

SERVICE SPECIFICATION

SupportCare

1. DEFINITION

This service is for those people who are eligible for SupportCare End-of Life Support and SupportCare Severe Medical Illness Support and who are assessed as requiring residential care placement.

SupportCare End-Of-Life

For those people assessed by CDHB or Community Palliative Care Clinicians operating under Purchase Unit ID COPL0001 "Palliative Community Services" as: -

- a) Having a prognosis (life expectancy) of less than 86 days and
- b) Being treated as terminally ill and
- c) Having a Supports Needs Level (SNL) assessment that identifies a level of disability equivalent to hospital level care

SupportCare End-Of-Life Support is available for a maximum of one 86 day period only. Patients, irrespective of age, who qualify, will receive fully funded care and will not be required to contribute towards the cost of their care for the 86 day period. The 86 day SupportCare funding rule applies from the date the patient is admitted to the facility or the date that the end-of-life package was commenced and they must be admitted into an approved facility within two weeks of funding having been approved. If the patient survives the 86 day period and is 65 and over then they may be required to contribute towards the cost of their ongoing care.

SupportCare End-Of-Life residential care may only be provided by selected aged continuing care hospitals which are certified by HealthCERT for geriatric and medical categories and which have an Age Related Residential Care Agreement with the Canterbury DHB.

SupportCare Severe Medical Illness

For those people who have been assessed by CDHB or Community Palliative Care Clinicians operating under Purchase Unit ID COPL0001 "palliative Community Services" as: -

- a) Having a combination of an advanced medical illness and associated disability and
- b) Being under 65 and having an anticipated prognosis (life expectancy) of more than three months and
- c) Having a support needs level (SNL) assessment of 3 to 5 (ie moderate to high need) and

- d) Having disability issues as a result of their combined complex needs that necessitates care in a residential care facility, either rest home or hospital

Patients who qualify for SupportCare-Severe Medical Illness Support may be required to contribute to the cost of their care when they turn 65 years of age or are deemed to be 'Close in Interest' to Older Persons.

SupportCare-Severe Medical Illness residential support may only be provided by selected aged rest homes or continuing care hospitals which are certified by HealthCERT and which have an Age Related Residential Care Agreement with the Canterbury DHB. A patient is still required to be reassessed if moving from rest home to hospital care.

Services will be provided in a fair, transparent and equitable manner through centralised funding, eligibility and screening criteria and a flexible seamless service delivery.

These definitions exclude: -

- a) Patients under 16 years of age or
- b) Patients who are already residing in a residential care facility or
- c) Retrospective applications

2. SERVICE OBJECTIVES

The purpose of the service is to:

- a) Provide support to those people who fulfil the criteria for SupportCare funding and require residential placement and
- b) Offer quality holistic palliative care with skill and expertise and
- c) Integrate palliative care services within Canterbury with improved care outcomes and
- d) Provide culturally safe care to Maori and ethnic groups and
- e) Ensure a seamless process surrounding placement

2.1 Maori Health

The Provider will ensure it has a comprehensive Maori Plan in place which outlines how it will contribute to Maori cultural safety for services contained in this service specification.

The plan should include the following objectives as a minimum: -

- a) How the Provider will identify and respond to the cultural needs of the patient in line with the New Zealand Maori Health Strategy He Korowai Oranga and

- b) How staff will be trained and educated about cultural safety and
- c) What links the service will have to support Maori and their Whanau and
- d) How the Provider will ensure acceptability and accessibility of the service and
- e) How the plans' objectives will be monitored and measured for Maori and
- f) Identify and eliminate barriers to Maori Residents within the service and
- g) Culturally safe practice for death of a Maori resident

3. SERVICE USERS

The client group is those people who fulfil the criteria for SupportCare funding in a residential care setting as an alternative to supported care in a community home based setting.

