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AMA submission to the Aged Care Worker Regulation Scheme Consultation

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Introduction

The AMA thanks the Department of Health for the opportunity to provide commentary on the aged care worker regulation scheme.

The AMA has in the past called for the introduction of mandatory minimum qualifications for personal care workers in aged care, noting that other professions that have the responsibility to care for people have mandatory minimum qualifications and are regulated[1]. The AMA has also called for the development of clearly defined roles within the aged care sector[2], particularly regarding the provision of clinical care.

The AMA welcomes the Department of Health progressing this important issue, especially considering the recent findings of the Royal Commission into Aged Care Quality and Safety and recommendations by the Royal Commission Counsel Assisting.

The AMA commentary to the consultation questions is outlined below.

[1] Australian Medical Association (2019) AMA Submission to the Royal Commission into Aged Care Quality and Safety
[2] Australian Medical Association (2018) AMA Submission to the Aged Care Workforce Strategy Taskforce – the aged care workforce strategy

Consultation questions:

1. **What is your preferred approach to aged care worker criminal history assessments?**

   - **Option A1** – Providers continue to assess criminal history for workers in line with aged care legislation, funding agreements and guidance
   - **Option A2** – Centralised assessment of criminal history for workers (based on NDIS model)

   The AMA preferred approach would be option A2, having a centralised assessment of criminal history for workers, based on the NDIS model. In the AMA view continuing option A would bring no change to the existing system. There have been multiple cases in the past where aged care workers who have record of misconduct have been able to move between different providers, without suffering any consequences for their actions[3].

2. **Are there other options that should be considered?**

   No comment.

3. **If there were to be a centralised assessment of criminal history, should any other matters be routinely taken into account? If so, which of the following options should be considered?**

   - **Option B1** – Information from disciplinary bodies such as health complaints bodies, the NDIS Commission and National Boards
   - **Option B2** – Information from relevant government agencies
   - **Option B3** – Information from courts and tribunals
   - **Option B4** – Information from employers

   In the AMA view, all the above options should be considered. However, only the information that has been proven through formal processes, be it disciplinary, administrative, or court procedures, should be accepted as evidence of satisfactory/unsatisfactory standing for aged care workers. Otherwise the risk of considering allegations that are unproven, especially if they originate from co-workers or employers, could lead to unwanted consequences.

   Relying on information obtained by employers or co-workers alone should not be sufficient when assessing someone for a centralised register of aged care workers. As seen from the case studies investigated by the Royal Commission referenced under question 1, there is insufficient transparency on the part of the aged care employers about the conduct of their staff.

[3] See for example Transcript of Royal Commission Into Aged Care Quality and Safety Hearing dated 17 October 2019, case study examining the conduct of a former employee of Japara Healthcare Limited, or Transcript of Royal Commission Into Aged Care Quality and Safety Hearing dated 11 February 2019, statement by Clive Robert Spriggs about the staff from Oakden facility in South Australia

4. Are there any other matters that should/should not be considered as part of any aged care worker screening scheme?

Over one third (37%) of workers in disability and aged care are of migrant background4. It is crucially important to be able to document worker criminal history in a timely manner so it does not delay their employment or deters them from working in the sector and at the same time ensures full transparency and safety of recipients of aged care services. The AMA advises the Department of Health may wish to explore the merging of data with that obtained by the Department of Home Affairs for the purposes of visa processing and approval. However, it is the AMA position that if this is done it will be vital to ensure that the data matching arrangements are transparent and that they protect the privacy of the workers being screened.

Additionally, the AMA supports the recommendation from the Future of Australia's Aged Care Sector Workforce Report, that developing any worker regulation in aged care must take into consideration historical issues impacting on employment of Aboriginal and Torres Strait Islander (ATSI) people[5]. It should acknowledge the specific skill set of the workforce that will care for ATSI older people, that may be best catered for by the ATSI workforce. Future worker regulation should take into consideration a lack of culturally appropriate training specifically targeted to ATSI people wishing to enter or remain in the aged care sector, the need to create culturally safe workplaces and the need for further promotion, and strengthening of self-empowerment of prospective ATSI aged care workers enabling them to influence the modelling of work training and care.

