Classification Principles 1997

as amended

made under subsection 96-1 of the

Aged Care Act 1997

This compilation was prepared on 1 July 2001
taking into account amendments up to *Classification Amendment Principles 2001 (No. 1)*

Prepared by the Office of Legislative Drafting,
Attorney-General's Department, Canberra

Classification Principles 1997

made under subsection 96-1 (1) of the

Aged Care Act 1997

Contents

Note: Part 2.4 of the *Aged Care Act 1997*

Part 2.4 of the *Aged Care Act 1997* is about the classification of care recipients.

Care recipients who are approved under Part 2.3 of the Act for residential care, or some kinds of flexible care, are classified according to the level of care they need.

A care recipient's classification affects the amount of residential care, or flexible care, subsidy payable to an approved provider for providing care to the care recipient.

The Classification Principles deal with a number of aspects of the classification of care recipients.

Part 1 Preliminary

9.1 Citation [*see* Note 1]

These Principles may be cited as the *Classification Principles 1997*.

9.2 Commencement

These Principles commence on 1 October 1997.

9.3 Definitions

In these Principles:

Act means the *Aged Care Act 1997*.

hostel care resident means a person who:

(a) is an eligible person under section 2 of the *Aged or Disabled Persons Care Act 1954*; and

(b) is not eligible for a personal care subsidy under subsection 5 (3) of the General Conditions formulated under section 10F of the *Aged or Disabled Persons Care Act 1954* and in force immediately before the commencement of the Aged or Disabled Persons Care (General Conditions) Determination 1997.

low level of care means care given to a care recipient who is appraised as being included in classification level 5, 6, 7 or 8.

Note: Definitions in Act

A number of expressions used in these principles are defined in the *Aged Care Act 1997* (see Dictionary in Schedule 1), including:

- aged care
- approved provider
- care
- classification level
- extended hospital leave
- flexible care service
- residential care
- residential care service
- respite care
- Secretary.

Part 2 Exclusion of care recipients

Division 1 General

9.4 Purpose of Part (Act, s 25-1)

This Part sets out the classes of care recipients that are excluded from classification under Part 2.4 of the Act, and the periods for which a care recipient in a class is excluded.

Division 4 Care recipients of multi-purpose services

9.9 Exclusion of recipients of multi-purpose services

Care recipients who receive flexible care, provided through a flexible care service that is a multi-purpose service under the *Flexible Care Subsidy Principles 1997*, are excluded from classification for an indefinite period.

Part 4 Appraisal procedures

9.16 Purpose of Part (Act, s 25-3)

This Part specifies procedures for making an appraisal of the level of care needed by a care recipient (other than a care recipient who is being provided with care as respite care), relative to the needs of other care recipients.

9.17 Appraisal procedures

(1) The steps in Table 3 must be taken, by the person appraising a care recipient (the ***appraiser***) and by the Secretary, to work out an aggregate figure, and a classification level, for the care recipient.

(2) The appraiser must take the steps in Table 3 for a care recipient from the first day when the care recipient enters the residential care service.

(3) However, for Questions 9 to 16 in Part 1 of Schedule 1, the appraiser should not include care needs of the care recipient for the period of 7 days starting on the first day when the care recipient enters the residential care service.

(4) Subsection (3) does not apply if section 9.23 applies to allow an appraisal to be made over a shorter period.

Table 3

Step 1	For each question in Part 1 of Schedule 1, the appraiser must consider the extent to which the care recipient needs care, assistance or support.
Step 2	For each question, the appraiser must note, on the appraisal form, the level of care, assistance or support mentioned in the Part (ie A, B, C or D) is needed by the care recipient. The appraiser must use the comments for each question to decide the most appropriate choice.
Step 3	For the response to each question, the Secretary must identify the score for the response. The scores are mentioned in Part 2 of Schedule 1.
Step 4	The Secretary must add up the scores to work out an aggregate figure for the care recipient.
Step 5	The Secretary must use Schedule 2 to identify the aggregate figure range for the aggregate figure worked out under Step 4.
Step 6	The Secretary must use Schedule 2 to identify the classification level for the aggregate figure range identified under Step 5. The classification

level identified by the Secretary is the classification level for the care recipient.

Part 5 How care recipients are classified

Division 1 Classification levels for non-respite care

9.18 Purpose of Division (Act, s 25-2)

This Division sets out classification levels for care recipients being provided with residential care or flexible care, other than care recipients who are being provided with residential care as respite care.

9.19 Classification levels — care that is not provided as respite care

(1) The classification levels are mentioned in column 3 of Schedule 2.

(2) If a person is approved as a recipient of a low level of care under section 5.9 of the *Approval of Care Recipient Principles 1997*, the Secretary must classify the care recipient in classification level 5, 6, 7 or 8.

(3) If a care recipient is a hostel care resident who, immediately before 1 November 1998, was not classified under Division 2 of Part 3, as in force before that day, the care recipient is taken to have a rating of A for each question in Part 1 of Schedule 1.

Division 2 Classification levels for respite care

9.20 Purpose of Division (Act, s 25-2)

This Division sets out how to classify care recipients provided with residential care as respite care.

9.21 Classification levels — residential care provided as respite care

If a care recipient receives residential care that is provided as respite care, the Secretary must classify the care recipient in accordance with:

(a) the level of care approved for the care recipient under section 22-2 of the Act; and

(b) section 5.9 of the *Approval of Care Recipients Principles 1997*.

Part 6 Appraisal periods

9.22 Purpose of Part (Act, s 25-3)

This Part sets out a circumstance in which an appraisal of the level of care needed by a care recipient may be made over a shorter period, and the shorter period applying to the circumstance.

9.23 Circumstance and shorter period

(1) If a care recipient leaves a residential care service while an appraisal is being made, the appraisal may be made over the number of days when the care recipient was provided with care in the residential care service.

(2) However, if the care recipient was provided with care by an organisation approved under section 15.8 of the *Flexible Care Subsidy Principles 1997*, the appraisal may be made:

(a) if the care recipient was provided with care for a continuous period of 10 days — over the period of 10 days; or

(b) if the care recipient leaves the organisation before receiving care for a continuous period of 10 days — over the period that the care recipient was provided with care by the organisation.

Part 6A When classifications take effect

9.23A Purpose of Part (Act, s 26-1)

This Part specifies the period within which the Secretary must receive an appraisal of the classification of a care recipient who enters care between 1 October 1997 and 31 December 1997 in order to determine when the classification takes effect.

9.23B Appraisals received within the appropriate period

(1) This section only applies if the day on which provision of care to a care recipient began between 1 October 1997 and 31 December 1997.

(2) A classification of a care recipient (other than a classification in relation to care provided as respite care) is taken to have had effect from the day on which provision of the level of care specified in an appraisal to the care recipient began, if the appraisal is received by the Secretary within 3 months after the day on which provision of the care to the care recipient began.

Part 7 When respite care classifications take effect

9.24 Purpose of Part (Act, s 26-3)

This Part specifies the day when a classification of a care recipient in relation to care provided as respite care takes effect.