4. ACCESS

4.1 Eligibility Criteria

Clients are eligible for Support Care End-Of-Life care if they have been assessed by CDHB or Community Palliative Care Clinicians operating under Purchase Unit ID COPL0001 "Palliative Community Services" as: -

- a) Having a prognosis (life expectancy) of less than 86 days and
- b) Being treated as terminally ill and
- c) Having a Supports Needs Level (SNL) assessment that identifies a level of disability equivalent to hospital level care

Clients are eligible for SupportCare Serious Medical Illness care if they have been assessed by CDHB or Community Palliative Care Clinicians operating under Purchase Unit ID COPL0001 "Palliative Community Services" as: -

- a) Having a combination of an advanced medical illness and associated disability and
- b) Being under 65 and having an anticipated prognosis (life expectancy) of more than three months and
- c) Having a support needs level (SNL) assessment of 3 to 5 (ie moderate to high need) and
- d) Having disability issues as a result of their combined complex needs that necessitates care in a residential care facility, either rest home or hospital

The process of managing the referrals is as follows

- e) A Service Needs Level (SNL) will be undertaken by either CDHB Social Workers, or Community Social Workers operating under Purchase Unit ID COPL0001 "Palliative Community Services" if assessed as being eligible for SupportCare and the referral will be directed to the Central Coordination Centre (CCC). The CCC is responsible for coordinating the services as outlined on the SNL. The CCC will contact eligible residential care services regarding placement of clients.
- f) SupportCare residents may only access your service if your contracted bed number (as per your agreement with the Canterbury DHB) is not exceeded
- g) SupportCare residents may only access your service if your service is certified to provide the required level of care by HealthCERT and you have an Age Related Residential Care Agreement with the Canterbury DHB
- h) SupportCare End-Of-Life residents may only access hospital, continuing care, services and the hospital service must be certified to provide geriatric and medical services
- i) SupportCare Severe Medical Illness Support can access rest home or hospital level care. Residents moving from rest home to hospital care would need their level of care reassessed.

4.2 Referral to the Service

Referral on to the SupportCare program is via CDHB, or Community Palliative Care Clinicians operating under Purchase Unit ID COPL0001 "palliative Community Services". All Residential Care placements are then referred through the Central Coordination Centre.

4.3 Reassessment

- a) SupportCare End-Of-Life residents who are 65 years or over must be referred for reassessment to the Older Person's NASC service. This should occur 21 days prior to the end of the approved 86 day period of funding under SupportCare if it is likely that they will live beyond the 86 day period. This is in order to ensure smooth transfer to health care of the Health of Older People funding and appropriate application for a subsidy through WINZ. A Needs Coordinator (NASC) may not need to see the resident and/or family in order to facilitate transfer to Income and Asset testing but may instead refer the resident and/or family to WINZ directly.
- b) If the resident is imminently dying then referral is not appropriate but must be reassessed at 7 days prior to the approved 86 days. A Needs Coordinator (NASC) may not need to see the resident and/or family in order to facilitate transfer to Income and Asset testing but may instead refer the resident and/or family to WINZ directly.

- c) If a NASC worker was not the resident's original Case Co-ordinator, the SNL will need to be faxed to Older Persons Health Needs Coordination Service.
- d) An Older Persons Health Residential Care form will need to be signed by an Older Persons Health Specialist.

4.4 Response Time

The response time for each referral will be within 48 hours if a bed is available for the resident. The service provider will: -

- a) Operate an effective and efficient system to receive and prioritise all referrals into the service. This system will be operated by staff who are knowledgeable of the type of service required
- b) Refuse any inappropriate referrals
- c) Document declining referrals

5. PAYMENTS

5.1 Payment During Temporary Absence

- a) Where a SupportCare resident is absent from your service for 5 days due to hospitalisation we will continue to pay you for the service to a maximum of 5 days from the first day of absence only for one period of five days within the each 86 day period.
- b) Where the SupportCare resident is absent and away with family or friends we will continue to pay you for the service to a maximum of 3 days from the first day of absence only for two periods of three days within each 86 day period.

