

Chapter 3

Attracting, training, and retaining aged care workers

...to ensure quality care, aged care services must have adequate numbers of skilled, qualified staff committed to providing person-centred care. The workforce must have appropriate education, training, skills and attributes to provide quality care for older people, including people with dementia, who frequently have complex care needs. To attract and maintain the right workforce, equitable pay conditions and appropriate career paths will be needed.¹

3.1 As Australia's aged population continues to grow, demand for aged care workers will also grow. This creates opportunities for people looking to pursue a career in aged care, but also creates challenges for the sector in attracting, training and retaining a sufficient workforce. Indeed these challenges are already being faced across the sector with providers reporting skills shortages and significant difficulties recruiting and retaining appropriately qualified staff. In order to meet future needs it will be crucial for the sector to adapt and adopt strategies that will ensure it is able to attract and retain a highly skilled and well trained workforce.

3.2 This chapter examines:

- the key challenges in attracting and retaining workers to the aged care sector;
- staffing ratios in residential aged care facilities; and
- the adequacy of training provided by Registered Training Organisations (RTOs).

Key challenges in attracting and retaining workers

3.3 As discussed in Chapter 2, the aged care workforce needs to grow by about two per cent annually in order to meet future demand. However, evidence received by the committee indicates that the aged care sector is already struggling to attract and retain skilled workers. This presents significant challenges for the sector in developing its workforce now and into the future.

3.4 Submitters argued that the key challenges in attracting and retaining workers arise from:

- poor sector reputation;²
- poor working conditions, including high client-staff ratios;³

1 Professor Graeme Samuel, Alzheimer's Australia, *Committee Hansard*, 3 November 2016, p. 29.

2 See, for example: Mrs Anne O'Reilly, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 5; Occupational Therapy Australia, *Committee Hansard*, 25 October 2016, p. 1; Mr Graham Kraak, Queensland Health, *Committee Hansard*, 23 February 2017, p. 11.

- a lack of career paths and professional development opportunities;⁴ and
- low rates of remuneration⁵.

3.5 These challenges are particularly acute for care providers in regional and remote areas of Australia, which submitters suggested experience additional 'challenges in accessing the necessary workforce to provide services to older Australians living in these areas'.⁶ The particular challenges faced by regional and remote care providers are discussed in Chapter 4.

Reputation

3.6 The committee heard that the poor reputation and perceptions of the aged care sector are major barriers to recruiting and retaining newly qualified graduates and people looking for work in the health and community sectors.

3.7 Professor Melanie Birks from James Cook University described to the committee the negative perceptions around aged care work:

...there is a perception that aged care nursing is less glamorous than nursing in the acute care sector. This perception is fed by a belief that nurses working in an aged-care setting require a lower skill set than those working elsewhere, and often there is this perception...that nurses who work in aged care work there because they could not get another job in another setting.⁷

3.8 These perceptions appear to develop early, with many nursing students indicating that they do not view aged care as an attractive career choice.⁸

3.9 For example, the Healthy Ageing Research Group (HARG) from La Trobe University submitted that undergraduate and graduate nurses generally prefer not to work in aged care settings.⁹ Some submitters attributed such preferences to a lack of

3 See, for example: Mr Tim Jacobson, Health Services Union, *Committee Hansard*, 28 April 2016, p. 9.

4 See, for example: Queensland Heath, *Committee Hansard*, 23 February 2017, p. 11; Northern Regional Aboriginal and Torres Strait Islander Corp., *Committee Hansard*, 23 February 2017, p. 19; Palms Aged Care, *Committee Hansard*, 23 February 2017, p. 2; MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 2; Southern Cross Care for Facility Pearl Supported Care, *Committee Hansard*, 25 October 2016, p. 10.

5 See, for example: MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 2; Southern Cross Care for Facility Pearl Supported Care, *Committee Hansard*, 25 October 2016, p. 10; Occupational Therapy Australia, *Committee Hansard*, 25 October 2016, p. 12; Anglicare Australia, *Committee Hansard*, 3 November 2016, p. 21; NSW Nurses and Midwives' Association, *Committee Hansard*, 3 November 2016, p. 54.

6 Aged and Community Services Australia, *Submission 229*, p. 2.

7 Professor Melanie Birks, James Cook University, *Committee Hansard*, 23 February 2017, p. 46.

8 See, for example: Professor Melanie Birks, James Cook University, *Committee Hansard*, 23 February 2017, p. 46; Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 8.

