

- **Specialist Health Service For Older People**

- **Service Specification**

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DEFINITION OF CARE PATHWAY USED IN THIS SPECIFICATION:

An agreed and explicit route an individual takes through health and social care services. Agreements between the various professional involved will typically cover the type of care and treatment, which professional will be involved and their levels of skills, and where treatment or care will take place. (NHS National Service Framework for Older People March 2001)

1 Philosophy

Specialist Health Services For Older People (SHOP) will be committed to working in collaboration with the range of health and social support providers to ensure that older people access health care at the right time and in the most enabling environment.

The service will actively work with consumers/families to identify the needs, abilities and resources within their situation, and will plan and evaluate health and social service inputs in partnership with the consumer.

Key elements of this approach are:

- Services are older person focussed and needs based
- The needs of carers are assessed and considered in conjunction with the older person
- The wellness model is promoted
- The older person's rights are protected

2 Definition

The Specialist Health Service For Older People is an integrated service delivered by interdisciplinary teams coordinated and delivered across Primary, Community, Secondary and Tertiary care.

The Specialist Health Service For Older People comprises of integrated:

- Geriatric medical services
- Psychiatry of old age services
- Interdisciplinary assessment, treatment and rehabilitation services

for older people with multiple or complex health or disability support needs. The service will provide specialist interventions to treat/rehabilitate/maintain the older person's functional capacity and to work with the caregivers/whanau/family of older people with disabilities. Where required the service will provide a supportive approach for people with progressive conditions who can benefit from rehabilitation.

Services will be provided by Interdisciplinary teams (IDT) of professionals who have advanced skills and knowledge in physical, social and/or psychiatric conditions, injury and disease processes in older people. Services should focus on community services to prevent deterioration and hospital admission in older people. In-patient services should focus on people who need access to specialist diagnostic or therapeutic services that cannot be provided in the community.

The service will also provide consultation, liaison and training on the care of older people to other services, for example:

- Acute medical/surgical units and other hospital services such as Emergency Departments
- Primary Healthcare providers
- General practitioners
- Home and community care providers
- Residential care
- Palliative services
- Voluntary groups
- Support groups/field workers

Where appropriate this will include shared care planning and development of referral protocols and care pathways.

3 Objectives

The objectives of this service are to:

- Improve the overall health outcomes for older people with complex medical, cognitive, functional and social needs
- Ensure that older people who have contact with the service have their care needs fully assessed and appropriate care provided
- To prevent or delay the onset of increasing levels disability/disease in older people with complex medical, cognitive, functional and social needs
- To reduce the need for older people with complex medical, cognitive, functional and social needs to be admitted to acute and residential care facilities
- To improve the overall consumer satisfaction with access to and provision of care
- To support the development of best-practice of care for older people with complex medical, cognitive, functional and social needs across all settings

3.1 Maori Health

The service will 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.

The service will identify and respond to the cultural values and beliefs that influence the effectiveness of care and support for Maori consumers and their whanau. The service will consider appropriateness and quality of care and support and address inequalities in access to and provision of care and support to Maori.

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)

3.2 Pacific Health

The service will 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 will 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 and quality of service and address inequalities in access to and provision of services to Pacific communities

3.3 Health For Other Ethnic Groups

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

4 Service Users

4.1 Inclusions

The service will be provided to the following consumer groups resident within C&C DHB:

- The 65+ age group who have complex health/physical cognitive and/or psychiatric and/or psychosocial needs
- People aged 50 - 64 who have early onset of an age-related disability or condition (eg. alzheimers dementia)*
- People over 50 years who have chronic medical illness resulting in a high need for health and/or disability services*

* This will allow people under the age of 65, notably Maori and Pacific, who may require health and disability support needs more commonly experienced in older age to be addressed.

4.2 Exclusions

The following consumer groups will be excluded from this service:

- Older people with non complex health and social problems eg a single diagnosis that can be managed by the relevant specialty or service
- Non eligible residents

5 Access To Service

5.1 Referral

Referrals can be made to the service by:

- Care Coordination Centre
- Allied health professionals
- Care managers
- Community agencies/PHOs
- General practitioners
- Nurses
- Other medical specialists

5.2 Guidelines For Referral

The following sections detail guidelines for referral to the service, however it is acknowledged that the service will develop more proactive and shared care arrangements to facilitate access to the service, involving appropriate screening as required.