9.25 Day of effect

The classification takes effect on the first day of entry to respite care.

Part 8 When classifications cease to have effect

Division 1 Expiry date for classification of care recipient — care provided as respite care

9.26 Purpose of this Division (Act, s 27-1)

This Division specifies the expiry date for a classification for care provided to a care recipient as respite care.

9.27 Expiry date

(1) The expiry date is the first day after the earlier of the following days:

(a) the last day of the period or periods for which respite care is approved for the financial year;

(b) the day when the approval lapses.

(2) The approval lapses 1 year after the day when the classification took effect.

Division 2 Expiry date for revised classification — significant change

9.28 Purpose of this Division (Act, s 27-1)

This Division specifies the expiry date for a revised classification that is worked out because a care recipient's circumstances have changed significantly.

9.29 Expiry date

The expiry date is the day 6 months after the day when the classification took effect.

Division 3 Expiry date for classification of care recipient — extended hospital leave

9.29A Purpose of this Division (Act, s 27-1)

This Division specifies the expiry date for a classification of a care recipient who takes extended hospital leave.

9.29B Expiry date for a classification of a care recipient — extended hospital leave

If a care recipient takes extended hospital leave that ends after what would, apart from this section, have been the expiry date under section 27-1 of the Act, the expiry date for the classification of the care recipient is the day on which that leave ended.

Part 9 How classifications are renewed

Division 1 Basis for reappraisal

9.30 Purpose of Division (Act, s 28-1)

This Division provides for reappraisal of a care recipient under Division 28 of the Act.

9.31 Records to be used in reappraisal

A reappraisal may be made using existing records about the care recipient's needs for care, assistance and support for the matters mentioned in Part 1 of Schedule 1.

Division 2 Significant change in care needs

9.32 Purpose of Division (Act, s 28-2)

This Division specifies the circumstances in which the care needs of a care recipient are taken to have changed significantly, and the steps that the approved provider must take if this happens.

9.33 Circumstances in which care needs are taken to have changed significantly

The care needs of a care recipient are taken to have changed significantly if the care recipient experiences a catastrophic event likely to change the level of care needed by the care recipient by 2 or more classification levels.

Division 3 Reappraisal period — lowest classification level

9.34 Purpose of Division (Act, s 28-3)

This Division deals with the reappraisal of care recipients to whom the lowest classification level applies.

9.35 Care recipients classified at lowest classification level

A reappraisal of a care recipient having the lowest classification level may be made by the care recipient's approved provider during any period after the care recipient's approval.

Division 4 Reappraisal period — expiry date of classification occurs in certain circumstances

9.36 Purpose of this Division (Act, s 28-3)

This Division specifies the reappraisal period for a care recipient where the expiry date for classification of the care recipient occurs in certain circumstances.

9.37 Reappraisal period for classification if expiry date occurs in certain circumstances

(1) The reappraisal period mentioned in subsection (2) applies where the expiry date of a classification of a care recipient occurs:

(a) while the care recipient is on leave from a residential care service; or

(b) within 1 month after the residential care service recommenced providing residential care to the care recipient after that leave ended.

(2) The reappraisal period is the period of 2 months beginning on the day on which the provision of residential care to the care recipient through the residential care service recommenced.

Schedule 1 Appraisal procedures

(section 9.17)

Part 1 Matters to consider in appraising a care recipient

Guidelines for the interpretation of resident classification scale questions

The resident classification scale is a relative resource allocation instrument

The resident classification scale consists of 20 questions, each having 4 ratings. The allocation of the 20 ratings, based on the assessed care needs of each care recipient, results in a score which places them on a nationally consistent scale, relative to all other people living in residential aged care facilities throughout Australia.

The elements in the resident classification scale have been selected as those elements of care that best discriminate between relative care needs. Therefore, the resident classification scale provides a ranking, ranging from people with the highest care needs to those with the lowest care needs.

Using the Questions

Although the description for recording **A** for most questions is summarised as 'No assistance' or 'Not applicable', this does not, in general, mean that no care is given. It may mean that 'minimal care' is given. The weightings have been zero rated for statistical reasons since the scale is designed to measure relative care need.

The requirements of the **B**, **C** and **D** ratings are minimums for attaining that level. Where a care recipient's care needs are above the minimum for that rating, that will remain the applicable rating if they do not meet the criteria of the higher rating.

Where questions list examples, they are listed as an indicative guide and are not exhaustive.

The scale has been developed, and the weights calculated, to reflect supervision, observation, support, prompting and encouragement in the provision of care as well as physical assistance. It incorporates the need for continuing assessment and the monitoring and review of care plans.

The resident classification scale is completed against a clearly defined and documented plan of care which has been based upon an assessment of the care needs of the care recipient. The care needs will have been documented and the care plan will state what services are to be provided to meet these care needs.

Volunteers/purchased services

The resident classification scale takes into account care provided by volunteers or purchased at market rates by the facility for provision to care recipients. If the care

recipient meets the cost of any service then the facility cannot claim for that service. Similarly, where services are provided by a government-funded service (either State or Federal) at a subsidised rate, or for free, they cannot be claimed for through the resident classification scale.

Q1 Communication

This question refers to the degree of assistance that the care recipient needs in communicating with staff, relatives and friends, and other care recipients, for whatever reason. It measures the additional effort taken by staff to facilitate effective communication where care recipients have:

- hearing loss not remedied by aids (or where there is resistance to the use of an aid);
- visual impairment not remedied by spectacles or contact lenses;
- speech impairments;
- language difficulties (for example, care recipients with little or no English proficiency who do not live in their ethno-specific environment);
- comprehension problems which contribute to communication difficulties.

It also takes into account the effort involved in cleaning and fitting hearing aids, spectacles and lenses.

If the care recipient has no difficulty with communication, record **A**.

If the care recipient requires assistance with cleaning and fitting of aids, record **B**.

If facility staff are required to spend additional time listening, speaking slowly and clearly, encouraging the care recipient to communicate or occasionally use non-verbal cues, record **C**.

If the care recipient requires assistance from facility staff on almost all occasions to communicate by translating or interpreting, or non-verbally — for example, signing, or using communication aids including talking boards or computers, record **D**.

Ratings		**Q1 Communication**
No difficulty	**A**	Requires no assistance.
Some difficulty	**B**	Requires assistance with cleaning and fitting of aids.
Major difficulty	**C**	Requires additional time listening, speaking slowly and clearly, encouraging communication or occasionally using non-verbal cues.

Ratings		Q1 Communication
Extensive difficulty	**D**	Requires assistance to communicate by translating or interpreting; **OR** Requires communication by non-verbal means on almost all occasions.

Independence — self-care

This section relates to independence in the activities of daily living.

Q2 Mobility

This question refers to the degree of assistance required by a care recipient with regard to mobility. This includes:

- assistance with walking on a one-to-one basis, including the provision of supervision, encouragement or physical support;
- assistance in the use of mobility aids, including wheel chairs and walking frames;
- assistance with moving to and from chairs, wheelchairs, beds or toilets.

Moving care recipients to and from beds and chairs etc is covered in this question.