5.2 Payment for Admission, Discharge, Transfer or Death

- a) Where a SupportCare resident is admitted to, discharged or transferred from your facility at any time on a particular day, we will pay you, for the full day on which that admission, discharge, or transfer occurred.
- b) Upon the death of the SupportCare resident, we will pay you for the day of that resident's death and the following day.
- c) You must notify the Central Coordination Centre of the SupportCare resident's death within 24 hours of their death.

5.3 Payment Link

The payments made by Canterbury DHB will link directly with the Age Related Residential Care Agreement bed day rates plus GST within the relevant service type eg rest home level or hospital continuing care level. The link will

include any funding increase as a result of the Age Related Residential Care Agreement review as per clause A21, and only A23 of that agreement if relevant.

6. SERVICE COMPONENTS

6.1 Compliance with Legislation and Standards

You must comply with all relevant legislation, including but not limited to:

- a) New Zealand Public health and Disability Act 2000
- b) Health and Disability Commissioner Act 1994
- c) Health and Disability Services (Safety) Act 2001
- d) Health and Safety in Employment Act 1992
- e) Health Act 1956
- f) Health Practitioners Competence Assurance Act 2003
- g) Medicines Act 1981
- h) Privacy Act 1993\
- i) Food Hygiene Regulations 1974
- j) Any legislation which supersedes, substitutes or amends the legislation listed
- l) Your facility will be certified by the Ministry of Health, HealthCERT for and you will have an Aged Related Residential Care Agreement with the Canterbury DHB.

6.2 Provider Policies

You must develop and document policies, procedures and protocols for the following elements of your service. These need to be approved by the CDHB, with advice from the SupportCare Advisory Group.

- a) Bereavement Support for the Resident and Family
- b) Bowel Care
- c) Death and Dying
- d) End-of-Life Care
- e) Medication Management
- f) Mouth Care

- g) Nutrition and Hydration
- h) Pain and Symptom Management
- i) Psychological Support for the Resident and Family
- j) Skin Management
- k) Spirituality and Counselling
- l) Wound care management

The following policies must be in place: -

- a) Complaints
- b) Personal Grooming
- c) Personal Hygiene
- d) Pet Visiting
- e) Preservation of Privacy and Dignity
- f) Providing Culturally Safe Care
- g) Restraint Minimisation and Safe Practice
- h) Sexuality and Intimacy

6.3 Documentation

- a) Clinical Record System

You must ensure that every Registered Nurse maintains a daily (hospital level) and weekly (Rest Home level) written record of progress for each SupportCare client. You must ensure that all written entries are legible, dated and signed with designation of person making the entry.

If a Medical Practitioner or other health practitioner visits the SupportCare resident you shall ensure that such health professionals enter their findings, and any treatment given to or ordered for the SupportCare resident, into relevant clinical records maintained on site at the time of attendance. You must ensure that all entries are legible, dated, and signed by the relevant health professional

- b) Handover report

You must ensure that at the commencement of each shift that there is a written handover report for staff on the following shift who will be responsible for providing care to the SupportCare resident. The report must be based on the SupportCare resident's care plan and be available for all care staff.

6.4 Care Assessment and Planning

Care plans address the SupportCare resident's current abilities, level of independence, identified needs and takes into account as far as practicable their personal preferences, individual habits, routines and support needs, likes and dislikes. Care plans should also encompass forward planning and crisis intervention.

A registered nurse will develop each care plan.

Care plans are available to all care staff and these are used to guide the care delivery provided according to the relevant staff member's level of responsibility.

a) SupportCare End-Of-Life

You will ensure that each SupportCare End-Of-Life resident's "End-Of-Life Specific Patient Care Plan" is completed within 24 hours of admission. You will ensure that this plan is reviewed by a registered nurse weekly or more often as the SupportCare resident's condition or needs change.

You are responsible for liaising with the Palliative Care team at Christchurch Hospital or with the Community Palliative Care Service for care plan advice if required.