5.2.1 General

Referral to the service should be considered in relation to, (but not limited to) the following scenario's, either individually or combined:

- Consumer has multiple co-morbidity requiring specialist geriatrician input, (specifically for in-patient settings, this can include older people with diagnoses such as hip fracture, stroke and lower limb amputation who frequently have multiple co-morbidity)
- Consumer has multiple co-morbidity and increasing usage of community support services
- Consumer has multiple co-morbidities and requires multiple specialist allied health/nursing input
- Consumer has had a recent unexplained deterioration in ability to undertake activities of daily living
- Consumer requires large unexplained increases in home and/or carer support

- Consumer has a recent history of unplanned admission(s) or A+E attendances
- Consumer safety is compromised as they are increasingly unable to undertake activities of daily living/life roles safely
- Consumer risks no longer being able to stay in their own residence

5.2.2 Specific Triggers

Referral to the service should always follow in these circumstances:

- Consumer is losing functional skills eg. mobility/transfers to a degree as a result of reversible or potentially reversible that places significant pressure/distress on the family/caregiver which may cause the family/caregiver's health status to be compromised
- Consumer has recently experienced a 'break down' in services/support network and the consumer has been admitted to secondary care
- Consumer is considered to be 'frail elderly' or a combination of disease and aging processes that make establishing diagnoses difficult
- Consumer is expected to have a measurable benefit from an inter-disciplinary approach to assessment, treatment and rehabilitation
- Consumer shows increasing confusion or cognitive impairment, acute episodes or chronic progression
- Consumer has delirium
- Psychogeriatrician input for consumers who have delirium where medical origins have been eliminated, dementia with behavioural and psychological symptoms (BPSD) or a recent onset functional illness such as depression
- Consumer risks experiencing irreversible deterioration of their health or functional/mobility status

Referral should include consultation with consumer, whanau and other providers already involved with the person as appropriate.

5.3 Exit From Service

A consumer will exit the service in the following situations:

- All risk factors are eliminated/managed within resources
- All needs effectively met within resources
- All consumer goals have been achieved
- The consumer will gain no further benefit from service
- Consumer/whanau declines further service input

5.4 Time

Initial access to in-patient specialist medical advice and assistance will be available 24 hours a day.

Services should have response times that ensure the function and health status of clients does not deteriorate while waiting for a service.

6 Service Components

SERVICE COMPONENT	DESCRIPTION
Referral process	<p>The C&C DHB Care Coordination Centre will include a single one point of entry for home and community services across the DHB. Clinical screening will ensure that appropriate referrals are forwarded to the community teams of the Specialist Health Services For Older people. All referrals for in-patient transfers will be made direct to the Specialist Health Service for Older people.</p> <p>Re-entry to the service eg through community teams will occur in consultation with the Care Coordination Centre.</p> <p>The service will ensure that efficient and appropriate processes are in place to receive and prioritise referrals.</p>
Consent Process	<ul style="list-style-type: none">• Legislation covering informed consent must be observed.• When assessing Maori, whānau should be involved in the consent process.• For Pacific peoples, consent is seen as a dynamic relationship rather than a one-off event and will require revisiting at times while the consumer is in contact with the service

