CATHOLIC HEALTH
Australia

AGED CARE WORKER REGULATION SCHEME
RESPONSE TO SURVEY QUESTIONS

Introduction

This paper responds to the online survey questions posed in association with the Aged Care Worker Regulation Scheme Consultation Paper.

In responding to the issues raised in the survey questions, Catholic Health Australia notes that it has done so without the benefit of full information on the administrative costs associated with the numerous options for the configuration of an aged care worker regulation scheme, and its potential relationship with other related employee regulation schemes.

Policy decisions as to how the various options might be paid for by government, employers or employees is an important consideration in deciding on the most appropriate configuration of any scheme. Inevitably, policy decisions will also involve a trade-off between policy purity and cost ie value for money, and who pays. Accordingly, the responses and issues below will be subject to further consideration and refinement in the light of the costs of various options and who pays for them.

Catholic Health Australia also notes, as acknowledged by the Consultation Paper, that aged care worker regulation encompasses a broad range of components and that the detail in the Consultation Paper often interchanges references to both screening and registration processes and administering bodies.

As a guiding principle, Catholic Health Australia notes that screening and registration of aged care workers are processes that do not necessarily have to be undertaken by the same body.

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)

Catholic Health Australia supports a centralised assessment of criminal history for aged care workers (Option A2) as it provides a nationally efficient and effective basis for administering the screening function of a worker regulatory scheme. Centralised assessment of criminal history for aged care employees would also enable the application of consistent risk assessment criteria and a more equitable engagement process for future staff, would reduce risks and recruitment delays for employers, and would provide a greater level of assurance for the public and the consumer.

Currently aged care providers have to assess the risk of employing staff on the basis of police certificate records alone which, other than significant criminal offences, have limited information on non-precluding offences and the time lapse since offending.

2. Are there other options that should be considered?

Option 2A above proposes the NDIS model whereby the screening function is undertaken separately by state/territory-based Worker Screening Units (WSUs). WSUs also perform a workforce screening role for other health and community sectors, thereby enabling a concentration of screening/assessment expertise and scale economies.

Given that the aged care workforce is likely to more than treble over the next decade to almost one million employees, and the increasing profile of aged care as an industry, Catholic Health Australia supports the establishment of a dedicated registration arrangement for aged care based on the model that separates screening and registration. It would also be more efficient for the aged care registration process to access WSU workforce screening and assessment expertise. The aged care specific workforce registration arrangements could fall under the APRHA umbrella.

The establishment and funding for a dedicated aged care registration arrangement would need to be the responsibility of Government, not PCWs, as their low income levels would prohibit costly registration fees.

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

Catholic Health Australia considers that it is preferable that information from all four options should be taken into account as part of the screening and assessment process, including relevant information obtained through the recently announced Serious Incident Reporting Scheme.

While collecting information from employers might be challenging (Option B4), better access to relevant information about individual employees will ultimately benefit the sector by enabling a more comprehensive screening process. For example, a difficulty with the current system is that reports of abuse rarely result in criminal conviction and therefore do not feature in police checks. A scheme that can capture staff terminations due to incidents of abuse or unacceptable patterns of conduct (eg contrary to a code of conduct) would assist with protecting aged care recipients from workers moving to another provider.

Option B4 will require, however, specific and consistent standards for employer assessment and reporting of employee misconduct, including the need to avoid reverse discrimination ie unwarranted negative assessments by employers. Such a scheme would require a strong appeal mechanism, such as the Victorian reportable conduct scheme for children.

Practically, however, the design of any aged care worker regulatory scheme will need to have regard to the cost of administering such a comprehensive arrangement, including implications for the timeliness of assessments (and hence the elapse time for the registration of workers). Further information about these administrative aspects is required to enable full consideration of the

practicalities and cost effectiveness of including all of the other matters referred to above, including consideration of who meets the costs involved.

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

Catholic Health Australia supports a requirement that all staff employed in Commonwealth subsidised aged care services who have regular contact with aged persons, should be screened.

This requirement should also include volunteers. Catholic Health Australia notes that most of its provider members already require police checks for volunteers, but reimburse the costs incurred by volunteers undergoing a police check.

An exception to screening that could be considered is students who are in placement across aged care given the prohibitive costs involved for students and the low risk given the supervision required.