Extensive manual handling for maintenance of skin integrity, eg frequent changing of the position of a chairfast or bedfast care recipient, is covered in Question 18.

If the care recipient usually changes location independently, record **A**.

If the care recipient requires assistance from staff for transfers or if the care recipient needs to be accompanied or supervised when walking, record **B**. Supervision includes escorting and directing for purposeful mobility.

If the care recipient is unable to walk, or the care recipient self wheels or is wheeled by staff, and has no other assistance that would merit a **D** rating, record **B**.

If the care recipient requires assistance from staff for transfers and also needs to be accompanied or supervised when walking, record **C**. If the care recipient does not need to be accompanied or supervised when walking except over wet patches on, say, a bathroom floor, this would be insufficient to satisfy the requirements for a **C** rating.

If the care recipient requires considerable assistance or encouragement from staff in order to maintain mobility, record **D**.

If the care recipient requires staff to use lifting equipment, including lifting straps, to assist with location change or, where the use of lifting equipment is not feasible, more than 2 staff would be required for transfer, record **D**.

Ratings		Q2 Mobility
No assistance	**A**	Usually independent.
Some assistance	**B**	Requires assistance from staff for transfers; **OR** Needs to be accompanied or supervised when walking.
Major assistance	**C**	Requires assistance from staff for transfers; **AND** Needs to be accompanied or supervised when walking.
Extensive assistance	**D**	Requires major assistance (as above) and encouragement from staff in order to maintain mobility; **OR** Requires lifting equipment for transfers.

Q3 Meals and drinks

This question refers to the degree of assistance that the care recipient requires with eating and drinking.

If the care recipient eats and drinks independently, only requiring observation, record **A**.

The clinical nursing aspects of tube feeding are covered in Question 18.

In this question:

limited individual assistance means setting up to enable the care recipient to manage independently. This may include some prompting but no other assistance.

individual assistance means prompting and assisting with eating for some elements of the meal, for example, starting or finishing off the meal.

one-to-one individual assistance means one-to-one individual assistance with eating and drinking. This means full assistance with eating or encouraging the care recipient to maintain independent function.

Ratings		Q3 Meals and drinks
No assistance or not applicable	**A**	Eats and drinks independently, observation only.
Some assistance	**B**	Requires limited individual assistance.
Major assistance	**C**	Requires individual assistance with eating or drinking.

Ratings		Q3 Meals and drinks
Extensive assistance	**D**	Requires one-to-one individual assistance with all meal time activities.

Q4 Personal hygiene

This question refers to the degree of assistance that the care recipient requires with showering and washing, dressing and undressing, and personal hygiene, including all grooming activities and the routine application of moisturisers for dry skin.

If the care recipient attends to his/her personal hygiene independently, record **A**.

If the care recipient has difficulty with these activities and requires staff to spend time to enable him/her to shower and wash, dress and undress and complete his/her grooming, record **B**, **C** or **D** depending on the degree of assistance given.

In this question, where staff are required to encourage or persuade the care recipient on a one-to-one basis to optimise self care function, record **D**. This includes where a care recipient requires extensive support to enable him/her to be able to see to his/her own personal hygiene requirements.

If 2 staff are required to carry out most activities, record **D**.

In this question:

requires assistance with some activities means that the care recipient is able to shower or wash self under supervision, or to complete some activities without assistance but requires limited help with others — for example, fastening buttons, cleaning teeth, putting on shoes.

requires staff to carry out most activities means that the care recipient can only complete limited aspects of personal hygiene — for example washing of face or hands, or combing of hair, and staff complete the rest of the tasks associated with personal hygiene.

optimise self care means that the care recipient is as independent as is practicable in seeing to his/her own personal hygiene requirements.

Ratings		Q4 Personal hygiene
No assistance	**A**	Attends to personal hygiene independently.
Some assistance	**B**	Requires assistance with some activities.
Major assistance	**C**	Requires 1 staff to carry out all activities.
Extensive support	**D**	Requires staff to encourage or persuade the care recipient on a one-to-one basis to optimise self care function; **OR** Requires 2 staff to carry out most activities.

Q5 Toileting

This question refers to the degree of assistance that the care recipient requires to use a toilet. This includes any kind of toilet such as a commode, urinal, bedpan or a continence sheet (kylie or bluey) used for a planned episode of evacuation of the bowel or bladder.

This question covers the interventions required to assist the care recipient:

- to use the toilet;
- to attend to personal hygiene related to the toileting function;
- to adjust clothing.

If the care recipient attends to toileting independently or if the care recipient cannot use any kind of toilet, record **A**.

Note that the care of catheters and colostomies are covered in Question 18. However, toileting aspects associated with a care recipient who has a catheter or a stoma bag, for example emptying drainage bags, personal hygiene and adjusting of clothing, are covered in this question.

For a care recipient with a catheter or a colostomy, emptying a drainage bag and the associated adjustment of clothing and attending to personal hygiene, record **B**.

When assessing ability to use the toilet, do not include location change that is assessed in Question 2.

In this question:

setting up means preparing the care recipient who then uses the toilet and attends to personal hygiene. It may require positioning the care recipient on the toilet.

some assistance means minor adjustment of clothing.

major assistance means that staff spend time and effort in encouraging and persuading the care recipient to be independent as far as he/she is able, rather than the staff undertaking the activities.

extensive assistance means that staff are required to carry out all activities related to the toileting process.

Ratings		Q5 Toileting
No assistance or not applicable	**A**	Attends to toileting independently or cannot use any kind of toilet.
Some assistance	**B**	Requires setting up and some assistance.
Major assistance	**C**	Requires staff to encourage and persuade care recipient to optimise self-care function.
Extensive assistance	**D**	Requires staff to carry out all activities.

Q6 Bladder management

This question relates to continence of urine and maintenance of continence of urine and the reduction of incontinence.

If the care recipient maintains continence independently and needs no program to remain continent, record **A**.

If the care recipient is able to remain continent of urine or have incontinence reduced, only because of the care provided by the staff, record **B**, **C** or **D**.

If the care recipient would be **occasionally** incontinent and his/her continence is supported by prompting only, or by using continence aids, record **B**.

If the care recipient is **frequently** incontinent and this cannot be improved by a continence program and continence aids such as pads, or urinary drainage systems are used at all times and are the only procedures used, record **C**.

If the care recipient is **frequently** incontinent and this cannot be improved by a continence program and, for behavioural or other reasons, he/she cannot use continence aids, record **C**.

If the care recipient would be **frequently** incontinent, but his/her continence level is optimised through an individualised continence program, record **D**.

A continence program is based on an individualised assessment of the continence state, with planning, implementation and evaluation guidelines. A program means more interventions than pads only, or prompting only — for example, maintaining adequate fluid intake, bladder retraining, habit training or scheduled toileting, and be drawn from information in the care recipient's continence assessment.

In this question:

prompting means reminding a care recipient to go to the toilet.

bladder retraining means progressive lengthening or shortening of toileting intervals.

habit training means using a flexible toileting schedule based on care recipient's pattern of incontinence. Reinforcement techniques may be used.

scheduled toileting means toileting to a fixed schedule while care recipient is awake.

occasionally incontinent means once a day or less.

frequently incontinent means twice or more a day.