<p>Assessment process</p>	<p>The service will offer a range of assessment processes which will be commenced in the most appropriate environment.</p> <p><u>Initial Multidimensional Assessment</u> The service will assign a key worker who will complete the initial multi-dimensional assessment/ care planning process, liaising with the CCC to organise support services which are immediately required.</p> <p>The initial assessment will aim to identify the client and carer's current health/functional/social situation and establish goals in these areas. It should also begin to identify the factors, which may be contributing to a decline in the client's situation and any impediments to the consumer's participation in AT&R and/or their own health management.</p> <p><u>Specialist inter-disciplinary assessment</u> The multidimensional assessment will provide a common source of information upon which discipline specific assessments can be built. The comprehensive assessment will be a dynamic process, covering such areas as; medical, physical, cognitive, cultural, social and emotional needs of the consumer and carer. The keyworker will ensure that communication occurs within the team so that the implications of discipline specific assessments are understood and incorporated into the team planning process, linking them to an overall care plan for treatment, rehabilitation, education, long term management options and support needs appropriate to the goals and circumstances of the person and their family/whanau.</p> <p>Use of validated and standardised assessment instruments concordant with the recommendations of the NZ Guidelines Group will form part of the process of assessment of older adults.</p> <p>Throughout the assessment process, the domains covered will at a minimum include:</p> <ul style="list-style-type: none"> • Risk factors for early intervention eg. disease prevention • Physical health/functioning and • Mental health/cognitive functioning • Polypharmacy • Personal care • Presence, abilities and needs of carers • Social functioning, support systems and environmental • Safety • Strengths and potential eg for rehabilitation • Current level of un-met needs • Other identified risks, eg environmental risks if services are to be provided in the home setting, manual handling risks
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	<p>The assessment process will include liaison with family, whanau, carers and other providers already involved with the person as appropriate. The assessment process will take account of Maori cultural requirements, and will make use of Maori assessors/assistance/advocates who understand health and disability services and conditions, as required by Maori. Where a Maori assessor with the necessary skills is not available, assessors will be supported by someone who is fluent in te reo Maori me ona tikanga and who is well known and respected in the community.</p> <p>The assessment process will take account of Pacific cultural requirements, and if required during assessment, will make use of Pacific assessors/assistance/advocates who understand health and disability services and conditions. Where a Pacific assessor with the necessary skills is not available, assessors will be supported by someone who is fluent in the language and culture of the consumer, and who is well-known and respected in the community.</p> <p>The assessment processes will take account of other ethnicity/cultural requirements as required and will include other advocacy and support services as required.</p>
Care Planning	<p>Following assessment the service will define a goal orientated care plan with the consumer that will be used for shared communication, planning and monitoring purposes.</p> <p>The care plan can define specific interventions/referrals and will define specified outcomes/goals, time frames and responsibilities. The care plan will be agreed with the consumer/family/Whanau and may include consultation with relevant service providers.</p> <p>The consumer will receive a copy of the care plan.</p> <p>A summary of the assessment and care plan will be held with the C&CDHB Care Coordination Centre.</p>

<p>Interventions and liaison</p>	<p>Interventions provided by the service will be provided in the most appropriate environment and will be coordinated by the keyworker. The service will provide:</p> <ul style="list-style-type: none"> • Interventions that treat reversible conditions, minimise symptoms and/or identify appropriate management strategies for people whose conditions are not reversible, reducing risk where appropriate • Interdisciplinary treatment and rehabilitation programmes for those with rehabilitation potential • Interventions which promote the wellbeing of carers and the sustainability of informal and formal care giving situations • Specialist assessments as required, eg for equipment • Consultation, liaison, assessment and care planning as required with other services as appropriate to facilitate provision of care. Liaison services across all settings are essential and should include development of referral protocols, care pathways and ongoing transfer of knowledge. <p>The service will carry out systematic reviews/reassessment of the consumers progress, monitor and evaluate the care plan with the consumer/family/whanau and will:</p> <ul style="list-style-type: none"> • Adjust interventions according to the consumer's achievements • Update care plans as required • Ensure that the consumer, and their caregiver or family/Whanau understand the manner in which the interventions will be delivered <p>As key changes to the care plan occur the service will liase with the Care Coordination Centre to update the summary care plan held there.</p> <p>The service will provide Care Management for a small proportion of people with very complex needs through Care Managers.</p>
<p>Discharge planning</p>	<p>The service will commence discharge planning during the initial contact phase/assessment period. All consumers will have a planned discharge date defined as soon as practicable after the initial assessment. Planning will take place with full consultation with the consumer and carers/family/Whanau.</p> <p>Planning will take place in conjunction with the Care Coordination Centre and other service providers/referrers as required.</p> <p>Discharge will occur when:</p> <ul style="list-style-type: none"> • Goals of consumer achieved • Risk factors are eliminated/managed within available resources • All needs effectively met within resources • No further benefit from service can be gained • Consumer declines service

	On discharge the service will update the care plan held by the Care Coordination Centre and a completed discharge summary will be available for the consumer and their GP/lead primary health carer.
Education and service development	<p>The service will be a source of knowledge/resource in the support and care of the older person by supporting and/or providing:</p> <ul style="list-style-type: none"> • Workforce development ie training and education in best practice for older people for other services • Training and education for support groups and formal/informal carers • Input into/information on up to date national/international guideline • Input into C&C Specialised Older Persons service standards and guidelines • Expertise to support the development of health promotion and injury prevention programmes

6.1 Service Settings

The service will be provided to the consumer at the most appropriate setting including Primary, Community, Secondary and Tertiary settings.

