and their caregiver/family/whanau to achieve their goals and participate in their community of choice with an holistic support package that includes a rehabilitation and habilitation focus.
- support caregivers/families/whanau to provide for the physical, emotional and social needs of consumers
- Provide holistic outcome focused services based on the assessed goals, needs and risks of consumers and their caregiver/family/whanau.
- Provide flexible, integrated and responsive services
- Provide a range of services within a contract
- Integrate with improved assessment and care planning processes
- Provide a seamless continuum of care through cooperative working arrangements with other services.
- work with consumers to identify care and support solutions from a wide variety of community based options
- be efficient and effective, including creative and innovative use of resources to address consumers' goals, needs and risks
- ensure that the dignity and safety needs of the consumer and their caregivers/family/ whanau are met.
- work within the funding and policy boundaries of the funder when allocating public resources

Maori Health

The service must recognise the particular needs of Maori and the commitment to Maori under the Treaty of Waitangi. Maori have a bigger burden in terms of chronic illness/ co-morbidities at a younger age than other cultures, but access proportionally less support/health services. As a Crown agency we consider the Treaty of Waitangi principles of partnership, proactive protection of Maori health interests, co-operation and utmost good faith, to be implicit conditions of the nature in which our organisation responds to Maori health issues.

The service will work within the whanau-ora framework of He Korowai Oranga Maori Health Strategy, and seek to provide care and support that promote:

- Te taha tinana (physical well-being)
- Te taha wairua (spiritual well-being)
- Te taha whanau (family well-being)
- Te taha hinengaro (mental well-being)
- Te taha matauranga (learning)
- Whanaungatanga (extended family well-being)

HCP providers whose clientele may include Maori, shall demonstrate how the policies and practices of their provider organisation and service delivery shall benefit that Maori clientele.

Demonstration should be measured by, but not limited to, the following:

- Workforce training focused on the delivery of services to Maori including the service's understanding of Maori principles / Tikanga;
- Consumer and family/whanau feedback on how they believe the provider has delivered in relation to Maori values and beliefs;
- Linkages with the local Maori community and how these are enhanced; and
- Consultation and input from Maori in service delivery and the management structure.

Pacific Health

The service must recognise the particular needs of Pacific people who have a bigger burden in terms of chronic illness/ co-morbidities at a younger age than other cultures, but access proportionally less support/health services.

The service must understand and respect the key principles and frameworks outlined in relevant Pacific health and disability strategy documents, including the Pacific Health and Disability Action Plan 2002, and demonstrate a commitment to these principles in the provision of services. The service will consider appropriateness of service and address inequalities in provision of services to Pacific communities

Other Ethnic Health

The service must identify and respond to the needs of consumers from other ethnic populations eg Asian who also access services disproportionately relative to health need.

Service Users

The focus of HCPs is on integrated service delivery to people with chronic illness and/or high health needs who need care and support with a habilitation/rehabilitation focus, (both short term or long term) in order to be able remain living in their own home and participate in their community.

The target consumers for these services are older people and people with:

- chronic illnesses, for instance chronic respiratory diseases
- conditions more commonly associated with older people, for instance dementia
- the need for home based services such as nursing and rehabilitation
- isolation issues
- multiple medications
- a risk of falls,
- a risk of unplanned hospital admission and/or admission to residential care.

Prioritisation

Where demand is greater than the availability of this service, access will be targeted to:

- those people with the greatest need and ability to benefit
- those people with the highest health needs, including Maori, Pacific peoples, and people with low socio-economic status.

Exclusions

- Non eligible people who reside outside the Capital & Coast DHB region are excluded from the service

- Consumers who reside in a certified residential care facility

HCPs do not include but link with:

- Paediatric services
- Non-age related DSS
- Non-age related Mental Health services
- Medical/surgical services
- Specialised nursing programmes including stoma, continence, oncology & home oxygen
- ACC funded consumers

Access to Services

Entry

The Care Coordination Centre determines and manages access to HCPs. The CCC does this by determining eligibility and undertaking screening and assessment of consumers' goals, needs and risks and those of their caregivers/family/whanau. The CCC defines an overarching care plan which includes review schedules.

The CCC defines a resource allocation for a service delivery period, including an indicative description of the type, mix and volume of services to be provided to each consumer within the period until the scheduled review. The services available under this specification are:

- Community Care (personal care, domestic assistance, social support)
- Complex Personal Care
- Community Nursing
- Allied Health
- Telephone Monitoring

To enable HCP providers to limit the number of workers who provide care for a consumer, the CCC will allocate resource for Community Care based on the higher level of care required. Eg: If a consumer requires any Complex Personal Care, the resource allocation for all the service under the category Community Care will be allocated at the Complex Personal Care rate, so that a Community Care Worker (CCW) with that level of competency can deliver all the Community Care for that consumer.

At a minimum, the allocation will include one registered nurse or allied health visit at the commencement of the package, and at least one visit 3 monthly, to establish the service plan and provide

the necessary Community Care Worker assessment of competency, training and supervision.

The HCP provider will work with the consumer and their caregiver/family/whanau to develop a detailed service plan. The HCP provider is able to take a flexible approach to the delivery of service volumes within the total resources allocated by the CCC for the period until the scheduled review.



Service Reviews:

The service delivery period will vary between 6 weeks and 1 year depending on the requirements of the care plan. At the end of the service delivery period the CCC will undertake a review that will consider the status and situation of the consumer and their caregiver/family/whanau, their future goals, needs and risks and the appropriateness of the service package that is in place.