Ratings		Q6 Bladder management
Not applicable	**A**	Continent of urine.
Some support	**B**	Would be occasionally incontinent but continence supported by prompting only; **OR** Wears external continence aids occasionally.

Ratings		Q6 Bladder management
Major support	**C**	Wears continence aids at all times related to frequent incontinence that cannot be improved by a continence program; **OR** Incontinent but, for behavioural or other reasons, cannot use continence aids.
Extensive support	**D**	Would be frequently incontinent but has an individualised continence program in place to optimise continence level.

Q7 Bowel management

This question relates to continence of faeces and maintenance of continence of faeces and the reduction of incontinence.

Stoma care (including colostomy care) is covered in Question 18. Routine emptying of colostomy drainage bags, personal hygiene and adjustment of clothing are covered in Question 5.

If the care recipient maintains continence of faeces independently and needs no program to remain continent, record **A**.

If the care recipient is able to remain continent of faeces, or to have incontinence reduced only because of the care provided by the staff, record **B**, **C** or **D**.

If appropriate appliances such as pads are the only procedure used, record **B**.

If the care recipient is on a **bowel management program** for the prevention of constipation, record **C**. A bowel management program includes monitoring and recording bowel activity, and may include any of the following:

- maintaining adequate fluid intake;
- laxatives and aperients;
- stool softeners or fibre supplements;
- high fibre diet;
- suppositories or enemas;
- exercise or massage.

If the care recipient would usually be incontinent but has an individualised continence program in place to optimise his/her continence level, record **D**. For this care recipient, a bowel management program may also be in place.

A **continence program** is based on an individualised assessment of the continence state, with planning, implementation and evaluation guidelines. A program means more interventions than pads only, or prompting only — for example, individualised habit training or scheduled toileting, and be drawn from information in the care recipient's continence assessment.

In this question:

prompting means reminding care recipient to go to the toilet.

habit training means using a flexible toileting schedule based on a care recipient's pattern of incontinence. Reinforcement techniques may be used.

scheduled toileting means toileting to a fixed schedule while care recipient is awake.

Ratings		Q7 Bowel management
Not applicable	**A**	Continent of faeces.
Some support	**B**	Wears continence aids at all times related to frequent incontinence that cannot be improved by a continence program.
Major support	**C**	Constipation is prevented or continence level maintained by a **bowel management program**.
Extensive support	**D**	Would usually be incontinent but has an individualised **continence management program** in place to optimise continence level.

Q8 Understanding and undertaking living activities

This question relates to the care recipient's ability to remember, understand, plan for, initiate and perform general living activities, and to react appropriately to information provided.

If the care recipient has no difficulty with understanding and undertaking living activities, record **A**.

If the care recipient requires staff to assist him/her to remember, understand, plan for, initiate and perform activities such as deciding whether or not and when to initiate activities such as eating, drinking, grooming and personal hygiene or with whom to initiate social interaction, record **B**, **C** or **D**, according to the level of support required.

If the care recipient needs cues, reminders to understand and react appropriately and can do so for a short period, record **B**.

If the care recipient has major difficulty remembering and understanding information, and requires frequent repetition and reminding to undertake and complete most activities, record **C**.

If the care recipient cannot remember and understand information and needs to be assisted to perform all living activities, or is unable to respond to any prompts for physical or cognitive reasons, record **D**.

Ratings		Q8 Understanding and undertaking living activities
No difficulty	**A**	Understands and undertakes living activities independently.

Some difficulty	**B**	Needs cues or prompting to initiate, undertake or complete living activities.
Major difficulty	**C**	Has major difficulty ascertaining, initiating, undertaking or completing most living activities and requires repetition and reminding.
Extensive difficulty	**D**	Cannot undertake living activities and needs to be shown or have explained every time; **OR** Unable to respond to any prompts.

Behaviour

Questions 9 to 14 relate to a care recipient's care needs which are caused by the care recipient's behaviour.

Ratings for these questions are related to the frequency of observations and interventions designed to:

(a) prevent recurrence of the behaviour itself or triggers for the behaviour; or

(b) reduce the frequency or duration of the behaviour; or

(c) reduce the impact of the behaviour on the care recipient or others.

If no problem behaviours are observed or no observation is required to prevent known problem behaviour from occurring, record **A**.

If a care recipient requires observation, the facility should document the particular behaviour that is to be observed and develop a strategy for managing it when it arises.

The need for observation is to be based on an assessment of the care recipient. However, the assessment may include information about behaviour which occurred before admission.

If a care recipient requires observation because of occasional, irregular and short-lived occurrences of the behaviour and interventions are required only for such occurrences, record **B**.

For new care recipients, if during the appraisal period it is decided that observation is required, based on advice from, for example, previous carers, family, an Aged Care Assessment Team or a medical practitioner, or if, in the appraisal period after the first week from admission, intervention is required, record **B**.

For both new and reappraised care recipients, if observation and intervention to prevent or manage behaviours are required at least weekly, but less than daily, record **C**.

If observation and intervention are required daily, record **D**.

For Questions 9 to 14:

daily means once during each 24 hour period.

intervention means particular strategies, including ongoing observation:

(a) to prevent the behaviour (for example, to redirect or distract the care recipient at times or in circumstances where there is an observed risk of the behaviour occurring); or

(b) to manage the behaviour, or reduce its impact, when it occurs.

observation means ongoing watching of the care recipient for signs of the occurrence of the behaviour and, if applicable, triggers to the behaviour.

Q9 Problem wandering or intrusive behaviour

This question relates to a care recipient wandering, absconding or interfering with other people or their belongings.

This question does not cover the movements of a care recipient who is able to leave and return to the facility as part of a lifestyle preference that is not a problem.

This question does not cover verbally disruptive, noisy or physically aggressive behaviours which interfere with or disrupt other persons in the facility. These behaviours are covered in Questions 10 and 11.

This question would cover the behaviour of a care recipient who makes repeated attempts to leave the facility or who goes uninvited into areas within or outside the facility where his or her presence is not welcome or is not appropriate (for example, kitchens or other care recipients' rooms). It would also cover problem wandering which results in staff spending time seeking and finding the care recipient and taking the care recipient back to his or her proper location.

Secure facilities may claim for problem wandering behaviour that requires observation or intervention (in addition to the provision of secure facilities).

Observing the behaviour of a care recipient as part of the general observation of all care recipients to ensure they do not wander into other care recipients' rooms or interfere with other people or their belongings, would not justify a rating other than **A**.

An example of when a **B**, **C** or **D** rating would be appropriate is if a care recipient has been assessed previously as having wandered into other care recipients' rooms causing a disturbance or taking other people's belongings. The rating would be appropriate if recurrence is likely and staff are required to observe the care recipient and to put in place interventions to prevent or manage the behaviour.

If the care recipient does not require observation for wandering or intrusive behaviour, record **A**.