The service should provide a significant component of its service in the community settings. In addition to community based teams this could include clinics in community settings eg within PHO and Marae settings.

The service should also provide support to prevent/divert hospital admissions, for example establishing close working with accident and emergency departments for consultation, liaison assessment and care planning purposes.

In-patient services should focus on people who need access to specialist diagnostic or therapeutic services that cannot be provided in the community and people who risk not being able to remain at home due to inadequate social & practical support systems.

Liaison services across all settings are essential and should include development of referral protocols, care pathways and ongoing transfer of knowledge.

6.2 Service Levels

6.2.1 Inpatient

Appropriate nursing and medical care will be available 24 hours a day seven days a week for in-patient services. The Psycho-geriatric in-patient service will be provided within a secure environment.

6.2.2 Community/Outpatient

Community and out-patient based services will be available 5 days a week.

6.2.3 Liaison Services

Liaison services for acute secondary care settings will be available for a minimum of five days a week. Liaison services for community and primary care will be available five days a week.

6.2.4 Equipment

Access to a wide range of equipment and appliances is required while clients are accessing the service.

Access to a short term loan pool for equipment and appliances for up to three months post discharge from the service should be arranged for people when it is anticipated their recovery will not necessitate long term loan or as an interim solution whilst awaiting long term loan equipment.

Applications to Enable NZ for long term loan equipment or housing modifications will be generated following assessment by allied health professional who are Accredited or Registered Assessors. These assessments will be completed as part of the discharge planning.

6.2.5 Support Services

The following services are included as support services:

- Diagnostic imaging including MRI, CT scan, ultrasound, fluoroscopy
- Pathology including tests referred to community laboratories
- Supplies and equipment including prostheses, contact lenses, hearing aids, artificial limbs, wheelchairs and other equipment
- Sterile supply
- Pharmacy

6.2.6 Facilities

Inpatient & outpatient facilities must have appropriate physical access for people with disabilities and appropriate areas for rehabilitation activities.

6.3 Key Inputs

The service will require input from the following which may be part of the interdisciplinary team or sourced from other services:

- Geriatricians
- Psycho-geriatricians
- Rehabilitation specialists
- Nurses
- Occupational Therapists
- Physiotherapists
- Social Workers
- Speech & Language Therapists
- Dietiticians
- Maori Health workers
- Pacific Health workers
- Psychologist
- Assistants and support staff

7 Service linkages

The service will be well coordinated with other community services as well as being well known to local providers and people. The service is required to demonstrate links with the following services, for which separate service specifications apply:

SERVICE PROVIDER	NATURE OF LINKAGE	ACCOUNTABILITIES
Care Coordination Centre (CCC)	Manage referrals liaise and work with this service to coordinate the care plan and ensure a seamless continuum of care for the consumer.	<p>CCC is responsible for forwarding/generating referrals to SHOP in a timely manner with appropriate information.</p> <p>SHOP is responsible for acknowledging and responding to referrals from the CCC.</p> <p>SHOP is responsible for lodging summaries of relevant assessment and care plans with the CCC.</p> <p>The CCC is responsible for receiving and storing summaries of relevant assessment and care plans from SHOP.</p> <p>The CCC is responsible for coordinating the care plan to ensure the consumer receives the care in a timely and appropriate manner.</p> <p>SHOP is responsible for ensuring updates of assessment and care plans are communicated to the CCC</p> <p>The CCC is responsible for ensuring that updates of assessment and care plans are stored and coordinated following any monitoring and review of care plans.</p> <p>SHOP is responsible for informing the CCC when discharge from the SHOP service is appropriate and ensuring that all relevant details for on going care are specified for the CCC to action.</p>