5. What is your preferred approach to a code of conduct? *(select one or more options)*

- **Option C1** – Retain existing arrangements requiring providers to ensure the conduct of aged care workers is in line with the Aged Care Quality Standards and Charter of Aged Care Rights (status quo)
- **Option C2** – Adopt the NDIS Code of Conduct for aged care workers
- **Option C3** – Develop a new code of conduct specific to aged care workers

In the AMA view, maintaining status quo is untenable, as evidenced by the consultation paper and the number of previous inquiries suggesting that the change is needed.

The AMA supports both option C2 and option C3, noting that if option C2 is adopted, there would be some need to change/broaden the scope and rename the NDIS code of conduct, ensuring it upholds both NDIS Rights of Participants[6] and the Charter of Aged Care Rights[7]. Apart from cost saving, the benefit of adopting the same code of conduct for both would be to avoid duplication and facilitate easier understanding/application by the shared workforce

[4] D.Brennan et al (2019), Markets, Migration & the Work of Care in Australia, University of New South Wales, Fact Sheet 3: Aged and Disability Carers
[5] Senate Community Affairs references Committee (2017), Future of Australia's aged care sector workforce
[6] NDIS Quality and Safeguards Commission, Rights of Participants
[7] Aged Care Quality and Safety Commission (2019), Charter of Aged Care Rights

between these two aspects of social care. Option C2 would also be in line with the recommendation 3 of the Senate Community Affairs References Committee - *Future of Australia's aged care sector workforce* - which recommended that the "aged care workforce strategy include a review of existing programs and resources available for workforce development and support and ensure consideration of the NDIS Integrated Market, Sector and Workforce Strategy to identify overlapping issues and competitive pressures between the sectors and how they may be addressed"[8].

The AMA also sees merit in developing a separate code of conduct for aged care workers that would be based on the Charter of Aged Care Rights and Aged Care Quality Standards. For example, both the Charter and the Quality Standards (Standard 1: Consumer Dignity and Choice) place an emphasis on valuing and supporting the identity, culture and diversity of aged care consumers. This would need to be reflected in the Code of Conduct for aged care workers, as PCWs are the ones that deal directly with aged care consumers and their conduct has to be reflective of the individual consumer needs and values.

6. What do you consider are the advantages and disadvantages of introducing a code of conduct for aged care workers?

The AMA sees many benefits to introducing the code of conduct for aged care workers. The AMA has previously called for the development of clearly defined roles within the aged care sector[9]. Having a code of conduct that clearly outlines performance and behavioural expectations for each worker in the aged care sector would prevent any misunderstandings by individual workers as to what their roles entail. Additionally, it would increase accountability for the care provided.

Similar to the NDIS approach, the chosen regulator for aged care workers (be it the same body as NDIS or a different body, pending the outcome of this consultation), should develop code of conduct guidance for workers and aged care providers[10]. Guidance will improve workers' understanding of expectations and potential consequences of not complying with the code of conduct. A guidance for aged care providers would outline the relationship between the code of conduct and the Aged Care Quality Standards and explain the role of providers in ensuring that their staff comply with the code.

7. What is your preferred approach to strengthening English proficiency in aged care?

- **Option D1** – Require providers to be satisfied that PCWs have the necessary English proficiency to effectively perform their role (extension of the status quo with improved guidance as to the expected thresholds for proficiency)

[8] Senate Community Affairs references Committee (2017), Future of Australia's aged care sector workforce
[9]Australian Medical Association (2018), AMA submission to the Aged Care Workforce Strategy Taskforce – the aged care workforce strategy
[10] NDIS Quality and Safeguards Commission, NDIS Code of Conduct, Guidance for Workers, Guidance for Service Providers

- **Option D2** – Establish a requirement for PCWs to demonstrate their proficiency in English as part of a registration process (consistent with the National Scheme)

The AMA supports option D2, establishing a formal requirement for PCWs to demonstrate defined level of English language proficiency to work in aged care. This AMA position is informed by experiences of many AMA members who work in aged care, who have often reported communication barriers with aged care staff from non-English speaking backgrounds. The language barrier for doctors can be particularly challenging when engaging with care staff around clinical matters.

