User Guide: Aged Care Assessment Team Guidance Framework for Home Care Package Level

This user guide provides a general indication on how to use the Aged Care Assessment Team Guidance Framework for Home Care Package Level (Guidance Framework). It does not replace clinical judgement.

Reason for the Guidance Framework

Stage one of the *Increasing Choice in Home Care* measures commences from 27 February 2017. One of the reforms is to move from an assessment for a broad-banded Home Care Package level – a 1-2 or 3-4 – to a specific Home Care Package level - a 1, 2, 3 or 4.

With this change, the Aged Care Assessment Teams (ACATs) indicated a need for guidance material to support and inform their decision-making, to better distinguish between the individual four home care package levels.

Development of the Guidance Framework

The Department developed the Guidance Framework, in conjunction with an ACAT stakeholder group. This group included nominated members from ACATs across Australia and provider representatives from Leading Aged Services Australia, Aged and Community Services Australia and the Aged Care Guild.

The stakeholder group developed a draft guidance framework and then recruited participants to take part in a Pilot project. The pilot was designed and conducted to ensure that the framework assists assessors to consistently select the most appropriate Home Care Package level for clients, according to their assessed need, and to identify any unintended consequences.

The pilot involved each of the 145 participants reviewing six client case studies, mapping them to the Guidance Framework and determining the appropriate Home Care Package level.

Feedback from the pilot indicated the Guidance Framework was a useful, simple, largely self-explanatory reference that can be used to supplement clinical reasoning. The Department also further refined several aspects of the framework in response to the feedback received, for example by separating the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) categories and changing the descriptors for case management.

About the Guidance Framework

The Guidance Framework reflects information about a person’s needs, as indicated by the frequency and complexity of services required. This information is collected as part of the comprehensive assessment.

The Guidance Framework comprises of domains, categories and descriptors.
Domains

The Guidance Framework is divided into five domains, to mirror the National Screening and Assessment Form (NSAF):

- Social
- Medical
- Physical
- Psychological, and
- Complexity / Vulnerability.

Categories

Within each of these domains are several categories. These categories do not include all those addressed in the NSAF, as it is not intended to be a repeat assessment. Instead, it includes those categories that the ACAT stakeholder group felt were the most important factors to consider in this domain, when determining the appropriate level for a Home Care Package. For example, the key categories under the physical domain are:

- ADL - includes activities oriented toward looking after yourself, such as personal care and hygiene, eating, mobility etc.
- IADL - includes activities more oriented towards interacting with your environment, such as driving, shopping, communication financial management etc.
- Falls risk
- Pain, and
- Sensory.
These categories align to questions from the NSAF. For example, the ‘nutrition’ category under the “Medical” domain aligns to several questions, including:

- Do you have problems swallowing?
- How is your appetite?
- Have you been eating poorly as a result of decreased appetite?
- Have you lost any weight without trying, or had other nutritional concerns in the last 3 months?
- Do you regularly drink more than 8 cups of fluid a day?

Other categories may mostly align predominantly to one question in the NSAF, for example the ‘social isolation’ category, under the “Social” domain aligns to the question:

- Is the client socially isolated?
Descriptors

Within each of the categories are four descriptors. These match to the Home Care Package levels 1, 2, 3, 4.

**PHYSICAL**

<table>
<thead>
<tr>
<th>ADL</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Unlikely to perform without assistance</td>
</tr>
<tr>
<td>3 Needs frequent assistance</td>
</tr>
<tr>
<td>2 Needs some/intermittent assistance</td>
</tr>
<tr>
<td>1 Independent</td>
</tr>
</tbody>
</table>

Broadly, across each of the levels, the frequency or level of ability described in the Guidance Framework is consistent:

- A level 1 has nil issues/is coping/can self-manage in this category
- A level 2 needs occasional/intermittent assistance and support
- A level 3 needs ongoing/regular/frequent assistance and support
- A level 4 needs full/frequent/ongoing assistance and support

A client’s level of ability is likely to vary across the different domains and activities.