5. What is your preferred approach to a code of conduct?

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

Catholic Health Australia supports the development of a code of conduct specific to aged care workers as it will provide greater clarity and consistency across the sector and contribute to lifting the profile and professionalism of the aged care workforce (Option C3). The key objective of Option C3 will be to draw a new model baseline for an aged care code of conduct across the sector.

In the public's mind, there is generally little association between disability and aged care services, nor their workforces, which would warrant a common code of practice across both.

Catholic Health Australia notes, however, that many providers across residential and home-based care already have codes of conduct for their staff, a process that is intrinsic to developing and maintaining a staff culture which contributes to and supports their brand identity and mission.

It will be important therefore that, while meeting the standards of a sector-wide code of conduct, providers should also have the flexibility to enhance and shape the code to reflect the culture and mission of their organisation.

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

A code of conduct specific to all aged care sector employees would set a consistent baseline for the sector and would provide a level of assurance for the public and consumers. It would also contribute to developing the professionalism and public profile of the aged care workforce.

Having a consistent code of conduct across the aged care sector would provide a benchmark for investigation of worker misconduct in a more equitable and nationally consistent manner, including in relation to screening processes under a worker regulatory scheme managed by a dedicated aged care registration body.

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)

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

Catholic Health Australia supports Option D1 which requires providers to be satisfied that PCWs have the necessary English proficiency to effectively perform their role. While there needs to be a certain level of competency in English, all aged care staff also need to be able to communicate and document interactions as a fundamental requirement of working in aged care. This is best established at interview and, if necessary, during a probationary period, and may be complemented by arranging additional training.

Having an English proficiency test for all PCWs as a requirement for registration may be a disincentive for people seeking to join the aged care workforce at a time when the sector will be needing to expand its workforce. Providers need to satisfy themselves as to the adequacy of each person's communication skills to suit local needs and circumstances, including through the use of technology. It is also the case that many providers arrange for staff to attend English language courses, either delivered in-house or through a Registered Training Organisation.

Catholic Health Australia also notes that in many cases a proficiency in a language other than English will be necessary to communicate effectively with older people of non-English speaking background, or with people living with dementia who have reverted to using their native language. Having this capability in an aged care home will be just as important in some aged care homes as English proficiency.

Finally, if there were to be an English proficiency test for PCWs, it needs to be tailored to the circumstances and communication needs for the effective delivery of personal care, not a generic test or a test applicable to clinical practice.

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

If proficiency in English were to be introduced as a requirement for PCWs, there is a case for exemptions for ethno-specific services where command of a language and idioms other than English is important to the provision of quality care.

It is inevitable that Australia will need to rely increasingly on overseas born PCWs if Australia is going to meet its expanding aged care workforce requirements. Accordingly, facilitating access by aged care workers from non-English speaking backgrounds to communications skills training courses developed specifically to meet the interpersonal and intercultural skills necessary to assist an older person effectively would be a useful initiative for the Commonwealth to pursue. **The Little Things** project currently being undertaken in Victoria to examine communication skills training for PCWs from culturally and linguistically diverse backgrounds is an example that should be considered further. This project is being undertaken by a consortium which includes the Victorian Department of Education and Training, Meaningful Australia and the Farnham St Neighbourhood Learning Centre.

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)

Catholic Health Australia supports Option E3 as it would provide a national baseline for qualifications for PCWs. Implementation of Option F3 would require considered and ongoing review to assess the distribution of course content across entry-level requirements and CPD, including in response to the evolution of best practice and technology.

Implementation of Option E3 would also require careful transition strategies to be developed with consideration of grandfathering arrangements where it is assessed that PCWs already meet minimum qualifications eg long service experience and recognition of prior learning.

Catholic Health Australia notes that having minimum qualifications is only one input to a successful recruitment decision. The assessment of diligence, aptitude, emotional intelligence and values as part of an interview process, and tested through a probationary period, is an essential part of a recruitment decision. Employers therefore will often focus recruitment on employing compassionate people with a desire to care for older people, and then train them for the skills required. In order to accommodate this approach, registration under Option E3 should be extended to include, as a separate class, PCWs who are enrolled for a Certificate III.

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

Providers would still be expected to encourage and facilitate ongoing professional development for PCWs.

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)

Catholic Health Australia supports both Options F1 and F2 as it allows providers to not only work with individual PCWs to determine their specific training needs and identify appropriate CPD to address these needs as outlined in Option F1, but also would make all providers accountable for ensuring that their PCWs have undertaken the minimum CPD.