In the AMA view, bilingual and bicultural staff hold the potential for improving cross cultural understanding in aged care. This is particularly important as, according to projections, one in every four people aged over 80 will be from culturally and linguistically diverse (CALD) backgrounds by 2026[11]. Having staff that are capable of catering for the needs of CALD consumers is therefore beneficial. However, it is important that CALD staff members have sufficient levels of English language skills to be able to care for all recipients of aged care services, and also to communicate with medical professionals and ensure the clinical care guidance provided by medical professionals is understood and followed.

Ensuring that all staff employed in aged care have a sufficient level of English language proficiency can provide multiple benefits to aged care consumers (improved communication, improved satisfaction with services, etc), providers of aged care (developing a skilled workforce, greater retention of staff, greater staff and consumer satisfaction) and CALD aged care workers themselves (increased options for career progression, further education and professional development)[12].

8. What are the other options for strengthening English proficiency in aged care (particularly for those providing personal and clinical care)?

It is the AMA position that workers from non-English speaking backgrounds should be supported by employers in aged care to further develop and improve their English language skills. The AMA supports recommendation 17 by the *Future of Australia's aged care sector workforce* report about the availability of on-site training and aged care workers accessing aged care training via upskilling service delivery organisations to deliver in-house training[13]. This approach could be applied to developing language skills, for example by pairing CALD workers with native English speakers during the daily implementation of their duties. Studies have shown that learning language from peers, along with implementation of other learning

[11] Australian Institute of Health and Welfare (2001) Projections of Older Immigrants, People from culturally and linguistically diverse backgrounds, 1996–2026, Australia, Department of Health and Aged Care May 2001 Page xviii

[12] Australian Medical Association (2019) AMA Submission to the Royal Commission into Aged Care Quality and Safety

[13] Senate Community Affairs references Committee (2017), Future of Australia's aged care sector workforce

techniques, can lead to better language learning outcomes due to immediate feedback and corrections provided by peers[14].

9. What is your preferred approach to minimum qualifications?

- **Option E1** – Providers must ensure that PCWs are competent and have the qualifications and knowledge to effectively perform their role (status quo)
- **Option E2** – Require providers to be satisfied that PCWs have certain minimum qualifications or competencies
- **Option E3** – Establish a requirement for PCWs to demonstrate their qualifications as part of a registration process (consistent with the National Scheme)

The AMA supports the approach outlined under option E3, establishing a National Scheme that will entail a registration process requiring PCWs to demonstrate a sufficient level of qualifications to work in aged care. The AMA has been calling for minimum mandatory qualifications for PCWs for some time.

However, as outlined in the Consultation Paper, a phased approach would be beneficial to implementing Option E3. A new approach would have to ensure that workers who are motivated to work in the aged care sector are not disadvantaged by a lack of formal qualifications and forced to exit the sector. In that sense, the AMA supports recognition of prior work experience and on the job training undertaken by individual workers, as part of the registration process. This should be coupled with support for workers to increase their qualifications.

The AMA supports the point from the discussion paper that any mandatory minimum qualifications should be considered in context of the average annual wage of aged care workers. It will be important to ensure that cost of education and training is not a major barrier for aged care workers. The Department of Health should consider the benefits of the down-stream effects of minimum qualifications that may save costs in the long run. For example, education around strategies to address common health issues and implementing health prevention may prevent major health issues in older people resulting in long, costly hospital stays.