When to use the Guidance Framework

The Guidance Framework is not intended to be mandatory or an additional assessment tool. It is a reference or resource that an assessor can choose to use when populating the support plan and providing a recommendation to the delegate. Alternatively, some assessors may choose to use it as a reference or checklist to confirm their recommendation for a client’s Home Care Package level.

How to use the Guidance Framework

The pilot revealed that assessors may use the Guidance Framework in different ways – as a document to complete or as a visual guide.

The feedback from the pilot also indicated that the Guidance Framework is likely to be most useful for less experienced clinicians, as more experienced clinicians are already running through these kinds of considerations when performing an assessment.
**Completing the Guidance Framework**

You may wish to complete the Guidance Framework by circling each of the descriptors under each category that best describes the client’s individual needs and circumstances.

For example, if the client needs frequent assistance to perform ADL and IADL activities, the client is at significant risk of falls, can self-manage their pain and do not have any visual, hearing or speech impairments, then each of the corresponding descriptors would be circled as follows:

<table>
<thead>
<tr>
<th>PHYSICAL</th>
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<tbody>
<tr>
<td><strong>ADL</strong></td>
</tr>
<tr>
<td>4. Unable to perform without assistance</td>
</tr>
<tr>
<td>3. Needs frequent assistance</td>
</tr>
<tr>
<td>2. Needs some / intermittent assistance</td>
</tr>
<tr>
<td>1. Independent</td>
</tr>
<tr>
<td><strong>IADL</strong></td>
</tr>
<tr>
<td>4. Unable to perform without assistance</td>
</tr>
<tr>
<td>3. Needs frequent assistance</td>
</tr>
<tr>
<td>2. Needs some / intermittent assistance</td>
</tr>
<tr>
<td>1. Independent</td>
</tr>
<tr>
<td><strong>Falls Risk</strong></td>
</tr>
<tr>
<td>4. High risk of fall</td>
</tr>
<tr>
<td>3. Significant risk of fall</td>
</tr>
<tr>
<td>2. Moderate risk of fall</td>
</tr>
<tr>
<td>1. Low risk of fall</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
</tr>
<tr>
<td>4. Specialised management required</td>
</tr>
<tr>
<td>3. Regular management required</td>
</tr>
<tr>
<td>2. Episodic management required</td>
</tr>
<tr>
<td>1. Self managed / nil issue</td>
</tr>
<tr>
<td><strong>Sensory</strong></td>
</tr>
<tr>
<td>4. Frequent assistance required</td>
</tr>
<tr>
<td>3. Regular assistance required</td>
</tr>
<tr>
<td>2. Intermittent assistance required</td>
</tr>
<tr>
<td>1. Self managing / nil issues</td>
</tr>
</tbody>
</table>

**Visual guide**

Alternatively, you may wish to use the Guidance Framework as a visual guide/prompt only and work your way through each of the categories to think of which descriptor best describes the client’s current needs and circumstances.
Interpreting the Guidance Framework

The Guidance Framework should provide a sense of the client’s range of care needs and therefore the appropriate package level.

The point of reference for completing the framework is not derived from responses to specific questions but rather an overall clinical judgement taking into account all information collected in the assessment.

For example, if on balance the client’s results are mostly level 2s – this will likely indicate that the appropriate Home Care Package is also a level 2. However, there may be some factors, such as ADL or continence that could substantially impact on the package level required. So, for example, if a client scores mostly 2s but has 4 in one or both of these categories, the Home Care Package level required could be higher due to more frequent services required.

In the previous example, the client had mostly 3s in the physical domain with two 1s. If, looking holistically at the remainder of the Guidance Framework the client also had mostly 3s, then depending on your clinical judgement and assessment and the areas of need, it may be that the client is recommended for a Home Care Package level 3.

As another example, a client who is generally managing well (i.e. mostly level 1s) but has a few level 2s, may be recommended for a level 1 overall, depending on the types of areas where the client requires assistance.

About this User Guide

As the Guidance Framework does not replace clinical judgement, this document provides a general indication of how to use the Guidance Framework. The definitions and guidance information included is consistent with the NSAF User Guide.

The following tables provide an explanation and guide for each of the domains, categories and descriptors in the Guidance Framework.