The CCC will inform the HCP provider of the outcome of the service review and any changes to the overarching care plan. As a result, the service package may:

- be discontinued
- remain the same with the same resource allocation
- change the mix of services but remain at the same resource allocation
- be decreased with a decrease in the resource allocation
- be increased with an increase in the resource allocation

If the package is discontinued the HCP provider will initiate the discharge process. If changes to the existing package are necessary, the HCP provider will then work with the consumer and their caregiver/family/whanau to establish a new service plan.

Setting

Services will be provided at the consumer's place of residence and at other community based sites as appropriate, in order to support consumers and/or their caregiver/family/whanau to address their agreed goals, needs and risks.

Hours of Service:

The service will be available over 24 hours, 7 days a week.

In usual circumstances services will be delivered between 7am and 9pm, 7 days a week. Appropriate service delivery times will be indicated in the overarching care plan and will be determined

through consultation between the HCP provider and the consumer and their caregiver/family/whanau, with approval by the CCC.

Within the resource allocation, the HCP provider will be able to vary the service delivery times in response to changes in a consumer's goals, needs and risks and those of their caregiver/family/whanau.

The goal in determining service times is balancing the need to address the goals, needs and risks of the consumer and their caregiver/family/whanau with the best use of the available resource.

Exit from the Service

A consumer will exit the service in the following situations:

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- the consumer requires a higher/more complex level of service than that delivered by HCPs
- the consumer becomes ineligible by moving out of the C&CDHB region
- the consumer no longer needs the service
- the consumer decides that they wish to access an alternative service provider
- the consumer declines further service
- the service provider withdraws the service
- A consumer's exit from the service must be a planned process during which the HCP provider follows the procedure detailed under '*Discharge Planning*'.

Key Inputs

The provider will:

- have adequate workforce to meet all the processing and timeframe requirements and to respond to all referrals according to the requirements for service listed in '*Referral Management*'.
- maintain a workforce that is competent, appropriately trained, qualified and, where relevant, currently registered with or licensed by the appropriate statutory and/or professional body
- have policies and procedures in place to deliver adequate and appropriate supervision and training for the workforce, and continuous quality improvement.

- provide a multidisciplinary team that may include but not be limited to:
 - Registered nurse
 - Community care worker/s
 - Allied health workers
 - Coordinators

The composition of the multidisciplinary team is dependent upon the nature of the consumer group.

Mechanisms should be in place to ensure an effective working relationship within the MDT, and between the team and other providers of care and support who may be involved with the consumer and their caregiver/family/whanau, both formal and informal.

- Have appropriate information management processes and systems for providing regular reports and for accessing information from the CCC.

Workforce Planning

The goal of the Home and Community Packages of Care is to provide flexible, responsive, outcome focused services that address the goals, needs and risks of consumers and their caregiver/family/whanau as defined in the care plan. The service approach will be proactive and restorative in order to prevent deterioration in both consumers and their caregivers, and to enable consumers to regain/ maintain function.

In order to achieve these goals, the HCP provider will take the necessary measures to provide a stable workforce in order to provide a safe, quality service. This will involve addressing workers' needs for:

- adequate remuneration - including an adequate base rate, payment for travel time and reimbursement of direct travel costs
- guaranteed minimum hours
- training
- supervision
- connection to a team
- general recognition and support within the organization.

C&C DHB will ensure that the price per hour/visit/telephone call is sufficient to remunerate Community Care Workers for travel, training, supervision, etc.

The provision of safe quality services will involve the HCP provider taking action to:

- Ensure that Community Care Workers (CCWs), coordinators and other healthcare professionals involved in delivering services undergo a process of training, assessment and peer review in a restorative approach to care, goal setting and goal attainment.
- Ensure that CCWs are competent to deliver combined personal care, domestic assistance and social support and are appropriately and adequately trained to undertake the tasks assigned to them.
- Ensure that CCWs are effectively supervised on an ongoing basis by a Registered Health Professional who is appropriate to the care provided, such as a Registered Nurse and/or an Allied Health Professional, and have ongoing access to advice and peer support.
- Ensure that Complex Personal Care is delivered by CCWs who have been assessed by a registered health professional as competent to deliver this level of care.
- Ensure that CCWs delivering Complex Personal Care are appropriately and adequately trained to deliver this level of care and are operating under the direct supervision (eg: available by phone or visit at any time the care is being delivered) of a Registered Health Professional who is appropriate to the care provided, such as a Registered Nurse and/or an Allied Health Professional.
- Ensure that CCW competence in relevant aspects of Complex Personal Care, eg: medication management, compression stockings, is monitored and assessed through an annual education programme and peer review.
- Ensure provision of suitable workers who are acceptable to the consumer, their caregivers/family/whanau and arrange alternative workers should the consumer request it or the workers become unavailable through illness or leave.
- Ensure that consumers are assigned a limited number of identified workers. The number to be determined by the

need to provide a safe level of service while maintaining worker/consumer familiarity.

- Undertake monitoring and review of the relationship between consumer and workers and the quality of care provided.
- Ensure contingency plans are developed to enable continuation of care in the event of untoward circumstances, eg: major flooding, earthquake etc, for those consumers whose safety would be at risk if personal care needs were not met.

Community Care Worker Supervision

The supervision of CCWs will be made up of two parts:

- 1) Initial planning, setting up and training of the care worker for the service package to be delivered
- 2) Ongoing supervision of the care worker once the service is being delivered

- 1) A Registered Health Professional who is appropriate to the care provided, such as a Registered Nurse and/or an Allied Health Professional, will work with the CCW when planning the service package. This health professional will ensure the CCW is competent to deliver the service package. This will entail the health professional:
 - Assessing the competency of the CCW to deliver the relevant care and support within the package
 - Training the CCW to deliver the relevant care and support within the package

The CCW's involvement in the planning and initial preparation/training should ensure the CCW:

- understands the goals, needs and risks of the consumer and their caregiver/family/whanau
- understands what services are to be provided and the reasons for the particular services in the package
- understands how the services are to be delivered
- understands the proposed outcomes

- 2) CCWs will have a registered health professional supervisor designated for their ongoing supervision. Once the service is being delivered, the CCW will receive supervision from a Registered Health Professional/s who is/are appropriate to the service package.