The AMA has outlined the following fields that should be included in aged care worker education and training to improve quality of care for older people[15]:

- Strategies for addressing common health issues that older people face.
- Strategies to prevent deterioration in health, such as exercise programs and providing adequate nutritious meals and hydration.
- Strategies to reduce distress in dementia patients.

[14] See for example M. Asnawi, M. Abbas (2017), The Effectiveness of Immersive Multimedia Learning with Peer Support on English Speaking and Reading Aloud, International Journal of Instruction, v10 n1 p203-218, or I. Sari et al (2017), The Effect of Peer Support on University Level Students' English Language Achievements, Journal of Education and Practice, v8 n1 p76-81

[15] Australian Medical Association (2018) *Resourcing aged care*.

- Intervention and management of elder abuse.
- Engaging with Culturally and Linguistically Diverse (CALD) older people.
- Palliative care skills.
- Mental health skills.
- Infection prevention and control.

10. What are the other options for strengthening the skills and knowledge of PCWs in delivering aged care?

Along with establishing a formal requirement for qualifications consistent with the National Scheme, continuous professional development (CPD) is of crucial importance for PCWs being able to properly implement their duties in aged care. Completion of a certain level of education and obtaining a degree should not be the end but rather the beginning of a specialised process of obtaining an occupational skill through on the job training[16].

For example, Aged Care Quality Standard 3 requires aged care providers to provide safe and effective clinical care to consumers. To be able to implement clinical care, the organisation needs to demonstrate "workforce orientation and training or other records that show how the organisation supports the workforce to follow the organisation's infection prevention and control program and how to meet this requirement." The AMA position is that infection prevention and control should be a core training component for anyone starting to work in aged care. It should be implemented as part of the induction training, and continuous refreshers should be required from the providers throughout one's employment with that provider. This is just one example of how skills and knowledge of PCWs could be continuously strengthened and updated.

11. What is your preferred approach to continuing professional development?

- **Option F1** – Retain existing arrangements whereby providers must ensure that PCWs are recruited, trained, equipped and supported to deliver the outcomes required by the Aged Care Quality Standards (status quo)
- **Option F2** – Require providers to be satisfied that PCWs meet specified minimum CPD requirements
- **Option F3** – Establish a requirement for PCWs to demonstrate they have met specified minimum CPD requirements as part of a registration process (consistent with the National Scheme)

The AMA preferred approach to continuing professional development is Option F3. However, the AMA would also call for assurances and protections to be put in place to ensure that the burden of professional development, in terms of cost, availability and time, is not put on PCWs alone.

[16] J.Mincer (1962), On-the-Job Training: Costs, Returns, and Some Implications, The University of Chicago Press Journals, Journal of Political Economy, Volume 70, Part 2, p50

The Government will need to support PCWs to ensure equity of access to CPD. If no funds are dedicated specifically for CPD, the aged care providers may choose not to invest sufficiently in training, even though it is part of their obligation under the Aged Care Quality Standards to employ a workforce that is "skilled and qualified to provide safe, respectful and quality care services"[17]. If professional development and training requirements are placed solely on PCWs, that may be a demotivating factor forcing them to exit the sector.

Evidence shows that for many PCWs accessing training during working hours may be impossible due to lack of time and work obligations[18,19]. If the burden of CPD is placed solely on PCWs, and they are expected to undertake CPD in their own time and at own cost, this could mean opting for shorter, less costly courses that do not provide sufficient training. As the consultation paper acknowledges, this could lead to many workers exiting the sectors, but also to de-incentivisation of workforce, higher turnover of staff and lack of opportunities for career progression for staff that are personally motivated to work in the aged care sector.

In the AMA view the Workforce and Quality and Ageing and Service improvement programs funded by Governments could be used for this purpose, with adequate funding, to ensure equity of access to training and registration[20]. Also, in our submission to the Royal Commission into Aged Care Quality and Safety, the AMA called on the Government to provide additional funding for specialised training of the aged care workforce, primarily PCWs. In the AMA view, this funding should cover a professional development leave option for those aiming to further develop their skills.