Feedback on the Guidance Framework

The Guidance Framework has been developed for, and informed by the ACAT assessors. However, if you would like to provide further feedback and suggestions about the Guidance Framework, you can email ACATGuidanceFramework@health.gov.au

Further information

If you would like more information about the priority for home care service, or seek a copy of the ACAT Guidance Framework for Home Care Package Level please visit: https://agedcare.health.gov.au/programs-services/my-aged-care/information-for-assessors to review the guidance material.
# ACAT Guidance Framework for Home Care Package Level

This guide has been developed for Aged Care Assessment Teams to inform and support their decision making when recommending a specific Home Care Package level. For further information, please refer to the User Guide.

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<th>MEDICAL</th>
<th>PHYSICAL</th>
<th>PSYCHOLOGICAL</th>
<th>COMPLEXITY/VULNERABILITY</th>
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<td><strong>Informal Support Network/Careers</strong></td>
<td><strong>Medical Conditions</strong></td>
<td><strong>ADL</strong></td>
<td><strong>Cognition</strong></td>
<td><strong>Case Management</strong></td>
</tr>
<tr>
<td>4 Unsustainable caring arrangements</td>
<td>4 Complex medical management required</td>
<td>4 Unable to perform without assistance</td>
<td>4 Severe cognitive decline</td>
<td>4 Ongoing need for high level case management</td>
</tr>
<tr>
<td>3 Signs of carer stress</td>
<td>3 Regular medical management required</td>
<td>3 Needs frequent assistance</td>
<td>3 Moderate cognitive decline</td>
<td>3 Ongoing need for low level case management</td>
</tr>
<tr>
<td>2 Carer’s needs occasional support</td>
<td>2 Infrequent medical management required</td>
<td>2 Needs some / intermittent assistance</td>
<td>2 Mild cognitive decline</td>
<td>2 Intermittent need for case management</td>
</tr>
<tr>
<td>1 Carer’s coping well / nil carer issues</td>
<td>1 Medical self-management / nil issues</td>
<td>1 Independent</td>
<td>1 No impairment evident</td>
<td>1 No need for case management</td>
</tr>
<tr>
<td><strong>Community Access</strong></td>
<td><strong>Medication Management</strong></td>
<td><strong>IADL</strong></td>
<td><strong>Behavioural Management Issues</strong></td>
<td><strong>Elder Abuse</strong></td>
</tr>
<tr>
<td>4 Unable to access without full assistance</td>
<td>4 Complex medication management required</td>
<td>4 Unable to perform without assistance</td>
<td>4 Issues require frequent interventions</td>
<td>4 Confirmed abuse</td>
</tr>
<tr>
<td>3 Needs ongoing assistance to access</td>
<td>3 Regular medication management required</td>
<td>3 Needs frequent assistance</td>
<td>3 Issues require regular interventions</td>
<td>3 Significant risk of abuse</td>
</tr>
<tr>
<td>2 Needs occasional assistance to access</td>
<td>2 Infrequent medication management required</td>
<td>2 Needs some / intermittent assistance</td>
<td>2 Issues require intermittent interventions</td>
<td>2 Moderate risk of abuse</td>
</tr>
<tr>
<td>1 Independent access / nil issues</td>
<td>1 Medication self-management / nil issues</td>
<td>1 Independent</td>
<td>1 Issues well managed / nil issues</td>
<td>1 Low risk of abuse</td>
</tr>
<tr>
<td><strong>Social Isolation</strong></td>
<td><strong>Nutrition</strong></td>
<td><strong>Falls Risk</strong></td>
<td><strong>Drug And Alcohol</strong></td>
<td><strong>Mental Health</strong></td>
</tr>
<tr>
<td>4 Social isolation – no contacts</td>
<td>4 Unable – full assistance required</td>
<td>4 High risk of fall</td>
<td>4 Condition requires frequent interventions</td>
<td>4 Condition requires frequent interventions</td>
</tr>
<tr>
<td>3 Social isolation – minimal contacts</td>
<td>3 Needs frequent assistance / monitoring</td>
<td>3 Significant risk of fall</td>
<td>3 Condition requires regular interventions</td>
<td>3 Condition requires regular interventions</td>
</tr>
<tr>
<td>2 Connects to community with support</td>
<td>2 Needs some assistance / monitoring</td>
<td>2 Moderate risk of fall</td>
<td>2 Condition requires intermittent interventions</td>
<td>2 Condition requires intermittent interventions</td>
</tr>
<tr>
<td>1 Connects to community independently / nil issues</td>
<td>1 Not applicable / nil issues</td>
<td>1 Low risk of fall</td>
<td>1 Issues well managed / nil issues</td>
<td>1 Condition well managed / nil conditions</td>
</tr>
<tr>
<td><strong>Financial Support</strong></td>
<td><strong>Skin Integrity</strong></td>
<td><strong>Pain</strong></td>
<td><strong>Sensory</strong></td>
<td><strong>Accommodation</strong></td>
</tr>
<tr>
<td>4 Unable to self-manage</td>
<td>4 Frequent monitoring / treatment required</td>
<td>4 Specialised management required</td>
<td>4 Frequent assistance required</td>
<td>4 Transient</td>
</tr>
<tr>
<td>3 Needs frequent support to manage</td>
<td>3 Regular monitoring / treatment required</td>
<td>3 Regular management required</td>
<td>3 Regular assistance required</td>
<td>3 Insure housing/unable to maintain</td>
</tr>
<tr>
<td>2 Needs some / intermittent support to manage</td>
<td>2 Intermittent monitoring / treatment required</td>
<td>2 Episodic management required</td>
<td>2 Intermittent assistance required</td>
<td>2 Secure housing with support</td>
</tr>
<tr>
<td>1 Manages own finances / nil issues</td>
<td>1 Self-managed / not applicable / nil issues</td>
<td>1 Self-managed / nil issues</td>
<td>1 Secure housing</td>
<td>1 Secure housing</td>
</tr>
</tbody>
</table>
### SOCIAL DOMAIN