You will involve family/whanau in care planning review as appropriate.

b) SupportCare Severe Medical Illness

You will ensure that each SupportCare Severe Medical Illness resident's initial care plan is developed within 3 days of admission and full care plan within 2 weeks of admission.

You will ensure that each SupportCare Severe Medical Illness resident's care plan is reviewed by a registered nurse monthly or more often as the SupportCare resident's condition or needs change.

You will involve family/Whanau in care planning as appropriate.

6.5 Primary Medical Treatment

- a) Each SupportCare resident will be examined by a General Practitioner within 2 days of admission whether or not a medical practitioner has examined the resident within the previous 2 days at another clinical setting.
- b) The SupportCare End-Of-Life resident will be reviewed by a General Practitioner no less than weekly.
- c) The SupportCare Severe Medical Illness resident will be reviewed by a General Practitioner no less than monthly unless it is clinically

documented by the General Practitioner that the resident is stable enough to be reviewed 3 monthly.

- d) On call emergency medical services are available to SupportCare residents at all times. You must cover all costs of such emergency medical services.
- e) You are responsible to provide palliative care to SupportCare residents. You will endeavour to obtain specialist palliative care and/or specialist medical and advisory support to maintain such care at your facility as appropriate and in the best interests of the SupportCare resident.

6.6 Discharge, Transfer or Death of SupportCare Resident

- a) If a SupportCare resident wishes to transfer to a new residential care provider of their own volition, you must support the transfer and work with the Central Coordination Centre to effect a smooth transfer of the SupportCare resident.
- b) You must ensure all relevant information relating to the SupportCare resident is made available to the new provider.
- c) You will ensure that appropriate referrals are made to relevant clinical services and the SupportCare resident's General Practitioner in case of discharge home. Any discharge home will be in collaboration with the Central Coordination Centre.
- d) A SupportCare resident will depart from your service if you fail to maintain certification status or hold an Age Related Residential Care Agreement with the Canterbury DHB.

6.7 Admission Agreement

- a) You must ensure that each SupportCare resident, or their nominated representative, signs an Admission Agreement on the day that the SupportCare resident commences receiving services at your facility. You must not charge the subsidised resident or any other person for preparing or providing an Admission Agreement.
- b) You must provide the SupportCare resident with a copy of the signed Admission Agreement.
- c) The Admission Agreement must contain a list of items that are excluded from the service and information about charges relating to any service or items.
- d) You must include your liability for damage or loss of the SupportCare resident's personal belongings, including clothing.
- e) You must include the procedure that a SupportCare resident must follow if he or she wishes to make a complaint about you or your service.

- f) You must include information relating to the SupportCare resident's rights in respect of the room where that SupportCare resident will live, including when that SupportCare resident is temporarily absent from the facility.
- g) Information about the reassessment process should the SupportCare resident's eligibility for SupportCare funding changes.
- h) You must include a description of transportation policies, procedures and costs and include staff accompanying protocols.

6.8 Accommodation and Services

- a) The buildings and facilities shall meet the accommodation needs of SupportCare residents (see definition) and reflect the special needs of the SupportCare residents.
- b) You must provide lodging with the use of all furniture, including a recliner chair (hospital level only) and electric bed (hospital level only) for the sole use of the SupportCare resident, fittings, fixtures, bedding and utensils, except to the extent that the SupportCare resident may choose, with your agreement, to use their own furniture and possessions where they can be reasonably and clinically safely accommodated.
- c) You must provide single room accommodation for the SupportCare Resident.
- d) You must provide cleaning services and supplies that maintain the facility in a clean, hygienic and tidy state.
- e) You must provide laundry services, which ensure a 24 hour turn around of the SupportCare Resident's personal clothing. You will take all reasonable precautions to minimise damage or loss of such personal clothing. Your financial liability is restricted to that agreed with the SupportCare Resident in the Admission Agreement.
- f) You must provide a garden/outside recreational area that incorporates sheltered seating and is easy to access. You must maintain the building and outdoor environment in a tidy, useable and safe state.
- g) You must ensure that the facility is clean, warm, safe, well maintained, homelike and comfortable and in such a manner to promote privacy, dignity and wellbeing.