Supervision Schedule

The schedule for the CCW supervision will be determined by the service level and/or the acuity/complexity of the consumer and their caregiver/family/whanau. Complexity in this instance includes the delivery of services that may be at the basic personal care level, in a situation or setting that requires higher skill levels and a more complex approach. Eg:

- A low level package for a consumer with behaviour issues or where family members have difficult behaviour
- A low level package for a consumer who is currently stable but who has health issues that make their condition potentially unstable

The supervision schedule will vary across a spectrum of

- Daily (very high level/acuity/complexity)
- Weekly
- Monthly

CCWs should have supervision monthly at a minimum. The nature of the supervision and the setting in which it is carried out will be as indicated by the level/acuity/complexity of the consumer and their caregiver/family/whanau. Supervision on site (eg: the consumer's home) should be carried out 3 monthly at a minimum. At other times, CCWs will have ready access to advice and support from their designated supervisor.

Apart from this supervision schedule, the HCP provider will ensure that CCWs have direct access to advice and support from a registered health professional at all times during service delivery.

Service Components

HCPs are governed by a number of NZ Regulations and Legislation, specifically:

- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Health (Infectious and Notifiable Diseases) Regulations 1966
- Health (Retention of Health Information) Regulations 1996
- Health and Safety in Employment Regulations 1995
- Human Rights Regulations 1993
- Privacy Act 1993
- Health Practitioner Competency Assurance Act 2003
- Health and Disability Services (Safety) Act 2001
- Health Information Privacy Code 1994

Services will be comprised of a number of components identified as being appropriate to address a consumer's agreed goals, needs and risks, and/or to support their caregivers/family/whanau as defined in the overarching care plan provided by the CCC. All services will be delivered with a restorative focus, with the goal of maximising the consumer's independence and connection with their family/whanau and wider community.

SERVICE COMPONENT	DESCRIPTION
Referral Management	<ul style="list-style-type: none"> • Referrals will be processed within one working day. • The HCP provider will operate an effective and efficient system to receive and prioritise all referrals into the service. This system will be operated by a workforce who is knowledgeable about the scope and nature of HCPs. • The response time for service for each referral will be based on the level of risk of the consumer, which will be assessed from the information given by the CCC with the referral. • Initial contact with the consumer may be by phone or visit. Where not otherwise specified, the time from receipt of referral to first contact with the consumer will be as given in the table below: <p>Risk Level</p> <p>Initial Contact (Voice to Voice)</p> <p>Face to Face contact</p> <p>Low Risk</p> <p>within 5 days of receipt of referral</p> <p>within 10 days of receipt of referral</p> <p>Medium risk</p>

	<p>Medium risk</p> <p>within 2 days of receipt of referral</p> <p>within 7 days of receipt of referral</p> <p>High or excessive level of risk</p> <p>within 24 hours of receipt of referral</p> <p>within 24 hours of receipt of referral</p> <p>To be undertaken as per the risk management framework in Appendix 1.</p>
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Agency Responsibilities	<ul style="list-style-type: none"> • The HCP provider will make best endeavours to provide services to any consumer who identifies that provider as the one of their choice. • The HCP provider will comply with agency responsibilities included in NZS 8158:2003. <ul style="list-style-type: none"> ➤
Consent	<ul style="list-style-type: none"> • The HCP provider will seek written informed consent from the consumer at the outset of the intervention in compliance with the requirements of the Code of Health and Disability Services Consumers' Rights 1996 and other relevant legislation. • A consumer's caregiver/family/whanau will be involved in the consent process, according to the consumer's wishes. • Consent is seen as a dynamic relationship, rather than a one-off event, and should be revisited at times while the consumer is in contact with the service
Risk Assessment	<ul style="list-style-type: none"> • The HCP provider will ensure an occupational safety and health risk assessment is either undertaken, if this has not been carried out by another provider (eg" the CCC/Care manager), or updated, and documented at the earliest opportunity in relation to the specific services to be delivered, in order to minimise the risk of harm occurring to the consumer or workers during the provision of care and support. • The risk assessment will meet OSH regulation requirements and will include an environmental risk assessment and a risk assessment for any manual handling tasks required. • The risk assessment will be updated as services change within the package, or if services change as a result of reassessment.

Service Plans

- The goal of the service is to enable consumers and their caregiver/family/whanau to remain living in their own home and participate in their community. Services that enhance social support and community linkages and involvement are key elements.
- The HCP provider will work with the consumer and their caregiver/family/whanau to find solutions, and will consider a wide range of options to address their goals, needs and risks as indicated by the overarching care plan supplied by the Care Coordination Centre/Care Manager. As part of this consultation, the HCP provider will determine what sensitive issues the consumer wishes respected during service delivery.
- The overarching care plan provided by the CCC will outline an indicative care package. Based on the consultation above, and the information in the overarching care plan, the HCP provider will work with the consumer and their caregiver/family/whanau to develop a written, goal orientated service plan that will take a restorative approach and will address the consumer's risk factors, optimise functional level, prevent deterioration and maximise self-management in a way that achieves the defined goals and meets the assessed needs of the consumer and their caregiver/ family/whanau.
- The provider will work with the consumer's strengths and the realistic achievement of their defined goals will drive the approach and determine prioritisation of resources.
- The service plan will be developed by a multidisciplinary team which will include an appropriate Registered Health Professional (as indicated by the care plan provided by the CCC), such as a Registered Nurse and/or an Allied Health Professional and the care worker/s who will be supporting the consumer and their