- A gauge of social isolation/loneliness and a typical measure of perceived support from family, friends and neighbours.

- **Recommended considerations are:**
  - Existing social support networks and key relationships
  - Current levels of support
  - Feelings of loneliness
  - Family issues (composition, history, dynamics, coping patterns, interactions)
  - Care support arrangements (level of support, nature of support, coping capacity, support for the carer, role of significant others)
  - Existing service providers (health, welfare, volunteer)
  - Social, cultural, religious affiliations
  - Transport access
  - Financial status
  - Levels of social interactions and isolation, and
  - Companion animals.

<table>
<thead>
<tr>
<th>Guidance Framework categories and descriptors</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| **Informal support network / carers** | • This category refers to carer relationships and informal support networks such as family, friends, neighbours and/or significant others who may be involved in some level of caring.  
  • The assessment could be based on information from the client, carer and/or the assessor’s clinical judgement.  
  • This category and the descriptors relate to:  
    - The level of support the carer provides to the client  
    - The sustainability of the caring relationship, and  
    - Whether the carer requires any support. |
| 4 Unsustainable caring arrangements | 3 Signs of carer stress  
  2 Carer/s needs occasional support  
  1 Carer/s coping well / nil carer issues |  |
| **Community access** | • Community access is based on the assessment of the:  
  - Client’s opportunity for involvement in social and community activities  
  - Client’s interests, strengths and abilities, and  
  - If there are supports in place for the client to access the community (if required).  
  • The descriptors relate to the amount of assistance the client requires for community access.  
  • A person’s mobility may contribute to their capacity to undertake community access.  
  • Assistance may mean a carer/other person accompanying the client to social and community activities. |
| 4 Unable to access without full assistance | 3 Needs ongoing assistance to access  
  2 Needs occasional assistance to access  
  1 Independent access / nil issues |  |
| **Social isolation** | • Social isolation is defined as “a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling and quality relationships”.  
  • Indicators of social isolation may include:  
    - Living arrangements e.g. living alone  
    - Support from family, friends, neighbours etc.  
    - Social contact e.g. through church groups, sporting, or social clubs, and/or  
    - Geographic isolation and associated difficulties with effective service provision.  
  • The descriptors relate to the degree of connectedness the client has with others. |
| 4 Social isolation – no contacts | 3 Social isolation – minimal contacts  
  2 Connects to community with support  
  1 Connects to community independently / nil issues |  |
| **Financial support** | • Financial support relates to where a client may be experiencing financial disadvantage or other barriers (mobility, vision, cognition etc.) that threaten their access to essential services, which in turn may threaten their ability to remain safely at home.  
  • For example, a person may have high medical expenses, accommodation costs or are living beyond their existing means which can result in insufficient available resources to pay for essentials such as:  
    - Healthy food  
    - Appropriate housing  
    - Utilities and services, and/or  
    - Medical and dental costs. |
| 4 Unable to self-manage | 3 Needs frequent support to manage  
  2 Needs some / intermittent support to manage  
  1 Manages own finances / nil issues |  |
### MEDICAL DOMAIN
Addresses overall health and wellbeing including health and mental health conditions, disability, nutrition, and oral health.