9 Healthy Ageing Research Group, *Submission 237*, p. 8.

exposure to aged care practice in clinical placements and poor understanding of aged care as a complex specialist environment.¹⁰

3.10 Benetas, a not-for-profit aged care provider in Victoria, submitted that 'the reputation of the Aged Care sector needs to be repositioned'.¹¹ Aged Care Illawarra Action Group (ACIWAG) agreed, submitting that aged care work needs to be promoted as highly skilled and rewarding, with multiple opportunities for career advancement.¹² Services for Australian Rural and Remote Allied Health (SARRAH) suggested a marketing campaign that highlights the benefits of working in aged care, would assist to attract a workforce, particularly in regional and remote areas.¹³

3.11 These and other submitters argued that Government has an important role in assisting to reposition the reputation of aged care within the health and community services industry.¹⁴ ACIWAG suggested that government and industry should work together to increase the profile of aged care by building on the work already being undertaken by ACIWAG in a regional context:

ACIWAG has responded to the competition for workers through the kinds of marketing collateral developed, a vibrant social media presence and the conduct of an annual Careers Expo for the sector. This work at a regional level could be greatly enhanced if supported by government initiatives that reinforced its key messages.¹⁵

3.12 However, submitters also noted the importance of ensuring that the sector attracts the 'right' type of workers.¹⁶ Submitters argued that people not only require the appropriate subject matter knowledge and practical competencies to be suited to work in aged care, but must also possess the necessary soft skills required by the

10 See, for example: Dementia Training Study Centres, *Submission 76*, p. 3.

11 Benetas, *Submission 78*, p. [2].

12 Aged Care Illawarra Workforce Action Group, *Submission 148*, p. [2].

13 Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 3 November 2016, p. 13.

14 See for example, Benetas, *Submission 78*, p. [2]; Aged Care Illawarra Workforce Action Group, *Submission 148*, p. [2].

15 At a regional level ACIWAG has been working to 'enhance community awareness about the Aged Care sector and improve its visibility in the community' through the Illawarra Regional Workforce Planning Strategy for the Aged Care Sector. The strategy involves a wide range of promotional activities, including production of promotional material, conducting career expos, promoting government programs and using social media platforms to advance the aged care sector. See: Aged Care Illawarra Workforce Action Group, *Submission 148*, p. [2].

16 Illawarra Forum, *Submission 212*, p. [7].

work.¹⁷ Such soft skills include communication, empathy, and ability to work as a member of a team.¹⁸

3.13 For example, Jewish Care Victoria submitted that some people only choose to work in aged care because they are unable to find work elsewhere:

There is a cohort of those drawn to do a Certificate III in aged care because they cannot find jobs in their preferred field or their qualifications (obtained overseas) are not recognised in Australia...These workers are often frustrated and demotivated doing roles that they deem 'beneath them' due to the poor perception of aged care work. This sometimes has ramifications in terms of the quality of care they provide...¹⁹

Committee view

3.14 The committee notes the concerns raised by aged care workers and providers about the poor reputation attached to working in the aged care sector, and the impact this has on attracting and retaining workers in the sector.

3.15 The committee also notes some of the innovative approaches being taken to try to change the negative image of the aged care industry.

3.16 The committee further notes that, underlying this negative image, are some key workforce factors outlined below, that, if addressed, would also help to change how potential aged care workers view the industry.

Working conditions

3.17 The aged care sector is generally associated with poorer working conditions than comparable areas of the health and community services sector.²⁰

3.18 The committee heard evidence from several nurses and personal care workers who described aged care as an unhappy and stressful environment in which to work due to:

- high resident to staff ratios, resulting in high workload pressures;²¹
- low registered nurses to personal care attendant ratios;²²
- working longer hours to cover staff shortages;²³ and

17 See, for example, Dr Richard Curtin, Public Policy Consultant and Visiting Fellow, Australian National University, *Submission 168*, p. 11; Dr Michael Bauer, Australian Centre for Evidence Based Aged Care, La Trobe University, *Committee Hansard*, 28 April 2016, p. 28.

18 See, for example: Dr Richard Curtin, *Submission 168, Attachment one*, p. 11; Department of Health, *Submission 293*, p. 51.

19 Jewish Care Victoria, *Submission 109*, p. 4.

20 Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 10.

21 See, for example: Name withheld, *Submission 10*, p. 2; Name withheld, *Submission 66*, p. 2.

22 See, for example: Ms Marilyn Murray, *Submission 39*; Name withheld, *Submission 224*, p. 3.

23 See, for example: Name withheld, *Submission 81*, p. 1; Name withheld, *Submission 161*, p. 2; Name withheld, *Submission 257*, p. 1.

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- an increase in strenuous activity, and workplace injury (related to an increase in complex care needs).²⁴

Workload pressures

3.19 The committee received evidence that direct care workers are managing workloads that are unsustainable, leading to compromised professional standards and quality of care, as well as adverse impacts on workers.