	<p>caregiver/family/whanau.</p> <ul style="list-style-type: none"> • The service plan will identify specific interventions, outcomes, goals, responsibilities and timeframes and will act as a shared communication, planning and monitoring/outcome tool. The development of the service plan may involve consultation with health care professionals and other appropriate sources (both formal and informal) of information and advice regarding the consumer's goals, needs and risks. The plan will include coordination of services with primary and secondary care, and appropriate responses for planned or unplanned admissions to Secondary care. • In developing the service plan, the HCP provider will support caregivers/family/whanau as appropriate in order to address their goals, needs and risks and enable them to be able to maintain their role and participate in their community. • The HCP provider will ensure consumers and their caregiver/family/whanau have access to good information about options and anticipated outcomes. The initial service package and subsequent changes to the package will be agreed in consultation with the consumer and their caregiver/family/whanau. The goal is for the consumer and their caregiver/family/whanau to understand the options and be actively involved in the decisions about their care and support. • In developing the service plan, the HCP provider will take account of the cultural requirements of consumers and their caregiver/family/whanau, including ethnicity, age, gender, sexuality and disability, and will endeavour to address these. • The service plan will also detail the processes to be followed in response to episodes
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	<p>that occur outside normal working hours. This will cover the processes the consumer, their caregiver/family/whanau and the HCP provider will follow in this situation, and will include appropriate contact details.</p> <ul style="list-style-type: none">• Occupational safety and health risk assessments (including any OSH risk assessments undertaken by a contributing service) will be included in the consumer's service plan. The HCP provider will have a procedure in place for documenting new risks as they arise and reporting them to their workforce, consumers and the CCC. Risk assessments will be updated as appropriate and will be reviewed immediately where an accident or incident occurs.• The service plan will be signed off by the consumer and/or their caregiver/family/whanau (as appropriate) and the HCP provider agency• The HCP provider will submit the service plan to the CCC. If the service plan is outside the parameters indicated by the CCC overarching care plan, approval from the CCC is required.• The service plan will be reviewed as indicated by the timeframe for review in the overarching care plan, or as required, in discussion with the consumer, their family/whanau/caregiver. Confirmation of changes to the plan will be forwarded to the CCC. Reviews of the HCP provider's Service Plan are to be documented by the provider so as to form part of the monitoring and audit process.
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<p>Coordination, monitoring, review and evaluation of the Service Plan</p>	<ul style="list-style-type: none"> • Ongoing coordination, monitoring, review and evaluation of the service plan are key functions of the HCP provider in order to maintain service flexibility and responsiveness and best address the goals, needs and risks of the consumer and the their caregiver/family/whanau. • The HCP provider will facilitate a process to ensure that the care and support is provided in the most appropriate setting for the consumer, and will ensure that the consumer and their caregiver/family/whanau understand the manner in which the service plan will be delivered. • The HCP provider will coordinate appropriate service changes based on the outcomes of monitoring and reviews or as indicated by a change in the status or situation of the consumer or their care giver/family/whanau. • The HCP provider will refer consumers to the CCC for reassessment in relation to (but not limited to) the impact of the following factors on the consumer or their caregiver/family/whanau: <ul style="list-style-type: none"> ➤ Deterioration in ability to undertake activities of daily living/their life roles ➤ Unplanned in-patient medical/surgical management ➤ Unexplained and/or sudden increased need for home and/or carer support ➤ Decrease in function eg. mobility/transfers skills to a degree that places significant pressure/distress on the caregiver/family/whanau ➤ Risks to ability to stay at home and involved in their community ➤
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Community Care

The goal of the Home and Community Packages of Care is to provide flexible, responsive, outcome focused services that address the goals, needs and risks of consumers and their caregiver/family/whanau as defined in the care plan. The service approach will be proactive and restorative in order to prevent deterioration in both consumers and their caregivers, and to enable consumers to regain/ maintain function.

To support this holistic approach, Community Care will be delivered by Community Care Workers (CCWs) who are competent to deliver combined personal care, domestic assistance and social support.

CCWs will be appropriately and adequately trained to undertake the tasks assigned to them and will undergo a process of training, assessment and supervision in a restorative approach to care, goal setting and goal attainment.

As well as taking a restorative approach to the support they provide, CCWs will, at times, within the level of their competency, assist consumers and their caregiver/family/whanau with a restorative/rehabilitation programme that has been prescribed for the consumer by an allied health professional.

CCWs will be effectively supervised on an ongoing basis by a Registered Health Professional who is appropriate to the care provided, such as a Registered Nurse and/or an Allied Health Professional, and will have ongoing access to advice and peer support.