A consideration under these options will be who pays for the delivery of minimum CPD requirements. It is unlikely given that PCWs are amongst the lowest paid employees in Australia, that training costs could be imposed on PCWs, thereby leaving the responsibility with employers. The funding system for aged care providers would need to recognise the costs of ensuring that all PCWs achieve minimum CPD requirements.

Another consideration is specifying the minimum auditable CPD requirement that would apply.

In recommending Options FI and F2, Catholic Health Australia recognises that personal care and clinical care roles are different, with the latter requiring more expansive CPD requirements to ensure currency of skills.

If Option F3 were to be pursued, the requirement to monitor and ensure that PCWs have completed CPD requirements should rest with the registration body. This approach would provide national consistency and would be consistent with the administration of CPD by AHPRA.

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

One means of strengthening CPD for PCWs is to clarify that CPD is an accountable expectation under the Quality Standards. This approach is more likely to result in a more consistent sector-wide effort by all providers to ongoing skills development. Placing responsibility for delivering CPD for PCWs only as in Option F1 may limit PCW access to CPD and some providers' commitment to CPD.

Another means for strengthening CPD for PCWs is for the Commonwealth to fund courses targeting emerging skill needs or best practice requirements. Such priority courses could be identified by the Aged Care Workforce Industry Council. A precedent for this approach was the Commonwealth making online infection control courses available in the COVID-19 pandemic context. Such courses could be made mandatory.

A variation on the above approach would be to fund providers according to the number of PCW employees to deliver CPD, on the condition that CPD expenditure is acquitted.

13. How should the register of 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

Consistent with other schemes such as AHPRA and the NDIS scheme, it would be preferable for the register of workers to include both a positive register and an exclusion list (Option G3) as this would provide more comprehensive information.

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

AHPRA administers the registration of health professionals with clinical scopes of practice that work in a variety of settings, including registered nurses and certain allied health professionals that work,

inter alia, in aged care. It would be efficient for AHPRA-registered health professionals to qualify automatically under an aged care worker regulation scheme.

However, given that the skills and knowledge of PCWs are specific to the needs of caring for older people, it would be more appropriate for PCWs to be included in a single dedicated registration arrangement to ensure a single source of information which is demonstrably associated with the aged care industry by all. It is relevant in this regard that a new dedicated aged care registration arrangement under the AHPRA umbrella, or as a separate body, would be expected to provide a registration role for a workforce that is projected to number approximately one million employees within 30 years.

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

A person registered to work with people with a disability should only be automatically registered to work in aged care if the screening and registration requirements to work in the disability sector either meet or exceed those that apply to an aged care worker regulatory scheme.

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

It would be sensible for health practitioners, including nurses and allied health practitioners, who have gained registration with AHPRA to be eligible for automatic registration in an aged care worker regulation scheme. However further information is required to ascertain the comprehensiveness of the screening process that AHPRA relies upon and whether it meets the requirements that is implemented for PCWs.

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

Relevant considerations include the following:

- AHPRA administers registration of health practitioners through an Intergovernmental Agreement that is costly to administer, including the need to agree and maintain nationally consistent legal requirements and National Boards, whose costs impact annual registration fees.

- AHPRA'S focus is the registration of health practitioners with a clinical scope of practice, including an emphasis on the quality and scope of tertiary education courses and rigorous CPD requirements to maintain currency of clinical skills and registration. It is questionable whether given the skill requirements and personal care nature of the work of PCWs whether such a rigorous and demanding process is necessary for PCWs. The training and skills requirements of PCWs are subject to those applying to the Vocational Education Training Sector, not the higher education sector and relevant National Boards that apply for most health practitioners.

- Currently AHPRA registers nurses and could continue to do so. However screening and registering over 108,000 current PCWs (whose number is projected to grow significantly) would represent a major change to the modus operandi and administrative focus of AHPRA, though a case can be made for having a single body to manage both health practitioner and PCW registration in that all are concerned with caring for vulnerable people.

- PCWs are neither as well paid as health practitioners nor could be expected to pay annual fees to maintain their registration. PCWs will find a requirement to pay annual registration fees a barrier to aged care employment. Unlike health practitioners, the cost of an aged care

regulatory scheme should be met by the Commonwealth as part of the cost of a quality regulatory framework.

Catholic Health Australia
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