The AMA also fully supports the recommendation by the Counsel Assisting the Royal Commission into Aged Care Quality and Safety of establishing a portable training scheme that would enable PCWs to get credits for time spent working that could be used in lieu of the provision of training[21].

12. What are the other options for strengthening the CPD of PCWs and others delivering aged care?

As explained under question 11 above, one option would be for Government funding dedicated specifically to specialised training and CPD of PCWs that would cover the professional development leave options for those wanting to undertake CPD.

[17] Aged Care Quality and Safety Commission (2019), Aged Care Quality Standards
[18] Royal Commission into Aged Care Quality and Safety (2019) Transcript of Proceedings 15.5.19 Pages 1685-86 29
[19] Rayner, J-A et al (2019) Research priorities in residential aged care services: A statewide survey Australasian J Ageing; 00: 1– 8
[20] In 2013-14 Government spending on Workforce and Service Improvement program was 0.3 billion, dropping to 0.1 in 2018-19, while the number of people accessing aged care services has been steadily increasing in the same period, and Government spending grew by 27%. More information available https://gen-agedcaredata.gov.au/Topics/Government-spending-on-aged-care
[21] Royal Commission into Aged Care Quality and Safety, Counsel Assisting Submission on Workforce, 21 February 2020, P73

13. How should the register of cleared workers be presented?

- **Option G1** – A list of workers who have been cleared to work in aged care (positive list)
- **Option G2** – A list of workers who have been excluded from working in aged care (negative list)
- **Option G3** – A list of workers who have been cleared to work in aged care and a list of workers who are excluded from working in aged care

The AMA supports the approach similar/same to NDIS, where a list of both cleared and excluded workers is available (option G3). Having a similar/same approach between the two systems could facilitate easier employment and transition of workers from NDIS to aged care and vice versa.

However, the AMA would like to warn that this approach may have broader implications for PCWs in aged care, particularly those in the vulnerable cohort, like refugees, migrant workers, international students, etc. Many of them have a personal motivation to work in the aged care sector, and for many of them aged care work is an opportunity to enter the job market in Australia[22]. Therefore, clear lines of responsibility within the aged care sector would have to be defined, in particular as to what constitutes a breach and under what circumstances should someone be added to the list of those excluded from working in aged care, as this may have broader implications for these workers, both professionally and personally down the track. The responsibility of the aged care providers for the wellbeing of recipients of aged care services must not be relegated in this process. For example, a PCW who is tasked with caring for an older person with dementia, without being trained to understand the symptoms, the behaviour of people living with dementia, how to manage dementia and reduce responsive behaviour etc, should not bear the sole responsibility for any accidents happening in their care. Responsibility should also lay with the aged care provider.

14. What are the advantages and disadvantages of different bodies managing screening of all aged care workers and/or registration of PCWs?

In the AMA view, the advantages and disadvantages are thoroughly elaborated in the consultation paper. They have also been explored by the Royal Commission into Aged Care Quality and Safety which identified significant gaps in the existing regulatory regime[23]. The Royal Commission recognised the importance of a consistent approach between worker registration in NDIS and aged care, and even their combining, accepting that their purposes are very similar. The AMA supports this finding by the Royal Commission.

The Review of National Aged Care Quality Regulatory Processes examined why aged care regulatory processes did not prevent the failures of the Oakden Older Persons Mental Health

[22] See for example research by V. Colic-Peisker and Farida Tilbury (2006) Employment Niches for Recent Refugees: Segmented Labour Market in Twenty-first Century Australia, Journal of Refugee Studies Vol. 19, No. 2, Oxford University Press that discusses aged care as a booming industry that creates a "labour market segment staffed by immigrants, and especially those assigned a subordinate position in society on the basis of race, ethnicity and 'culture'", or research by Goel K, Penman J. Employment experiences of immigrant workers in aged care in regional South Australia. Rural and Remote Health 2015; 15: 2693.