Personal Care

Base level personal care will have a restorative approach and may include (but not be limited to):

	<ul style="list-style-type: none"> • Assistance with personal hygiene e.g. bathing, showering, oral hygiene, hair washing • Assistance with dressing/undressing, grooming of hair • Observing / Monitoring of skin and scalp integrity including prevention of potential pressure problems • Physical assistance with mobility e.g. encouraging safe use of mobility aids such as walking frame, hand rails, bed lever. Use of a wheelchair • Assistance, coaching or supervision of safe transfer methods • Coaching of an exercise programme designed to increase mobility or prevent falls, as prescribed by an allied health professional • Input into posture, correct sitting positions, direction to use identified safe furniture • Monitoring of general safety of aids and appliances, referring as necessary when maintenance or replacement is required • Giving guidance and direction in simple ADL's for people with dementia or other cognitive limitations • Reminding and assisting in timely management of elimination (toileting); Help with application and management of incontinence products; Addressing hygiene and skin care where incontinence is an issue • Management of urinary collection devices including changing, emptying & cleaning of collection bags; application of uridomes • Assistance with eating or drinking, monitoring intake, alteration of texture e.g. puree diet, assistance with use of specific utensils • Management of infection control • Identifying and managing potential hazards in the home environment • Monitoring and discussing the consumer's response and changing needs with the coordinator so that further rehabilitation support or a change in programme can be implemented • Overnight support as sleepover • Direct support for carers of consumers with dementia or safety issues who cannot be left
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	<p>alone through attending the consumer in the home while the full time carer takes time out to attend to personal needs such as going to a medical / dental appointment, doing errands, attending social commitments.</p> <p>CCWs will have a role in reinforcing the restorative approach to care and support with consumers and their caregivers/family/whanau.</p> <p>➤</p>
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Domestic Assistance

Assistance with tasks normally performed in and around the home will have a restorative approach and may include (but not be limited to):

- Routine household cleaning / tidying
- Preparation and storage of food
- Grocery shopping
- Laundry management
- Infrequent cleaning tasks such as windows, fridge, oven, kitchen cupboards

CCWs will normally assist consumers with the performance of these tasks, however, there may be occasions when it is deemed appropriate and/or when it is designated in the care plan, that these tasks may be performed for the consumer. In such cases, the goal will be to assist the consumer to regain the ability to perform these tasks for themselves wherever possible.

The domestic assistance component may also include (but not be limited to):

- Working alongside the consumer where possible to help them to regain lost confidence and ability
- Assistance with meal planning
- Coaching in safe use of kitchen facilities
- Management of infection control
- Identifying and managing potential hazards in the home environment
- Assisting with appropriate low level changes to the home environment to make it simpler to function in a safe and independent manner
- Accompanying the consumer on outings where practical assistance is needed with shopping, errands, hairdressing appointments, library visits, doctor's visits, etc.

Continued monitoring of the domestic assistance component of the individual package is

	required to ensure the design of the package remains appropriate to the consumer's habitation or rehabilitation goals. Monitoring by the Coordinator will contribute to reporting to and consultation with the Care Manager or CCC
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	<p>Community & Social Support</p> <p>The goal of community and social support is to assist the consumer and the caregiver/family/whanau to maintain or regain the ability to participate and interact in the community without the assistance or facilitation of the CCW wherever possible. This will involve:</p> <ul style="list-style-type: none"> • Interaction with the consumer experiencing isolation or living alone • Interaction with the caregiver/family/whanau to relieve feelings of isolation while caring for their partner/family/whanau member • Assistance to find appropriate options for maintaining and/or re-establishing social connections in the consumer's community. EG: <ul style="list-style-type: none"> ➤ Facilitation of visits to local community facilities ➤ Facilitation of visits to family, friends and social events ➤ Facilitation of attendance at a group or club that will meet some of the consumer's social support needs ➤ Facilitation of attendance at a 'day care' programme that meets the consumer's needs for interaction, occupation and safe supervision ➤ Use of Community Resource Network database • Management of the relationship between the agency, the consumer and community organisations to ensure appropriate use of resource • The consumer is responsible for the costs they would normally incur for these activities (eg: bus, taxi fares).

<p>Complex Personal Care</p>	<p>Complex personal care will be delivered by Community Care Workers who have been assessed by a registered health professional as competent to deliver this level of care to consumers with higher health/care needs.</p> <p>CCWs must be appropriately and adequately trained to deliver this level of care and must be operating under the direct supervision (eg: available by phone or visit at any time the care is being delivered) of a Registered Health Professional who is appropriate to the care provided, such as a Registered Nurse and/or an Allied Health Professional.</p> <p>CCW competence in relevant aspects of Complex Personal Care, eg: medication management, compression stockings, will be monitored and assessed through an annual education programme and supervision review.</p> <p>Complex Personal Care may include:</p> <ul style="list-style-type: none"> • Any aspect of basic personal care that involves an added understanding of the consumer's more complex medical or physical issues in order to be provided in a safe manner e.g. feeding of consumers at high risk of choking • Personal care involving the use of a mechanical lifting or standing hoist • Any aspect of personal care that requires a particular skill set that is outside the usual required to perform basic personal care and that may require the oversight and monitoring of a qualified health professional e.g. application of compression stockings • Safety oversight of consumers with epilepsy, diabetes, dementia, mental health issues • Care of the consumer at the end of their life, providing care responsive to the needs of the consumer/family/whanau when dying • Monitoring at a higher level including weekly report on how the care provided is meeting the expected outcomes
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- Medication management at a basic level, supporting independence with medication through the dispensing of oral medication in blister packs which the CCW is able to monitor
- Application of medicated ointments and creams in a safe manner with appropriate training and guidance
- Delivery of other medium level medications such as oral liquids, nebulised inhalants, eye drops
- Delivery of services that may be at the basic personal care level, in a situation or setting that requires higher skill levels and a more complex approach. Eg:
 - A low level package for a consumer with behaviour issues or where family members have difficult behaviour
 - A low level package for a consumer who is currently stable but who has health issues that make their condition potentially unstable
- Overnight support as sleepover for care at a complex personal care level

Support and education for caregiver/family/whanau at the Complex Personal Care level on:

- Infection control practices
- Safe moving and transfer techniques
- Safe use of equipment in the home
- Assisting the consumer with their exercise or other restorative programme
- Identifying and managing potential hazards in the home environment
- Effective techniques for assisting with daily hygiene, feeding, toileting, positioning, mobility etc that prevent injury to the carer

Direct support for carers of consumers with dementia or safety issues who cannot be left alone through attending the consumer in the home while the full time carer takes time out to attend to personal needs such as going to a medical / dental appointment, doing shopping or errands, attending social or community commitments, meeting with friends.