		<p>The CCC is responsible for receiving discharge notification from SHOP and storing discharge information on the consumer's file.</p> <p>The Centre is responsible for establishing services for discharge and ensuring that the ongoing oversight of the consumer's health status is transferred to their PHO/lead primary carer.</p>
Acute HHS Services eg Internal medicine, accident & emergency, Mental Health services	<p>Liaise and work with these services to develop referral protocols, care pathways and establish care plans to ensure a seamless continuum of care for the consumer.</p>	<p>The referring service is responsible for referring appropriate consumers to SHOP and communicating appropriate information on referral in a timely manner.</p> <p>SHOP is responsible for providing a consultation and liaison service, communicating to referring services regarding assessment outcomes and advice for ongoing care.</p> <p>All services are responsible for liaising with each other regarding outcomes of assessment, care plans, ongoing care as required to ensure the consumer receives care that meets their needs in a timely and appropriate manner.</p> <p>Referring services and SHOP are responsible for agreeing transfer of consumers to/from care of SHOP</p> <p>All services are responsible for agreeing care pathways for appropriate consumer groups as required. This may include shared care planning and ongoing management as appropriate.</p>
PHOs and GPs	<p>Liaise and work with these services to develop referral protocols, care pathways and establish care plans to ensure a seamless continuum of care for the consumer</p>	<p>The referring service is responsible for referring appropriate consumers to SHOP via the CCC and communicating appropriate information on referral in a timely manner.</p> <p>SHOP is responsible for providing a liaison service and communicating to referring services regarding assessment outcomes and advice for ongoing care.</p> <p>Primary care services and SHOP are responsible for agreeing care pathways for appropriate consumers groups as required. This may include shared care planning and ongoing management as appropriate and facilitating PHO based clinics as appropriate.</p>

Care Manager Service (external to SHOP)	Liaise and work with this service to develop referral protocols, care pathways and establish care plans to ensure a seamless continuum of care for the consumer	<p>Care Managers are responsible for referring appropriate consumers to SHOP via the CCC and communicating appropriate information on referral in a timely manner.</p> <p>SHOP and the Care Managers are responsible for liaising with each other regarding outcomes of assessment, care plans, ongoing care and providing advice as required to ensure the consumer receives care that meets their needs in a timely and appropriate manner.</p>
ACC	Liaise and work with this service to establish care plans and ensure a seamless continuum of care for the consumer	SHOP will be responsible for meeting requirements for relevant contracts held with ACC and liaising with ACC Case Managers and contact centres where relevant to provide input into assessments and on going treatment that ACC have commissioned.
Other primary/community health providers eg residential care facilities	Liaise and work with these services to ensure a seamless continuum of care for the consumer	<p>Other primary/community health providers are responsible for referring appropriate consumers to SHOP via the CCC and communicating appropriate information on referral in a timely manner.</p> <p>SHOP is responsible communicating to other community health providers regarding assessment outcomes, advice for ongoing care and transfer of consumers to/from care of SHOP.</p> <p>All services are responsible for ensuring joint working occurs where relevant.</p>

<p>Other government departments and local body agencies, eg: WINZ, Family Court, Council housing services, etc.</p>	<p>Liaise and work with these services as appropriate to ensure a seamless continuum of care for individual consumers.</p>	<p>SHOP is responsible for establishing appropriate links with agencies involved in the formal and informal care and support of the consumer.</p>
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Significant interfaces will exist with:

- Maori community care services
- Other appropriate Maori organisations
- Pacific community care services
- Other appropriate Pacific organisations
- Other ethnic/cultural advocacy/support groups
- Consumer advocacy services, including Maori/Pacific advocacy services
- Home support care providers
- Residential care providers
- Equipment Management Services
- Family Court
- WINZ
- Consumer/Carer Support
- Chaplaincy
- Disability Information Centres
- Consumer support groups
- Interpreting services

8 Quality Requirements

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

1. *NZS 8134:2001 Health and Disability Sector Standards*
2. *NZS 8142:2000 Infection Control*
3. *NZS 8141:2001 Restraint Minimisation and Safe Practice*

The service will develop a plan to improve access to the service by Maori, Pacific, consumers from other ethnic groups and those in low socio-economic groups who access services disproportionately relative to health need.

8.1 General

The provider is responsible for implementing a strategy for planning, implementing and reviewing service delivery to clients, from a client perspective. All clients should be involved in the development of their service plan and personal outcome objectives. In addition, outcome measures should be developed for each client, their family and whanau.

8.2 Access

Services based in a facility should be provided from facilities that are easily accessible to the client and should meet New Zealand Standards 4121.