6.8.1 Nutrition

- a) You must provide a food service of adequate and nutritious meals, refreshments and snacks at morning/afternoon tea and supper times. This will reflect the nutritional requirements of the SupportCare resident, and as much as possible take into account the personal likes and dislikes of the SupportCare resident. It will also address medical/cultural restrictions and be served at times that reflect community norms and also meet the needs of the SupportCare resident.

- b) Additionally, you will provide nutritional supplements as prescribed by a dietician which promote and enhance nutrition for the SupportCare Resident.
- c) You will ensure that a Registered Dietician reviews the SupportCare Resident's dietary and nutritional requirements where clinically indicated

6.9 Equipment for Residents Requiring SupportCare

You will have the following available within your facility to provide for SupportCare clients, as required: -

- a) Pressure relieving mattresses
- b) Oxygen
- c) A minimum of two syringe drivers suitable for subcutaneous medication delivery (hospital level only)
- d) Communal aids and equipment for personal care and general mobility including but not limited to urinals, bedpans, wash bowls, walking frames, wheelchairs, commodes, shower/toilet chairs, raised toilet seats, pressure relieving equipment, over and above the pressure relieving mattress, to promote skin integrity.
- e) A lifting hoist (hospital level only)
- f) All other equipment as required under the Age Related Residential Care Agreement.
- g) You must ensure that radio, television, newspapers, and personal mail inward and outwards and telephones for private convenient use in private are made available to SupportCare residents.

7.0 SUPPLIES

7.1 Continence Supplies

- a) You will provide disposable continence management products which are of an appropriate standard to meet the needs of the SupportCare Resident, as documented in the care plan.
- b) For those SupportCare residents identified as requiring specialist continence advice you will obtain specialist advice, if need be, from a continence advisory service in order to ensure maximum comfort and dignity for the SupportCare Resident.

7.2 Provision of Dressing Supplies

- a) You must provide all dressings and supplies used in treatments. These must be of an appropriate standard, as determined by a Registered Nurse, to meet the needs of the SupportCare Resident.
- b) You will obtain specialist wound advice from a wound advisory service if required to adequately treat complex wounds of the SupportCare resident

7.3 Provision of Pharmaceuticals

- a) Your liability for payment of prescribed medication is limited to the payment of the Government's prescription charge, any manufacturers surcharge and any package and delivery charge by the Pharmacist.
- b) You will ensure that you have an appropriate pharmaceutical stock to meet the needs of SupportCare (hospital level) residents. Essential drugs include, but are not limited to:
 - 1) Morphine sulphate ampoules, 10mg/ml, 30mg/ml and Morphine Tartrate 120mg/1.5ml
 - 2) Haloperidol ampoules 5mg/ml
 - 3) Metoclopramide ampoules 10mg/2ml
 - 4) Clonazepam drops (0.1mg/drop)
 - 5) Clonazepam ampoules 1mg/ml
 - 6) Hyosine Hydrobromide ampoules 400mcg/ml
- c) You will ensure that all controlled medication is locked in a safe within a locked cupboard

7.4 Transportation

- a) You must meet the costs of ambulance transport for clinical reasons.
- b) As part of your service you will ensure that the SupportCare Resident is accompanied to clinical appointments. You will provide a staff member to accompany the SupportCare Resident if a family member or friend is not available to do so.