Community Nursing

Registered Nursing care shall be provided to address the highly complex clinical needs of the consumer and also to provide insight, planning, training, assessment and guidance to high acuity personal support required by consumers experiencing complex health issues.

Community nursing may include:

- Development of a nursing service plan based on nursing diagnoses, objectives, monitoring and evaluation
- Wound care:
 - Post surgical wound dressing and management including removal of sutures
 - Chronic wound management including liaison with specialist wound care clinicians where indicated
 - Advise on appropriate dietary intake for optimum wound healing
 - Report, monitor and treat any early signs of infection to prevent avoidable complications
 - Employ best practice techniques and consumables in an economically sustainable manner to achieve the optimal outcome for wound healing
 - Regular assessment of skin integrity where the risks are high and early intervention may minimise that risk
- Management of bladder care:
 - Implementation of appropriately timed catheter flushes and changes
 - Aiming to maintain patency and avoid problems that may lead to hospital admission
 - Integrated into the individual package so as to cause least disruption to the consumer's day to day lifestyle needs
- Management of the consumer's bowel regime:
 - Where intervention is indicated the nurse will assist the consumer with planning an

	<p>appropriate and effective bowel regime</p> <ul style="list-style-type: none">➤ Visit at the appropriate time to best fit with the other components of the service package to deliver the agreed intervention➤ Monitoring and appropriate response to functional problems that may occur from time to time
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- Medication management
 - Injectable medications e.g. insulin, Vit B12, by subcutaneous or intramuscular injection delivered by registered nurses in response to clinical direction
 - With the exception of supervising blister packs, the nurse delivering medication will observe the 5 rights rule - right dose, right drug, right consumer, right time, right route - according to the written and signed prescription.
 - The nurse will have access to information re compatibility, drug actions, contraindications, purpose, side effects and routes.

- Management and supply of medical consumables
 - Incontinence products
 - Dressing consumables
 - Urinary drainage consumables

- Education and support of consumers and their caregiver/family/whanau with:
 - Infection control practices
 - Safe moving and transfer techniques
 - Safe use of equipment in the home
 - Assisting the consumer with their exercise or other restorative programme
 - Identifying and managing potential hazards in the home environment
 - Effective techniques for assisting with daily hygiene, feeding, toileting, positioning, mobility etc that prevent injury to the carer

- Supporting consumer self management of their chronic condition and monitoring their adherence to prescribed therapies
- Monitoring, assessment and provision of a written report of each intervention
- Assessment of the appropriateness and viability of the service provision based on its ability to meet the stated consumer outcomes

	<ul style="list-style-type: none">• Training, supervision and assessment of CCWs delivering complex personal cares to ensure a safe standard of care
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<p>Allied Health Care</p>	<p>Physiotherapy</p> <ul style="list-style-type: none"> • Liaise with the consumer and their caregiver/family/whanau and others to plan and implement a rehabilitative programme of exercise • Provision of a written plan focused on improving strength, flexibility, range of movement, mobility, balance as appropriate. • Attend during service provision to teach the specific inputs to the rehabilitative programme recommended • Assess the efficacy of the programme at 6 weeks and provide further professional input to the consumer and the CCWs undertaking supervision of the consumer in their exercise programme • Provide integrated feedback to the Coordinator to be included in the consultation with the Care Manager/Care Coordinator. <p>Occupational Therapy</p> <ul style="list-style-type: none"> • Plan for, teach and direct the lead CCW and team to support the consumer's participation in a rehabilitative programme for their activities of daily living. • Attend the consumer and provide support and guidance to their caregiver/family/whanau and others for achievable activities of daily living • Provide direction and guidance to family/whanau members who wish to be actively involved in supporting the consumer to remain functional in their home environment • Support the consumer and their caregiver/family/whanau and CCWs in the safe and appropriate use of aids and equipment during the consumer's restoration to improved independence • Assess the continued appropriateness to the consumer's rehabilitative process of any planned inputs at the 6 week period • Provide integrated feedback on the attainment of expected outputs to the Care Manager/Coordinator
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	<p>Recognition and support of the role the caregiver plays in the success of the package through providing allied health education on:</p> <ul style="list-style-type: none">• Safe moving and transfer techniques• Safe use of equipment in the home• Assisting the consumer with their exercise or other restorative programme• Identifying and managing potential hazards in the home environment• Effective techniques for assisting with daily hygiene, feeding, toileting, positioning, mobility etc that prevent injury to the caregiver• Supporting consumer self management of their chronic condition and monitoring their adherence to prescribed therapies
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Phone Monitoring	<ul style="list-style-type: none"> • For the purpose of ensuring safety of the consumer living alone • Telephone call following a planned checklist appropriate to the consumer (eg: prompts to take medication, secure house at night, etc). • Monitoring of change in response levels as an indication of possible deterioration in mood, physical, emotional, spiritual or mental well-being • Assessment of the consumer's ability to safely manage specific aspects of self care, e.g. taking medication, eating meals, securing property at night • Continued evaluation of situation with reporting to the CCC if this level of service is no longer needed or is no longer sufficient to meet the consumer's goals
Equipment	<ul style="list-style-type: none"> • Low cost equipment for the purpose of undertaking activities of daily living (eg: showering or bathing) will be supplied by the provider in accordance with the assessment and overarching care plan. • The need for equipment that must be sourced through short term or long term loan will be referred to the Care Coordination Centre. The CCC will arrange for an assessment from an accredited assessor, who will coordinate the supply and installation of equipment from the appropriate source. • The consumer is responsible for the cost of items they would normally cover when undertaking activities of daily living. For example: <ul style="list-style-type: none"> ➤ materials required for household management and personal care ➤ costs associated with meeting basic needs eg: transport
Complaints	<ul style="list-style-type: none"> • The HCP provider will make available to all consumers and their caregiver/family/whanau information detailing the procedure by which they may request a review of a part or the whole of the service plan. Such procedures are to include the following elements:

	<ul style="list-style-type: none">➤ Ability to resolve through discussion complaints arising through misunderstandings➤ Use of a person not involved in the development of the previous service plan to undertake a review or to develop a new service plan➤ Process for making changes to the service plan• The above steps to be at the HCP provider's expense.• If the consumer and/or their caregiver/family/whanau remain dissatisfied then they will have access to a second level of review by the CCC.
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Discharge Planning

- Planning for discharge from the HCP will take place as a collaborative process involving the the consumer and their caregiver/family/whanau, the CCC, health care professionals and others involved in the care and support as appropriate.
- Discharge planning will be appropriate when:
 - the consumer requires a higher/more complex level of service than that delivered by HCPs
 - the consumer becomes ineligible by moving out of the C&CDHB region
 - the consumer no longer needs the service
 - the consumer decides that they wish to access an alternative service provider
 - the consumer declines service
- Discharge may involve a hand-over to the service provider who will have ongoing oversight of the consumer's health and disability status. Eg: Primary Health Care Practitioner.
- On completion of discharge the consumer's data and a discharge summary of the service and outcomes achieved will be sent to the CCC in order to update the overarching care plan held by the CCC. The consumer will receive a copy of this information.
- Apart from the normal reasons for discharge, the HCP provider may exit the service for other reasons following negotiation with the consumer and the CCC. Possible scenarios may be issues around safety of workers, or the inability to provide workers appropriate to the consumer.
- The consumer may at any time contact the CCC to request referral to another provider.

Resource Allocation Management

The CCC will provide the HCP provider with a care plan and a resource allocation for each consumer, based on the InterRAI assessment. The care plan will have time-frames for review of the service plan.

The HCP provider will then work with the consumer and their caregiver/family/whanau to develop a service plan that will address their defined goals, needs and risks. The service plan must be managed within the resource allocation.

HCP providers have the flexibility to respond to changes in the condition or situation of the consumer and/or their caregiver/family/whanau within the amount of the resource allocation, for the period of the time-frame for review of the service plan. This can be done without the involvement of the CCC. EG:

- If a consumer becomes ill with the flu or has a fall, the provider can increase the volume of services or add extra services the consumer needs for a limited period.
- If a consumer is away on holiday or has a relative staying, the provider can cease or reduce services for that period.
- If a family/whanau caregiver who provides some support becomes ill the provider can replace that support for the consumer for a limited period.

If the HCP provider observes changes in the condition or situation of the consumer or their caregiver/family/whanau (based on the criteria in *'Coordination, Monitoring, Review and*

	<p><i>Evaluation of the Service Plan</i>) that require a service response that is outside the parameters of the resource allocation the provider will refer the consumer to the CCC for reassessment.</p> <p>Once the consumer has been reassessed, if appropriate, the CCC will provide the HCP provider with a new resource allocation for the consumer, based on the reassessment. The provider will then develop a new service plan with the consumer and their caregiver/family/whanau.</p> <p>The HCP provider will submit invoices on a fortnightly basis for validation by the CCC. The consumer service record will contribute to the administrative process for validation of provider invoices.</p>
<p>Information Management</p>	<ul style="list-style-type: none"> • The HCP provider will implement information systems that identify the structure of service components within a service package and account for and evaluate them. • The HCP provider will establish an information transfer protocol with the CCC that will facilitate ease of transfer, efficacy of service coordination and aid administration.

Service Linkages

HCP providers will establish and sustain effective relationships with other organisations and individuals involved in assisting consumers and their caregiver/family/whanau to address their goals, needs and risks. These relationships will reflect the profile of the population served by the provider, and may include Primary and Secondary health services, community organisations, voluntary groups and other public sector agencies.

Beyond the services they provide directly, HCP providers may assist people to access services from other providers and other care and support available within their community. For key agencies, providers should have in place memorandums of understanding, protocols and other liaison mechanisms that agree how the relationship will be conducted. C&CDHB will require HCP providers to provide evidence of the effectiveness of relationships.

HCP providers will also need to provide evidence of effective linkages with the community, involving Maori, Pacific Peoples, disability groups, support networks and advocacy groups. Relationships will be managed in a way that has regard for the interrelationships that exist between consumers, their networks and social support systems.

Information Requirements

Providers will have information systems to enable access, recording or reporting on the following information per consumer:

<ul style="list-style-type: none"> • Patient NHI • Patient ACC number if applicable • Patient Name • Patient Date of Birth • Patient Gender • Patient Ethnicity • Contact Details • Emergency contact details • Next of kin/carer details including contact details • Residence type • Known access/safety issues • Preferred language • GP details • PHO details 	<ul style="list-style-type: none"> • Referral source • Referring Practitioner Name or name of referrer • Referring Practitioner Registration Number (where possible) • Date of referral to service • Reason for Referral (issue/diagnosis) • Known Previous medical history/ diagnosis • Services referred for • Date referral accepted/rejected (case made active) 	<ul style="list-style-type: none"> • Date of assessment(s)/review(s) • Assessor name(s) + contact details where possible • Main problems/issues • Main goals • Other services/providers involved + contact details • Assessment/review information generated from InterRAI tools for those consumers completing an InterRAI assessment • Summary of identified risks other than clinical eg environmental, manual handling • Service(s)/inputs required to achieve objectives • Date of service(s) starting • Amount of service(s) required + contacts provided • Changes to service package • Significant changes in consumer or caregiver/family/whanau condition/situation • Processes to be followed in response to episodes that occur outside normal working hours • Provider of service • Contact details of service provider • Significant changes to service(s) providers – reason/date/new provider + service details • Date service(s) stopped + reason • Review dates + reviewer • Date of discharge (case made inactive) • Discharge summaries 	<ul style="list-style-type: none"> • Provider Contract details • Cost per service per consumer • Provider invoice details • Provider payment details
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Quality

Standards

The service is required to comply with the General Terms and Conditions and the Provider Quality Specifications as defined in the C&C DHB contract.