If the care recipient has been assessed as exhibiting problem wandering or intrusive behaviour and recorded as needing observation or intervention for occasional, irregular and short-lived occurrences of the behaviour, record **B**, or if both observation and intervention are needed, record **C** or **D**.

For new care recipients, if during the appraisal period it is decided that observation is required, based on advice from, for example, previous carers, family, an Aged Care Assessment Team or a medical practitioner, or if, after the first week from admission, intervention is required, record **B**. If no observation or intervention is required in the appraisal period, record **A**.

For both new and reappraised care recipients, if observation and intervention to prevent or manage behaviours are required at least weekly, record **C**.

If observation and intervention are required daily, record **D**.

		Q9 Problem wandering or intrusive behaviour
Not applicable	**A**	Does not require observation.
Occasionally	**B**	Requires observation or intervention.
Regularly	**C**	Requires observation for recurrence and intervention at least weekly, but less than daily.
Extensively	**D**	Requires observation for recurrence and intervention daily.

Q10 Verbally disruptive or noisy behaviour

This question relates to verbally disruptive or noisy behaviour of a care recipient, including abusive language and verbalised threats directed at another care recipient, a visitor or a member of staff.

The question would cover the behaviour of a care recipient who causes sufficient noise to disturb other people and require intervention. The noise may be vocal or non-vocal (for example, rattling furniture or other objects).

Monitoring the language of a care recipient as part of the general observation of all care recipients, would not justify a rating other than **A**.

An example of when a **B**, **C** or **D** rating would be appropriate is if a care recipient has previously been assessed as having been disruptive by making a significant degree of noise around meal times. The rating would be appropriate if recurrence is likely and staff are required to observe the care recipient to prevent the behaviour or manage it by reducing the degree of noise created. The rating would not be justified, for example, merely because all metallic items that can be clanged together have been removed.

If the care recipient does not require observation for verbally disruptive or noisy behaviour, record **A**.

If the care recipient has been assessed as exhibiting verbally disruptive or noisy behaviour and recorded as needing observation or intervention for occasional, irregular and short-lived occurrence of the behaviour, record **B**, or if both observation and intervention is needed, record **C** or **D**.

For new care recipients, if during the appraisal period it is decided that observation is required, based on advice from, for example, previous carers, family, an Aged Care Assessment Team or a medical practitioner, or if, after the first week from admission, intervention is required, record **B**. If no observation or intervention is required in the appraisal period, record **A**.

For both new and reappraised care recipients, if observation and intervention to prevent or manage behaviours are required at least weekly, record **C**.

If observation and intervention are required daily, record **D.**

		Q10 Verbally disruptive or noisy behaviour
Not applicable	**A**	Does not require observation.
Occasionally	**B**	Requires observation or intervention.

		Q10 Verbally disruptive or noisy behaviour
Regularly	**C**	Requires observation for recurrence and intervention at least weekly, but less than daily.
Extensively	**D**	Requires observation for recurrence and intervention daily.

Q11 Physically aggressive behaviour

This question covers any physical conduct that is threatening and has the potential to harm another care recipient, a visitor or a member of staff. It includes, but is not limited to, hitting, pushing, kicking or biting.

Observing the behaviour of a care recipient as part of the general observation of all care recipients would not justify a rating other than **A**.

An example of when a **B**, **C** or **D** rating would be appropriate is if a care recipient has previously been assessed as having been physically aggressive around bedtime, requiring staff to put in place an intervention to prevent or manage the behaviour. The rating would be appropriate if an intervention was put in place to modify the behaviour of the care recipient at times or in circumstances where there is a higher risk of physical aggression.

If the care recipient does not require observation for physically aggressive behaviour, record **A**.

If the care recipient has been assessed as exhibiting physically aggressive behaviour and recorded as needing observation or intervention for occasional, irregular and short-lived occurrences of the behaviour, record **B**, or if both observation and intervention are needed, record **C** or **D**.

For new care recipients, if during the appraisal period it is decided that observation is required, based on advice from, for example, previous carers, family, an Aged Care Assessment Team or a medical practitioner, or if intervention is required after the first week from admission, record **B**. If no observation or intervention is required in the appraisal period, record **A**.

For both new and reappraised care recipients, if observation and intervention to prevent or manage behaviours are required at least weekly, record **C**.

If observation and intervention are required daily, record **D**.

		Q11 Physically aggressive behaviour
Not applicable	**A**	Does not require observation.
Occasionally	**B**	Requires observation or intervention.
Regularly	**C**	Requires observation for recurrence and intervention at least weekly, but less than daily.
Extensively	**D**	Requires observation for recurrence and intervention daily.

Q12 Emotional dependence

This question relates to one-on-one interventions required by staff to respond to, manage and alleviate behaviours which result from a care recipient having a strong attachment or reliance on another person or persons.

This question is limited to the following behaviours:

(a) active and passive resistance other than physical aggression;

(b) attention seeking;

(c) manipulative behaviour;

(d) withdrawal.

Interventions to address these behaviours may include considerable additional personal attention by staff in order to calm the care recipient after visitors leave, or the careful design and scheduling of activities to distract the care recipient when he or she is at particular risk of adopting these behaviours.

This question also applies to one-on-one intervention by staff to manage the behavioural needs of a care recipient with withdrawal or depression.

This question does not relate to group activities that are covered in Question 15.

The rating should be based on the effort required to implement the intervention to prevent or manage the behaviour.

If the care recipient does not require observation for emotionally dependent behaviour, record **A**.

If the care recipient has been assessed as exhibiting emotionally dependent behaviour and recorded as needing observation or intervention for occasional, irregular and short-lived occurrences of the behaviour, record **B**, or if both observation and intervention are needed, record **C** or **D**.

For new care recipients, if during the appraisal period it is decided that observation is required, based on advice from, for example, previous carers, family, an Aged Care Assessment Team or a medical practitioner, or if intervention is required after the first week from admission, record **B**. If no observation or intervention for emotionally dependent behaviours is required in the appraisal period, record **A**.

For both new and reappraised care recipients, if observation and intervention to prevent or manage emotionally dependent behaviours are required at least weekly, record **C**.

If observation and intervention are required daily, record **D**.

		Q12 Emotional dependence
Not applicable	**A**	Does not require observation.
Occasionally	**B**	Requires observation or intervention.
Regularly	**C**	Requires observation for recurrence and intervention at least weekly, but less than daily.
Extensively	**D**	Requires observation for recurrence and intervention daily.

Q13 Danger to self or others

This question covers high-risk behaviour requiring observation or intervention and strategies to prevent, reduce or manage the behaviour. Examples of such behaviour include, but are not limited to, unsafe smoking habits, walking without required aids, leaning out of windows, self-mutilation and suicidal tendencies. It applies where there is an imminent risk of harm.

This question is about behaviour and does not apply to a medical condition that might lead to injury, for example, the risk of injury due to fitting or loss of consciousness. It does not apply to a range of behaviours which may in the long term cause damage to health such as smoking generally.

This question does not cover acts of physical aggression. These behaviours are covered in Question 11.