<table>
<thead>
<tr>
<th>Guidance Framework categories and descriptors</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| **Medical conditions** | • Medical conditions could include:  
  o Health conditions  
  o Mental health conditions, and/or  
  o Disability.  
  • The descriptors relate to the management of the medical condition/s, and level of assistance required which may include:  
    o Practical assistance from carer or friend  
    o Practical assistance from a doctor or specialist, and/or  
    o Attendance at a community/hospital clinic e.g. for continence, diabetes, falls.  
  • The descriptors relate to the amount of medical management the client requires for their medical conditions. |
| 4 Complex medical management required |  
  3 Regular medical management required |  
  2 Infrequent medical management required |  
  1 Medical self-management / nil issues |  
| **Medication management** | • Medication management refers to whether the client can take their own medication and level of assistance required. This could be affected as a result from either cognitive or physical reasons.  
  • This could include, for example where the client has visual impairment and is unable to read labels correctly, arthritic hands causing difficulty in opening medication containers, and/or memory difficulties or confusion.  
  • Factors to consider are whether the client:  
    o Is able to take the right doses of medication at the right time  
    o Needs some assistance, for example if someone prepares their medication or prompts with a reminder, or  
    o Is completely unable to organise, dispense or take their own medication and/or has compliance issues with their medication regime.  
  • The descriptors relate to the amount of management the client requires to manage their medications. |
| 4 Complex medication management required |  
  3 Regular medication management required |  
  2 Infrequent medication management required |  
  1 Medication self-management / nil issue |  
| **Nutrition** | • Nutrition refers to a client’s appetite and whether they have been eating poorly as a result. It may also relate to their intake of fluid (e.g. whether the client drinks more than 8 cups of fluid a day).  
  • Assistance with nutrition could include assistance with:  
    o Dietary intake  
    o Shopping, preparing food, cooking and/or feeding, and/or  
    o Teeth, mouth or swallowing problems.  
  • The descriptors relate to the amount of assistance the client requires to maintain adequate nutrition. |
| 4 Unable – full assistance required |  
  3 Needs frequent assistance / monitoring |  
  2 Needs some assistance / monitoring |  
  1 Not applicable / nil issue |  
| **Skin integrity** | • Skin integrity refers to the ability of the skin to protect the client from the external environment. Skin issues may include:  
  o Pressure or other skin ulcers  
  o Healing surgical wounds  
  o Skin tears, cuts or lesions, and/or  
  o Other skin problems such as rashes, itching, bruises and eczema.  
  • The descriptors relate to the amount of monitoring/treatment the client requires for any skin issues. This could include applying creams to prevent dry skin, wound management and the frequency of the treatment. |
| 4 Frequent monitoring / treatment required |  
  3 Regular monitoring / treatment required |  
  2 Intermittent monitoring / treatment required |  
  1 Self-managed / not applicable / nil issue |  
| **Continence** | • Continence includes any bladder or bowel issues that affect the client’s lifestyle. Assistance may be a result of both cognitive or physical reasons and may include assistance with:  
  o Hygiene following an incontinence episode  
  o Continence aids  
  o Catheter, colostomy or other  
  • The descriptors relate to the amount of assistance the client requires for any continence issues. The language used is broadly consistent with the related question in the NSAF. |
| 4 Frequent assistance required |  
  3 Regular assistance required |  
  2 Intermittent assistance required |  
  1 Self managing / not applicable / nil issues |  

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PHYSICAL DOMAIN
A key determinant of independence in activities of daily living and a contributing factor to overall health status and quality of life. It includes mobility, i.e. the ability to stand, sit, walk, turn, transfer and climb.