3.20 Nurses working in aged care expressed particular concern about their ability to manage workloads as well as supervise other staff. For example, the Queensland Nurses' Union submitted that as the numbers of RNs on shift at any one time has declined, increased workloads have been placed on remaining RNs to supervise a greater number of carers, diminishing RNs ability to provide quality care to patients.²⁵

3.21 The Australian Nursing and Midwifery Federation (ANMF) included in its submission short statements from some of its members who described the workload pressures for nurses in residential care:

I am still unable to leave my section in the morning between 6-7am as there is no staff member to supervise the section, if I ask for help from another staff member then that staff member will be leaving their section unattended and they also will not be able to complete their round compromising resident care.

I am unable to safely complete my clinical responsibilities to residents. One section upstairs is not safe for only one staff member to work there, the residents are highly confused/delirious and are at high risk for falls. Wanderers, aggressive and physically abusive toward staff and other residents, they are mostly needing two staff to assist with care, and there is only one staff member to look after them all.²⁶

3.22 Mrs Sonya Peck, an RN and member of the ANMF also explained to the committee at its Launceston hearing, the immense workload pressures and competing priorities nurses in residential facilities face:

As registered nurses we look after up to 36 patients per wing. From the time the nurses hit the floor they are running to have their handover, count medications, get their pill rounds started, and do their wound care and direct staffing care. They are just the general aspects. You also have admissions. For example, in the last few weeks we have had seven new admissions to one wing. It really did put a great deal of extra workload onto the registered nurses to complete all the paperwork in a timely manner and to get the ACFI funding assessments started. It also took time away from direct

24 See, for example: Presbyterian National Aged Care Network, *Submission 190*, p. 4; Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 10; Mr Tim Jacobson, Health Services Union, *Committee Hansard*, 28 April 2016, p. 9; Doctor Jodi Oakman, La Trobe University, *Committee Hansard*, 28 April 2016, p. 14.

25 Queensland Nurses' Union, *Submission 215*, p. 4.

26 Australian Nursing and Midwifery Federation, *Submission 225*, p. 22.

patient care, because you only have so many hours to do that care and then you have to move on to your paperwork...

Nurses do not take breaks. They are unpaid for their half-hour meal breaks and very rarely do any of our nurses take it, because they cannot get through their workloads. The cuts at the moment are also impacting on our work. We are having to do extra pain management – to make sure our residents are not in pain, we have added massages which the physios were doing – and that is an extra 40 minutes plus a day that can be added into the nurses' time...Most of the residents do not finish on time; most of the nurses are rostered off dayshift to finish at 2.45 but you can still see the bulk of them sitting there from 3.30 to 4 o'clock completing paperwork and patient care. They are not paid for that time – it is not authorised overtime – but they are not willing to walk away and leave care, even though they may be directed to hand it over. The next shift is also extremely busy. We cannot do all the work we are expected to do in our time frame. Sometimes you are actually threatened with disciplinary action if you do not complete what is expected of you on your shift. They are not giving you new strategies on how to fit this workload in.²⁷

Workplace health and safety

3.23 The incidence of workplace injuries has increased as the needs of patients have become more complex and workload pressures have risen. For example, the Health Services Union (HSU) told the committee that physical injury rates, such as back, neck and shoulder injuries, are high, but that mental health issues are also increasing, largely due to high workload and stress related issues.²⁸

3.24 The HARG noted that residential work in particular is recognised as being physically and emotionally demanding, which can lead to risks to employee health and wellbeing. Such risks may include development of work-related musculoskeletal disorders, low job satisfaction and poor health.²⁹

3.25 In its submission the Health Workers Union (HWU) noted that it has represented members who have sustained injuries and musculoskeletal disorders from aged care work. While manual handling aids are available to avoid such injuries, the HWU suggested they are not being widely utilised because there are insufficient staff to help operate the devices, causing workers to lift and transport patients without proper supports.³⁰

27 Mrs Sonya Peck, Australian Nursing and Midwifery Federation, *Committee Hansard*, 31 October 2016, p. 11.

28 Mr Tim Jacobson, National Assistant Secretary, Health Services Union, *Committee Hansard*, 28 April 2016, p. 9.

29 Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 10.