Observing the behaviour of a care recipient as part of the general observation of all care recipients would not justify a rating other than **A**. A rating of **B**, **C** or **D** rating would be appropriate if a care recipient has previously been assessed as endangering themselves or others. The rating would be appropriate if recurrence is likely and staff are required to observe the care recipient and to put in place interventions to prevent or manage the behaviour.

If the care recipient does not require observation for high-risk behaviour, record A.

If the care recipient has been assessed as exhibiting behaviour endangering themselves or others and recorded as needing observation or intervention for occasional, irregular and short-lived occurrences of the behaviour record **B**, or if both observation and intervention are needed, record **C** or **D**.

For new care recipients, if during the appraisal period it is decided that observation for high-risk behaviours is required, based on advice from, for example, previous carers, family, an Aged Care Assessment Team or a medical practitioner, or if intervention is required after the first week from admission, record **B**. If no observation or intervention is required in the appraisal period, record **A**.

For both new and reappraised care recipients, if observation and intervention to prevent or manage behaviours are required at least weekly, record **C**.

If observation and intervention are required daily, record **D**.

		Q13 Danger to self or others
Not applicable	**A**	Does not require observation.
Occasionally	**B**	Requires observation or intervention.
Regularly	**C**	Requires observation for recurrence and intervention at least weekly, but less than daily.
Extensively	**D**	Requires observation for recurrence and intervention daily.

Q14 Other behaviour

This question covers behaviours not covered in Questions 9 to 13 that require staff to spend time and effort in addition to support for daily activities.

Examples of behaviour are not given for this question as it is intended as a 'catch all' for any problem behaviour requiring additional staff time and effort not covered by Questions 9 to 13.

Observing the behaviour of a care recipient as part of the general observation of all care recipients would not justify a rating other than **A**. A rating of **B**, **C** or **D** would be appropriate where a care recipient has previously been assessed as exhibiting a certain behaviour requiring observation or an intervention by staff to prevent or manage the behaviour.

If the care recipient does not require staff observation or intervention for behaviours other than those listed in Questions 9 to 13, record **A**.

If the care recipient has been assessed as exhibiting other behaviour and recorded as needing observation or intervention for occasional, irregular and short-lived occurrences of the behaviour record **B**, or if both observation and intervention are needed, record **C** or **D**.

For new care recipients, if during the appraisal period it is decided that observation for other problem behaviours is required, based on advice from, for example, previous carers, family, an Aged Care Assessment Team or a medical practitioner, or if intervention is required after the first week from admission, record **B**. If no observation or intervention is required in the appraisal period, record **A**.

For both new and reappraised care recipients, if observation and intervention to prevent or manage behaviours are required at least weekly, record **C**.

If observation and intervention are required daily, record **D**.

		Q14 Other behaviour
Not applicable	**A**	Does not require observation.
Occasionally	**B**	Requires observation or intervention.
Regularly	**C**	Requires observation for recurrence and intervention at least weekly, but less than daily.
Extensively	**D**	Requires observation for recurrence and intervention daily.

Q15 Social and human needs — care recipient

This question relates to the care recipient's need for support other than physical care.

The time and effort taken by staff to give guidance and emotional support to the care recipient are covered in this question.

The care recipient's social, cultural and religious needs, and chosen lifestyle preferences are covered in this question.

The management of withdrawal due to depression is not covered in this question. This is covered in Question 12.

Activities which are part of a program claimed for in Question 19 or 20 are not covered in this question.

The time taken to give guidance and emotional support to relatives and friends of the care recipient is not covered in this question. This is covered in Question 16.

For routine, in-house group activities such as watching television, playing bingo, group singing and craftwork, record **A**.

Examples of activities covered in this question are:

- conversation and board games (individual activities);
- reading to the visually impaired;
- group activities requiring one or more staff with a group of care recipients including outings, attendance at church and escorting groups to clinics;
- accompanying a care recipient to external appointments.

For extensive (more than 30 minutes on each day) one-on-one recreational, social, cultural or religious activities, including providing counselling or support for palliative care and highly disabled care recipients, record **D**.

In this question:

some minor support means the care recipient is assisted by staff to participate in a group activity, other than routine, in-house activities, at least once a week, or in a one-to-one activity at least once in a 21 day period. In this case, record **B**.

major support means the care recipient is assisted by staff to participate in a group activity, other than routine, in-house activities, on at least a daily basis, or in a one-to-one activity at least weekly. In this case, record **C**.

extensive support means staff dedicate at least 30 minutes a day for the above activities in a one-on-one situation with the care recipient. In this case, record **D**.

Ratings		**Q15 Social and human needs — care recipient**
No support	**A**	Requires no specific support.
Some support	**B**	Requires some minor support.
Major support	**C**	Requires major support.
Extensive support	**D**	One-on-one support for activities for more than 30 minutes daily.

Q16 Social and human needs — families and friends

This question relates to activities related to the care recipient, involving one or more staff members interacting with families, friends, or the community. The activity may or may not involve the care recipient.

Guidance and other activities not related to the care recipient are not covered in this question.

Activities such as giving guidance and emotional support, care planning, legal or guardianship matters, cultural and religious matters are covered in this question. This would include support to family and friends where the care recipient requires such care as palliative care, a continence program, management of problem behaviours and care for increasing dementia.

Community is used in this question to refer to community groups such as church groups, social groups and groups or bodies of cultural significance to the care recipient. It does not refer to linkages with medical professions — for example, doctors, dentists, podiatrists, etc.

In this question:

some means less frequently than weekly.

major means at least weekly, but not daily.

extensive means support on a daily basis.

Ratings		**Q16 Social and human needs — families and friends**
No support	**A**	Requires no specific support.
Some support	**B**	Requires support less frequently than weekly.
Major support	**C**	Requires support weekly or more often.
Extensive support	**D**	Requires support daily or more often.

Q17 Medication

This question refers to medication(s) administered on a regular basis. Infrequent, or less than weekly, administration of oral analgesic medication(s) is not covered in this question.

Injections such as an influenza vaccination or a multi-vitamin injection are not covered in this question.

This question assumes that administration of medication(s) will be carried out in accordance with requirements in relevant State/Territory legislation.

This question includes prescribed eye and ear drops, nebulisers, metered aerosols, turbuhalers, canisters and inhalers, the application of transdermal medication patches, other topically applied prescribed medication(s) and rectally or vaginally administered prescribed medication(s).

This question excludes intravenous infusions which are covered in Question 18. However, intravenous drug administration through a cannula or hypodermic are included in rating **D**.

This question excludes aperients, which are covered in Question 7.

In this question, if a care recipient would have a **B** rating, but he/she is resistant to medication administration, for example, because of dementia, and staff are required to spend time and effort in giving significant encouragement (greater than prompting and reminding), record **C**.

In this question:

assist means giving the correct medication(s) to the care recipient, in the correct manner and at the appropriate times, and ensuring that medication(s) is ingested.

administer means providing physical assistance so that the care recipient completes the ingestion or taking of prescribed medication(s).

a controlled drug means a schedule 8 drug. In some States this may be called a dangerous drug. In some States or Territories, this may include schedule 4D drugs where there is a legal requirement for the recording and storage of schedule 4D drugs to be the same as for schedule 8 drugs.