<table>
<thead>
<tr>
<th>Guidance Framework categories and descriptors</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| **ADL**                                       | • ADL includes activities such as:  
  4 Unable to perform without assistance  
  3 Needs frequent assistance  
  2 Needs some / intermittent assistance  
  1 Independent  
  ○ Toileting  
  ○ Dressing  
  ○ Bathing  
  ○ Eating, and/or  
  ○ Ability to transfer and mobilise with/without an aid.  
  • The descriptors relate to the amount of assistance the client requires for any ADL activities. The language used is broadly consistent with the OARS ADL and Barthel Index descriptions. |
| **IADL**                                      | • IADL includes instrumental activities of daily living such as:  
  4 Unable to perform without assistance  
  3 Needs frequent assistance  
  2 Needs some / intermittent assistance  
  1 Independent  
  ○ Shopping  
  ○ Preparing meals  
  ○ Travel in the community  
  ○ Housework, and  
  ○ Managing finances.  
  • This category relates to a person’s ability to perform a task rather than, for example their choice/decision not to do the activity.  
  • The descriptors relate to the amount of assistance the client requires for any IADL activities. The language used is broadly consistent with the OARS ADL descriptions. |
| **Falls risk**                                | • Falls includes slips and drops.  
  4 High risk of fall  
  3 Significant risk of fall  
  2 Moderate risk of fall  
  1 Low risk of fall  
  • Environmental, behavioural and health factors may contribute to a falls risk. This includes, for example:  
  ○ Poor lighting  
  ○ Irregular walking surfaces or inappropriate footwear  
  ○ Lack of safety equipment e.g. grab rails  
  ○ Medication side effects  
  ○ Poor balance/strength  
  ○ Vision impairment  
  ○ Hypotension.  
  • The descriptors relate to the degree of the client’s risk of falling. |
| **Pain**                                      | • Pain may impact the ability for a client to carry out everyday tasks and also impact their physical/psychological wellbeing.  
  4 Specialised management required  
  3 Regular management required  
  2 Episodic management required  
  1 Self-managed / nil issue  
  • Pain management strategies could include:  
  ○ Medication  
  ○ Attendance at a pain clinic  
  ○ Massage  
  ○ Heat/cold packs  
  ○ Changing position on a regular basis, and/or  
  ○ Sleeping upright in a chair.  
  • The descriptors relate to the degree of any pain management assistance required. |
| **Sensory**                                   | • Consistent with the NSAF, sensory refers particularly to issues with:  
  4 Frequent assistance required  
  3 Regular assistance required  
  2 Intermittent assistance required  
  1 Self managing / nil issues  
  ○ Vision  
  ○ Hearing, and  
  ○ Speech.  
  • The descriptors relate to the amount of assistance the client requires for any of these sensory impairments. |
**PSYCHOLOGICAL DOMAIN**

- This domain includes:
  - Cognitive impairment
  - Capacity for decision-making
  - Depression
  - Dementia
  - Behaviour
  - Delirium, and
  - Judgement and insight.