8.0 KEY INPUTS

1. SupportCare Hospital Level

The service may include, but not be limited to, the following mix of skills:-

- a) 24 hour Registered Nurse coverage
- b) 24 hour Care Giver coverage
- c) Medical Practitioner

- d) Pharmacist
- e) Chaplain
- f) Dietician
- g) Wound Nurse Specialist
- h) Continence Adviser
- i) Occupational Therapist
- j) Physiotherapist
- k) Podiatrist

2. SupportCare Rest Home Level

The service may include, but not limited to, the following mix of skills:

- a) Registered Nurse care
- b) 24 hours Care Giver coverage
- c) On-call Registered Nurse
- d) Medical Practitioner
- e) Pharmacist
- f) Chaplain
- g) Dietician
- h) Wound Nurse Specialist
- i) Continence Adviser
- j) Occupational Therapist
- l) Physiotherapist
- m) Podiatrist

3. Staffing Levels

- a) You will ensure that staffing levels meet the needs of the SupportCare Resident and are no less than minimum requirements in the Age Related Residential Care Agreement which you have with the Canterbury DHB
- b) Where possible, you ensure that the SupportCare Resident has a key worker responsible for their overall care

8.1 Service Linkages

- a) Social Workers
- b) Palliative Care Team Christchurch Hospital
- c) Palliative Community Services
- d) Central Coordination Centre
- e) Chaplaincy Services
- f) Needs Assessment and Coordination (NASC)
- g) Primary Health Organisations and General Practice Teams
- h) District nursing services
- i) Laboratory services
- j) Radiological services
- k) Dental services
- l) Specialist medical services (Including the Oncology Service)
- m) Advocacy services
- n) Maori provider organisations
- o) Interpreter Services

8.2 Education and Training

You must plan and implement a program of staff development and in-service education to maintain staff competency to provide SupportCare. You must keep a written record of staff education and competencies.

Hospital level competency

- a) You will ensure that all care givers in your service responsible for caring for the SupportCare resident have attained or are in the process of attaining the certificate for the Palliative Carers Course “Palliative Care Education for Care Assistants”.
- b) All Registered Nurses caring for the SupportCare resident will be certified to use syringe drivers.
- c) All Registered Nurses caring for the SupportCare resident will have attained or be in the process of attaining certification from the Christchurch Hospital Palliative Care Service (Resource Groups Part 1 and Part 2) or via Hospice/ Palliative Care Education (Postgraduate Certificate in Hospice Palliative Care Modules).

8.3 Staff Support

You will ensure that all staff delivering SupportCare have access to support and debriefing within your facility.

9. QUALITY REQUIREMENTS

The service will: -

- a) Develop and implement a quality improvement programme that is able to measure the service's performance
- b) Result in ongoing improvement to ensure a high standard of clinical and support services in accordance with approved palliative care standards as required in education and training in this service specification
- c) Evaluate the programme for its effectiveness
- d) Evaluate how the Maori Health Plan has been put into effect through the provision of services
- e) Conduct regular internal audits to evaluate service effectiveness including and not limited to: infection rates; falls rates; medication errors; pain management; care planning effectiveness; documentation; clinical records; referral responses; Resident satisfaction surveys; staff satisfaction surveys.

9.1 Risk Management Plan

The Service will: -

- a) Maximise the safety of services delivered to the SupportCare Resident through implementing operational management strategies which minimise risk of unwanted events and enhance quality
- b) Protect the SupportCare Resident, visitors and staff from avoidable and/or preventable risk and harm
- c) Document and implement policies and practices in relation to infection control; occupational health and safety; safe food handling; safe management and administration of medications; safe storage of chemicals and poisons; prevention and removal of abuse and neglect of SupportCare residents, visitors and staff; falls prevention.
- d) Have a risk management plan which, identifies, evaluates and prioritises risk, and states controls to mitigate those risks

10. ACCEPTABILITY

Every SupportCare Resident will be provided with meaningful information about their care and will enjoy a collaborative care delivery model.

11. REPORTING REQUIREMENTS

You are required to report: -

- a) Any significant quality or service delivery issues to the service's Contract Manager
- b) CDHB bed occupancy census data
- c) The death, discharge or transfer of any SupportCare Resident

Additionally you may be required to report the following SupportCare Resident's details upon request by CDHB

- d) Name
- e) NHI number
- f) Date of birth
- g) Gender
- h) Ethnicity
- i) Referring practitioner name
- j) Date of referral to service
- k) Date of admission to service
- l) Date of assessment
- m) Date of any reassessment