Ratings		Q17 Medication
No assistance	**A**	Care recipient self-manages medication.
Some assistance	**B**	Requires staff to give medication to the care recipient, the care recipient takes the medication him/herself and staff confirm that the medication has been ingested.
Major assistance	**C**	Requires staff to administer and assist with the taking of prescribed medication; **OR** Care recipient is resistant to medication administration, and staff are required to give significant encouragement (greater than prompting and reminding).
Complete assistance	**D**	Requires daily administration of a controlled drug; **OR** Requires staff to administer subcutaneous (s/c), intramuscular (i/m) or intravenous (i/v) drug at least daily.

Q18 Technical and complex nursing procedures

This question relates to technical and complex nursing procedures. The following lists of procedures are indicative and not exhaustive.

This question assumes that procedures in list 1 will be carried out in accordance with requirements in relevant State/Territory legislation.

LIST 1 includes:

- maintenance of skin integrity, including changing of position of a chairfast or bedfast care recipient;

- eye care other than eye drops which are covered in Question 17;
- assistance with nebulisers, metered aerosols, turbuhalers, canisters and inhalers;
- oral hygiene (excluding cleaning teeth which is covered in Question 4);
- blood pressure measurement;
- blood sugar measurement;
- simple wound dressings;
- tube feeding and cleaning of tube following feeding;
- catheter care other than insertion or removal of a catheter, including perineal/penile toilet and change of drainage bag;
- stoma maintenance, including replacement of stoma bags and wafer maintenance;
- oxygen therapy where the supply of oxygen is continuous and has been prescribed by a medical practitioner, or where the care recipient is capable of self-managing oxygen;
- implementation of a pain management or palliative care program (more than regular or 'prn' analgesic);
- care and fitting of prosthesis;
- anti-embolic stockings.

Note that if (say) assistance with a nebuliser is given twice a day and care and fitting of a prosthesis is given twice a day and blood pressure is measured once a day, then the total is 5 procedures daily.

For procedures such as dressings, anti-embolic stockings and prosthesis, the putting on (say) at the beginning of the day is 1 procedure and the taking off at (say) the end of the day is 1 procedure. For an occasion of removal and immediate replacement, this occasion is 1 procedure. For an occasion of removal and replacement where replacement is not immediate, for example removal before a shower and replacement after a shower, removal is 1 procedure and replacement is 1 procedure.

If a procedure or procedures from list 1 total 1 to 3 times daily, record **B**.

If a procedure or procedures from list 1 total 4 to 6 times daily, record **C**.

If a procedure or procedures from list 1 total more than 6 times daily, record **D**.

If a combination of procedures from lists 1 and 2 totals more than 6 times daily, record **D**.

This question assumes that procedures in list 2 will be carried out by a registered nurse or other health professional appropriate to the particular procedure, based on initial and ongoing assessment, planning and management of the care recipient's care by a registered nurse. Examples include medical practitioners, stoma therapists, physiotherapists, speech pathologists or qualified practitioners from palliative care teams.

LIST 2 includes:

- establishment and supervision of a complex pain management or palliative care program including monitoring and managing any side effects;

- insertion, care and maintenance of tubes including intravenous and naso-gastric tubes;
- establishing and reviewing a catheter care program, including the insertion, removal and replacement of catheters;
- establishing and reviewing a stoma care program;
- complex wound management;
- suppositories;
- risk management procedures relating to acute or chronic infectious conditions;
- special feeding for care recipients with dysphagia (difficulty with swallowing);
- suctioning airways;
- tracheostomy care;
- enema administration;
- oxygen therapy which requires ongoing supervision due to variable need;
- dialysis treatment.

Note that if (say) suctioning of airways is carried out twice a day and special feeding is carried out twice a day and an enema is given once a day, the total is 5 procedures daily.

If a procedure or procedures from list 2 total 1 to 3 times daily, record **C**.

If a procedure or procedures from list 2 total more than 3 times daily, record **D**.

If a procedure or procedures from lists 1 and 2 total more than 6 times daily, record **D**.

Ratings		**Q18 Technical and complex nursing procedures**
No assistance	**A**	No procedures are provided.
Some assistance	**B**	A procedure or procedures from **list 1** totalling 1 to 3 procedures daily.
Major assistance	**C**	A procedure or procedures from **list 2** totalling 1 to 3 procedures daily; **OR** A procedure or procedures from **list 1** totalling 4 to 6 procedures daily.
Extensive assistance	**D**	A procedure or procedures from **list 2** totalling more than 3 procedures daily; **OR** A procedure or procedures from **lists 1** and **2** totalling more than 6 procedures daily.

Q19 Therapy

This question relates to therapy provided to care recipients where the facility provides the therapy, or the facility pays for the therapy, and the therapy is documented as a care need. The therapist should meet the requirements for full membership of the therapist's national or state body OR be a registered nurse for physical therapy. The therapies include:

- physiotherapy;
- physical therapy developed by registered nurses, for example:
  passive movements for unconscious or severely disabled care recipients;
  techniques such as pelvic floor exercises to promote continence;
- occupational therapy;
- diversional therapy;
- speech therapy.

Music therapy and aromatherapy are not claimed for in this question, but are covered in Question 20.

The therapist's role is to individually assess the care recipient's need for the therapy and to develop a personalised therapy plan.

The program does not need to be implemented by the therapist, but may be implemented by a staff member *at the direction of the therapist*. However, it is the role of the therapist to regularly evaluate, by assessment, the effectiveness of the therapy program.

If the care recipient requires no therapy, record **A**.

If a therapy program is provided 1 or 2 times a week, record **B**. This might be to maintain the care recipient's existing level of function.

If a therapy program is provided 3 or more times a week, but not daily, record **C**. This might be to improve, or to minimise, loss of the care recipient's existing level of function, correct a deficit, or, in the case of physiotherapy, maintain or minimise loss of joint range of movement or prevent contractures.

If a therapy program is provided in either daily blocks, or 3 or more times a week in large blocks of time (at least 30 minutes duration), record **D**.

Therapy provided by different categories of therapists are added together to determine the frequency of the provision of therapy.

Ratings		**Q19 Therapy**
No support	**A**	No therapy required.
Some support	**B**	Therapy provided 1 or 2 times a week.
Major support	**C**	Therapy provided 3 times a week.

Ratings		Q19 Therapy
Extensive support	**D**	Therapy program provided either daily or at least 3 times a week in large blocks of time.

Q20 Other services

This question relates to services provided to care recipients where the facility provides the service or the facility pays for the service and the service is documented as a care need. These services are services other than those covered in Questions 1 to 19. These include, but are not restricted to, services provided by:

- psychologist;
- dietitian;
- podiatrist;
- social worker;
- music therapist;
- aromatherapist.

The provider of these services individually assesses the care recipient's need for the service and develops a personalised plan for the provision of the service(s). The program may be implemented by other staff. However, it is the role of the provider to regularly evaluate, by assessment, the effectiveness of the program.

If the care recipient requires no other services, or services less frequently than weekly, record **A**.