<table>
<thead>
<tr>
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<th>Explanation</th>
</tr>
</thead>
</table>
| **Cognition**                                 | • Cognition is very different to mental health. It refers to the ability to learn new things and remember.  
• Cognition is the basis for how we reason, judge, concentrate, plan, problem solve and organise.  
• Cognitive decline may impact on the client’s ability to undertake everyday activities.  
• The descriptors used reflect the degree of mental decline (if any). |
| 4 Severe cognitive decline                     | 1 No impairment evident |
| 3 Moderate cognitive decline                   | 2 Mild cognitive decline |
| 2 Issues require frequent interventions        | 1 Issues well managed / nil issue |
| 3 Issues require regular interventions         | |
| 2 Issues require intermittent interventions    | |
| 1 Issues well managed / nil issue              | |

**Behavioural management issues**

- Behavioural issues may include behaviour that is:
  - Aggressive verbally, such as yelling, making threats etc.
  - Aggressive physically, such as hitting, biting, scratching, throwing things, using weapons etc.
  - Resitive, such as opposing or withstanding help or tasks such as eating, taking medication etc.
- The descriptors relate to the amount of intervention required for any behavioural issues.
**COMPLEXITY/VULNERABILITY DOMAIN**

This domain refers to measurable characteristics of a client’s circumstances that may relate to service provision and the urgency of any interventions. Complexity and vulnerability includes factors such as homelessness, risk of abuse, emotional/mental health issues, difficulty communicating, and/or certain demographic indicators e.g. veterans, Aboriginals, Torres Strait Islanders, living in rural/remote areas etc.

<table>
<thead>
<tr>
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</table>
| **Case management**                           | • Case management is where a client requires ongoing support and coordination for multiple care needs that impact their ability to remain living in the community.  
• The descriptors relate to the degree of the client’s need for case management and associated complexity.  
• Case management can be provided by family/carer or service provider. |
| 4 Ongoing need for high level case management  |             |
| 3 Ongoing need for low level case management  |             |
| 2 Intermittent need for case management        |             |
| 1 No need for case management                  |             |
| **Elder abuse**                               | • Elder abuse is defined as “any pattern of behaviour or action resulting in financial, psychological, physical, sexual or social harm to an older person”. The abuse behaviours may be intentional or unintentional and include neglect.  
• Key risk factors for abuse include:  
  o Carer stress  
  o Difficulties accepting care due to health status  
  o Family violence or conflict  
  o Isolation  
  o Dependency, and/or  
  o Psychological problems and/or addictive behaviours in the abuser.  
• The descriptors relate to the degree of the client’s risk of abuse. |
| 4 Confirmed abuse                              |             |
| 3 Significant risk of abuse                   |             |
| 2 Moderate risk of abuse                      |             |
| 1 Low risk of abuse                           |             |
| **Drug and alcohol**                          | • The issues resulting from the use of drugs or alcohol may result from, and cause psychological, physical and/or medical impacts. The person may be also exposed to risks due to their substance abuse.  
• The person may also refuse assistance or services when they are clearly required to maintain safety and wellbeing of the client.  
• The descriptors relate to the frequency of any interventions required. |
| 4 Issues require frequent interventions        |             |
| 3 Issues require regular interventions        |             |
| 2 Issues require intermittent interventions   |             |
| 1 Issues well managed / nil issue             |             |
| **Mental health**                             | • Mental health is recognised as complex in the elderly due to factors such as:  
  o Previous psychiatric history  
  o Isolation  
  o Medical interactions, and  
  o Decline in cognitive state due to dementia.  
• Emotional or mental health issues may limit the ability for the client to self-care.  
• The client may require intensive supervision and/or frequent changes to support.  
• The descriptors relate to the frequency of any interventions required. |
| 4 Condition requires frequent interventions    |             |
| 3 Condition requires regular interventions    |             |
| 2 Condition requires intermittent interventions |         |
| 1 Condition well managed / nil condition      |             |
| **Accommodation**                             | • Accommodation relates to the client’s living arrangements and whether these are compromising, or placing at risk, the client’s health, wellbeing and ability to remain living in the community.  
• Factors to consider may include whether the client is:  
  o Homeless  
  o Living in squalor  
  o Behind in rental payments or tenancy is at risk  
  o Living in accommodation without secure tenure e.g. hostel, boarding house  
  o Informal supports are breaking down, and/or  
  o Living arrangements are placing them at risk.  
• The descriptors relate to the client’s degree of housing security. |
| 4 Transient                                   |             |
| 3 Insecure housing/unable to maintain         |             |
| 2 Secure housing with support                |             |
| 1 Secure housing                              |             |