8.3 Acceptability

The service should be provided in a way that is sensitive to the needs of the community within which the provider operates and should have effective working relationships based on co-operation with a range of relevant community and support link groups.

Client satisfaction surveys should explicitly measure satisfaction with the service.

In addition, acceptability to Maori should be included in the review conducted by the provider in conjunction with Maori. Support services to Maori requiring your services should be proactively offered and available.

8.4 Safety and Efficiency

The provider will ensure that all persons who supply or provide or assist in the provision of this service are competent, appropriately qualified and, where relevant, currently registered with or licensed by the appropriate statutory and/or professional body.

9 Information Requirements

At a minimum the service will collect the following information for all patients seen by the service:

- Patient NHI
- Patient ACC number if applicable
- Patient Name
- Patient Date of Birth
- Patient Gender
- Patient Ethnicity
- Contact Details
- Next of kin/carer details including contact details
- Referral source
- Referring Practitioner Name or name of referrer
- Referring Practitioner Registration Number (where possible)
- Date of referral to service
- Reason for Referral
- Diagnoses
- Date of first assessment with service
- Outcome of referral eg accepted/declined (with reason)
- Date of service starting
- Residence on admission
- Level of function on admission
- Level of function at discharge
- Residence on discharge
- Date of discharge
- Number and types of contacts

The service will be expected to collect data in line with NATIONAL MINIMUM DATASET (HOSPITAL EVENTS) DATA DICTIONARY Version 6.4 August 2004

10 Purchase Units & Reporting

This service is associated with the following purchase units. Reporting is detailed as the table below.

Purchase Unit Code (PUC)	Purchase Unit	Purchase Unit Measure	Frequency Reports Received	Reporting Requirements
DSS214	ATR Inpatient	Bed days	Quarterly	<ol style="list-style-type: none"> 1. Number of clients on waiting list (waiting to access service) by month 2. Average time on waiting list (days) by month
DSS235	ATR Inpatient Mental Health Services for the Elderly	Bed days	Quarterly	<ol style="list-style-type: none"> 3. Number of clients on waiting list (waiting to access service) by month 4. Average time on waiting list (days) by month
DSS215a	ATR Outpatient Clinics	Attendances	Quarterly	<ol style="list-style-type: none"> 7. Total number of attendances by month 8. Number of clients by month by <ul style="list-style-type: none"> • Gender (male, female) • Ethnicity (Maori, Pacific Island, Other) • Disability type (age-related, psychiatric, intellectual, physical/sensory) <p>Number of clients on the waiting list (waiting for entry to service) by month</p> <p>Average time in days from when referral first received until client attends by month</p>
DSS217	ATR Outpatient Domiciliary	Visits	Quarterly	<p>Total number of visits by month</p> <p>Number of clients by month by</p> <ul style="list-style-type: none"> • Gender (male, female) • Ethnicity (Maori, Pacific Island, other) • Disability type (age-related, psychiatric, intellectual, physical/sensory) <p>Number of clients on the waiting list (waiting for entry to service) by month.</p> <p>Average time in days from when</p>

				referral first received until first contact by month.
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10.1 Quality Measures

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

- Improvements in ADL scores from admission to discharge
- Improvements in IADL scores from admission to discharge
- Prevalence of falls or any injuries while under care of service
- Changes in residence from admission to discharge ie from home to rest home, rest home to home
- Consumer satisfaction with service
- Referral response times
- Development and review of pathways of care with reference to best practice
- Progress against service quality plans as per NZS 8134:2001 standards

In addition the service can report, where appropriate, specific outcomes and quality measures from the InterRAI tool where this is used in the service, eg community teams.

10.2 Service Planning

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

MEASURE	REPORTS BY	FREQUENCY
Average and median length of stay	<ul style="list-style-type: none">• Ethnicity• Age band 50-54, 55-64, 65-74, 75-79, 80+• number of days	Quarterly
Referrals and admissions by source	Source of referral eg GP, in-patient unit	Quarterly
Service staffing levels	<ul style="list-style-type: none">• Grade• Profession• Ethnicity	Quarterly
Service Access	<ul style="list-style-type: none">• Progress against service access improvement plans and changes in access to service by Maori, Pacific, consumers from other ethnicities and those from low socio-economic groups	Quarterly