[23] Royal Commission into Aged Care Quality and Safety (2020) Transcript of Proceedings 21.02.2020, P-7888

Service[24]. The three-way division of regulation (The Department of Health, the Quality Agency, and the Complaints Commissioner) that was recently replaced by the Aged Care Quality and Safety Commission as a result of the Review is an example of what can occur if there is a lack of consistency or communication between regulatory bodies. The findings of this Review must be thoroughly considered when deciding which body will manage the screening/registration of PCWs. Coordination between regulatory bodies is absolutely critical to the quality and safety of the aged care system.

15. In principle, should a person cleared to work with people with a disability be automatically cleared to work in aged care?

Yes, with the assumption that NDIS and aged care registration processes are aligned.

16. Are there any other clearances that should support automatic clearance in aged care?

No comment.

17. What are the relevant considerations regarding the interplay between AHPRA (and any other professional registrations) and PCW registration for aged care?

The AMA opposes PCWs being regulated by AHPRA, for reasons that range from aged care practice and policy, to practicalities of AHPRA systems and processes.

All professions that are on the AHPRA register list require tertiary education and qualifications and have extensive requirements for continuous CPD[25]. The option considered by this paper for the acquired level of education for PCWs is the Certificate III level education and care qualification, which is significantly below the qualifications for all other professions assessed by AHPRA.

For example, to become a nurse, a person has to go through three years of university education, including continuous exposure to clinical work during those three years. Therefore, without the presence of a medical practitioner, nurses in aged care are the only staff uniquely qualified to provide clinical care in aged care. The AMA has consistently called for an increase in the number of nurses working in aged care and the availability of registered nurses in RACFs 24/7. In the AMA view PCWs provide personal care in aged care, they are not trained nor equipped to provide nursing care to residents. Having PCWs regulated by AHPRA could lead to confusion and conflating of professions and roles in aged care that are evidently different.

Registration with AHPRA requires mandatory indemnity insurance which will be costly to PCWs who, as the Consultation Paper points out, work on an average annual wage of

[24] Department of Health (2017) *Review of National Aged Care Quality Regulatory Processes*.
[25] AHPRA (2020) Registration standards

$35,828.00. Additionally, indemnity insurance for nurses for example covers the duty of care and making relevant decisions pertaining to care of their patients for which they are professionally and legally liable. Although the introduction of establishment of a national registration scheme for PCWs is expected to introduce the concept of individual responsibility for care of older persons in aged care, it should be noted that PCWs in aged care should and do work under supervision and should not be expected to make isolated decisions about the personal care of older people in their care. The risk of going down this path entails potential transfer of liability for care from aged care providers to individual workers. Any future registration scheme will have to strike a balance between the responsibility of aged care providers and PCWs regarding care provision. This will also depend on the consumer complaints processes in the future and whether they are amended as a result of the worker registration scheme.

Importantly, there are several steps to be considered before a group of professionals can be added to the list of registered professions by AHPRA. PCWs would first have to establish a formal association, then a national board for PCWs would have to be established, etc. These are all steps in a process that require significant time and financial investments. For example, in 2016 it was estimated that it would cost about $8.2 million to register social workers with AHPRA, including the fixed cost of establishing a board which was estimated to be around $1.4 million[26]. The campaign by the Australian Council of Social Workers that started in 2012 to establish a process for registration of social workers with AHPRA[27] which has to this date been unsuccessful[28].

Conclusion

The AMA thanks the Department of Health for the opportunity to provide feedback to the consultation on Aged Care Worker Regulation Scheme. The AMA sees personal care worker regulation as one of the key steps in improving the quality of care provision in aged care. The process of developing a policy approach to this important issue requires detailed consideration in order to ensure that outcomes of the process are to the benefit of both the older people receiving aged care services and the personal care workers.

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[26] Delloite Access Economics (2016) The Registration of Social Workers in Australia
[27] Australian Association of Social Workers, National Registration and Accreditation Scheme
[28] Australian Association of Social Workers, Latest campaign actions - Registration of social work