If other services are provided 1 or 2 times a week, record **B**.

If other services are provided 3 times or more a week, but not daily, record **C**.

If other services are provided daily record **D**.

Services provided by the above providers are added together to determine the frequency of the provision of services.

Ratings		Q20 Other services
No support	**A**	No other services required.
Some support	**B**	Other services provided 1 or 2 times a week.
Major support	**C**	Other services provided 3 or more times a week but not daily.
Extensive support	**D**	Other services provided daily.

Part 2 Scores to be applied to the appraisal

Column 1 Question	Column 2 Question description	Column 3 Level of support	Column 4 Score
Q1	Communication	A	0.00
		B	0.28
		C	0.36
		D	0.83
Q2	Mobility	A	0.00
		B	1.19
		C	1.54
		D	1.82
Q3	Meals and drinks	A	0.00
		B	0.67
		C	0.75
		D	2.65
Q4	Personal hygiene	A	0.00
		B	5.34
		C	14.17
		D	14.61
Q5	Toileting	A	0.00
		B	5.98
		C	10.65
		D	13.70
Q6	Bladder management	A	0.00
		B	2.22
		C	3.82
		D	4.19
Q7	Bowel management	A	0.00
		B	3.32
		C	5.72
		D	6.30
Q8	Understanding and undertaking living activities	A	0.00
		B	0.79
		C	1.11
		D	3.40
Q9	Problem wandering or intrusive behaviour	A	0.00
		B	0.80
		C	1.58
		D	4.00
Q10	Verbally disruptive or noisy	A	0.00
		B	1.19
		C	1.75
		D	4.60
Q11	Physically aggressive	A	0.00
		B	2.34
		C	2.69
		D	3.05

Column 1 Question	Column 2 Question description	Column 3 Level of support	Column 4 Score
Q12	Emotional dependence	A	0.00
		B	0.28
		C	1.50
		D	3.84
Q13	Danger to self or others	A	0.00
		B	1.11
		C	1.54
		D	1.98
Q14	Other behaviour	A	0.00
		B	0.91
		C	1.82
		D	2.61
Q15	Social and human needs — care recipient	A	0.00
		B	0.95
		C	1.98
		D	3.01
Q16	Social and human needs — families and friends	A	0.00
		B	0.28
		C	0.55
		D	0.91
Q17	Medication	A	0.00
		B	0.79
		C	8.55
		D	11.40
Q18	Technical and complex nursing procedures	A	0.00
		B	1.54
		C	5.54
		D	11.16
Q19	Therapy	A	0.00
		B	3.64
		C	6.10
		D	7.01
Q20	Other services	A	0.00
		B	0.71
		C	1.46
		D	2.93

Schedule 2 Classification levels

(section 9.17)

Column 1 Item	Column 2 Aggregate figure range	Column 3 Classification level
1	0 — 10.60	Classification level 8
2	10.61 — 28.90	Classification level 7
3	28.91 — 39.80	Classification level 6
4	39.81 — 50.00	Classification level 5
5	50.01 — 56.00	Classification level 4
6	56.01 — 69.60	Classification level 3
7	69.61 — 81.00	Classification level 2
8	81.01+	Classification level 1

Note Column 3 of the Schedule indicates the range of classification levels that may apply to a care recipient according to the aggregate figure for the care recipient in an item in Column 2. The classification levels are indicated on a numerical scale from the lowest level (classification level 8) to the highest (classification level 1).

Notes to the *Classification Principles 1997*

Note 1

The *Classification Principles 1997* (in force under subsection 96 (1) of the *Aged Care Act 1997*) as shown in this compilation is amended as indicated in the Tables below.

For all application, saving or transitional provisions *see* Table A.

Table of Principles

Title	Date of notification in *Gazette*	Date of commencement	Application, saving or transitional provisions
Classification Principles 1997	29 Sept 1997 (*see Gazette* 1997, No. S380)	1 Oct 1997	
Classification Amendment Principles 1998 (No. 1)	26 Aug 1998 (*see* Gazette 1998, No. S423)	S. 11: 1 Oct 1997 Remainder: 1 Nov 1998	—
Classification Amendment Principles 2001 (No. 1)	15 June 2001 (*see Gazette* 2001, No. S212)	1 July 2001	R. 4

Table of Amendments

ad. = added or inserted am. = amended rep. = repealed rs. = repealed and substituted

Provision affected	How affected
S. 9.3	am. Amt. No. 1, 1998
Note to s. 9.3	rs. Amt. No. 1, 1998
Div. 2 of Part 2 (ss. 9.5, 9.6)	rep. Amt. No. 1, 1998
Ss. 9.5, 9.6	rep. Amt. No. 1, 1998
Div. 3 of Part 2 (ss. 9.7, 9.8)	rep. Amt. No. 1, 1998
Ss. 9.7, 9.8	rep. Amt. No. 1, 1998
Part 3 (ss. 9.10–9.15)	rep. Amt. No. 1, 1998
Ss. 9.10–9.15	rep. Amt. No. 1, 1998
S. 9.17	am. Amt. No. 1, 1998
S. 9.19	am. Amt. No. 1, 1998
S. 9.23	am. Amt. No. 1, 1998
Part 6A (ss. 9.23A, 9.23B)	ad. Amt. No. 1, 1998
Ss. 9.23A, 9.23B	ad. Amt. No. 1, 1998
Heading to Part 7	rs. Amt. No. 1, 1998
Div. 3 of Part 8 (ss. 9.29A, 9.29B)	ad. Amt. No. 1, 1998
Ss. 9.29A, 9.29B	ad. Amt. No. 1, 1998
Div. 4 of Part 9 (ss. 9.36, 9.37)	ad. Amt. No. 1, 1998
Ss. 9.36, 9.37	ad. Amt. No. 1, 1998
Schedule 1	rs. Amt. No. 1, 1998 am. Amt. No. 1, 2001

Table A Application, saving or transitional provisions

Classification Amendment Principles 2001 (No. 1)

4 Transitional

(1) The *Classification Principles 1997* as in force on 1 July 2001 (the ***new criteria***) apply in relation to the appraisal, or reappraisal, of a care recipient that begins on or after 1 July 2001.

(2) The *Classification Principles 1997* as in force immediately before 1 July 2001 (the ***old criteria***) continue to apply in relation to an appraisal, or reappraisal, of a care recipient that begins before 1 July 2001.

Examples

1 If a new care recipient enters a facility on 1 June and the appraisal for the classification of the care recipient begins on 25 June, the approved provider uses the old criteria to appraise the care recipient even though the Secretary may not receive the appraisal until 7 July.

2 If the classification of an existing resident expires on 3 July but the reappraisal for the care recipient begins on 28 June, the approved provider uses the old criteria to reappraise the care recipient even though the reappraisal is given to the Secretary in July.

3 If an appraisal (or a reappraisal) for the classification of a care recipient begins on or after 1 July, the approved provider must use the new criteria.

Note Changes to the criteria to be applied to an appraisal or reappraisal of a care recipient do not affect the date of effect of a classification or the date of effect of renewal of a classification under the Act.