The service is required to comply with the Home & Community Support Sector Standard NZS 8158:2003.

In some instances, these Standards are superseded by the quality requirements detailed in this service specification.

The following specific quality requirements also apply.

Facilities

The Service must be compliant with NZS 4121 for accessibility.

Purchase Units

The Service incorporates the following purchase units from the Nationwide Service Framework. These purchase units include other services as defined by C&CDHB and specified in this service specification. The service will be purchased on a price volume basis.

Purchase unit Code	Purchase unit Description
Community Care	Hours
Complex Care	Hours
Community Nursing	Visits
Allied Health	Visits
Telephone Monitoring	Telephone calls

Reporting Requirements

Purchase Units

Templates supplied for reporting will require monthly information but will be reported quarterly.

PURCHASE UNIT CODE	REPORTING	REPORTING REQUIREMENTS
Community Care	Volumes by consumer	To CCC via invoice validation
Complex Care	Volumes by consumer	To CCC via invoice validation
Community Nursing	Volumes by consumer	To CCC via invoice validation
Allied Health	Volumes by consumer	To CCC via invoice validation
Telephone Monitoring	Volumes by consumer	To CCC via invoice validation

Quality Measures

These are to be reported on an annual basis and can form the basis of a narrative report based on aggregate information.

MEASURE	REPORTS
Consumer satisfaction	Summary of surveys Goal attainment
Quality management	Progress against service quality plans as per NZS 8158:2003 standard
Restorative model	Profile of workforce positions either on staff, contracted or by MOU Number of vacancies in each position Narrative report on performance against training plan for restorative approach Numbers attending restorative training module/s
Integrated & coordinated services	% consumers assigned an identified coordinator Narrative report on performance against formal

	communication plan
Social Support	% service plans signed off by carers % reviews covering carers goals, needs & risks
Flexibility	% review schedules met
Workforce sustainability	Community Care Worker surveys on work satisfaction Turnover numbers by position description % workforce as agency workers % workforce by position type with guaranteed minimum hours Ratio of community care workers to supervisors % workforce by position type with recognised qualifications

Reporting and Service planning information

The service will submit reports using the following framework and submit the reports on the template provided. Additional reports can be raised at any time if there are issues that the service wishes to raise.

MEASURE	REPORTS BY	FREQUENCY
Referrals	Numbers received Services indicated by overarching care plan eg nursing/home care	
Average waiting time to first contact from the service	% achieved	Quarterly
Average waiting time to first service delivery	% achieved	Quarterly
Access to services	<ul style="list-style-type: none"> Progress against service access improvement plans and changes in access to services by Maori, Pacific, consumers from other ethnicities and those from low socio-economic 	Annually

	groups	
Service workforce levels	<ul style="list-style-type: none"> • Positions/grades • Ethnicity • Coordinator turnover rates • Community Care Worker turnover rates 	Annually
Workforce development	<ul style="list-style-type: none"> • Narrative report on workforce development noting training and supervision for the range of positions in the service. • Narrative report on training and supervision in relation to goal setting/attainment, service planning, a restorative approach and the attainment and maintenance of competencies in relation to the service delivered. 	Annually

Definition of Terms:

Health Care Professional – Care Manager, General Practitioner, Medical Practitioner, Registered Nurse, Allied Health Professional

Caregivers/family/whanau - people who have principal, active responsibility for the ongoing and frequent care of a person with a long term disability or chronic medical condition.

Flexible Services - Flexibility applies across a number of aspects of service delivery. To deliver quality services to successfully meet the needs of consumers, flexibility applies to 'what, when and how'. It requires services that are able to respond to the changing needs of consumers and/or their caregiver/family/whanau on a day to day basis as well as responding to their changing needs over longer periods.

APPENDIX 2: Risk Assessment Framework

High Risk:

Failure to provide the service may result in the person:

- Being subject to unacceptable level of risk, eg: lack of fluids and food, unable to toilet
- being in unnecessary pain
- Requiring unplanned admission to emergency department or acute care
- imminently being admitted as an in-patient for symptom control
- experiencing deterioration of their health status requiring their long-term in-patient medical/surgical management
- no longer being able to stay in their own residence

Medium Risk:

Failure to provide the service may result in the person:

- being subject to unacceptable level of indignity, eg: unable to shower, dress
- being unable to self-manage with resulting dependency on alternative options which may compromise their health status
- having to be referred to a specialist for consultation and/or management of a health condition
- continuing with compromised health status which is not life-threatening but if left unmanaged would lead to more extensive and/or additional problems
- being unable to self-manage thus placing significant pressure on the caregiver/family/whanau which may cause their health status to be compromised
- being admitted to short-term care to provide respite for the caregiver

Low Risk:

Failure to provide the service may result in the person:

- Living with a limited degree of compromised health status which is not in any way life threatening but intervention would enable them to return to optimal health status and/or function safely and independently.