30 Health Workers Union, *Submission 248*, pp. 46-47.

3.26 The HWU also noted that it has received reports from its members that some clients also direct verbal and physical abuse toward staff, which can also lead to injury.³¹

3.27 The New South Wales Nurses and Midwives' Association (NSWNMA) echoed these concerns, submitting that:

Over 90% of 'aged care workers had been subject to some form of aggression from residents so it is unsurprising that workers are not only demotivated to work in aged care, but quickly seek alternative employment in lower risk environments.³²

3.28 An example of the injuries and abuse workers in aged care facilities may experience was provided by Ms Jude Clarke, a delegate of United Voice, at the committee's hearing in Perth:

My injuries over the years – I have had broken wrists from residents grabbing on, saying, 'No I don't want to be moved. I don't want to shower. I'm not going to eat,' so they grab your wrists. Your wrists get pretty tender after a while, so I have had both wrists broken quite a few times. I have my arm pulled out of its socket and ribs taken off the front and back by that injury. That took me two years to come back from...

...I have been stabbed with scissors. I have been stabbed with forks. I have been pushed, punched, kicked, had hair pulled out... That is the risk that we take every day when we are out on the floor.³³

3.29 Professor Yvonne Wells, Coordinator at the HARG, told the committee that the working environment in aged care facilities, particularly the physical and emotional demands of the work, impacts staff attrition, attraction and retention, and provision of quality of care.³⁴

Committee view

3.30 The committee is concerned at the evidence presented to it in relation to poor working conditions and threats to workers' health and safety, which the committee has heard are impacted by issues including insufficient staffing levels and the need for existing staff to cover staff shortages. These issues in turn impact on the quality of care, and contribute to the poor reputation of the industry.

3.31 The committee considers poor working conditions an urgent matter given the impacts on the need to grow and sustain the aged care workforce and on the ability of staff to deliver a standard of care expected by the community.

31 Health Workers Union, *Submission 248*, pp. 46.

32 NSW Nurses and Midwives Association, *Submission 134*, p. 19.

33 Ms Jude Clarke, United Voice, *Committee Hansard*, 27 September 2016, p. 50.

34 Professor Yvonne Wells, Healthy Ageing Research Group, *Committee Hansard*, 28 April 2016, p. 13.

Lack of career paths

3.32 Lack of clear career paths and opportunities for professional development were cited by various submitters as disincentives for people to work and stay in the aged care sector.³⁵ This was felt across a broad range of skill levels, from personal care workers through to nurses and allied health professionals.³⁶

3.33 For example, JewishCare Victoria submitted:

Career paths are not well defined or articulated for most aged care workers and there is an inconsistent approach within the industry for career and succession planning that feeds into a public perception of a 'dead end' career.³⁷

3.34 The Quality Aged Care Action Group Incorporated also argued that 'there is no career pathway in aged care', and suggested that workers are not rewarded for seeking to enhance their qualifications:

Those workers who do gain extra qualifications in palliative care or gerontology do not get any extra pay, even if they achieve post graduate qualifications. We want to encourage expert knowledge in aged care but we don't reward or value it.³⁸

3.35 Doctor Linda Isherwood, Research Fellow at the National Institute of Labour Studies commented that qualitative research and interviews of nurses and personal care workers in aged care showed that workers 'did not feel there were sufficient career pathways once you were in aged care' and were keen to upskill and assume more responsibility, such as supervisory roles or more clinical responsibility.³⁹

3.36 The NSWNMA agreed, submitting that many workers are passionate about working in aged care, but 'feel stifled in their roles due to a lack of a structured career pathway and very few nurse practitioner and/or leadership opportunities'.⁴⁰ Ms Brenda Oganyo from United Voice also told the committee that 'there is zero progression for the personal-care workforce within the industry'.⁴¹ One of the biggest challenges for aged care workers in respect of career progression appears to be the lack of 'expert roles' which they can strive to progress towards.⁴²

35 See, for example: Mrs Hazel Gordon, Wattle Hill Lodge Inc, *Committee Hansard*, 28 September 2016, p. 30.

36 See, for example: Mrs Hazel Gordon, Wattle Hill Lodge Inc, *Committee Hansard*, 28 September 2016, p. 30.

37 JewishCare Victoria, *Submission 109*, p. 4.

38 Quality Aged Care Action Group Incorporated (QACAG Inc), *Submission 182*, p. 4.

39 Doctor Linda Isherwood, National Institute of Labour Studies, Flinders University, *Committee Hansard*, 7 March 2017, p. 46.

40 NSW Nurses and Midwives' Association, *Submission 134*, p. 20.

41 Ms Brenda Oganyo, United Voice, *Committee Hansard*, 27 September 2016, p. 51.

42 NSW Nurses and Midwives' Association, *Submission 134*, p. 20.

Mechanisms to address lack of career paths

3.37 Queensland Health suggested that a career structure in aged care would help to attract more workers to the sector. Queensland Health explained to the committee the career structure that it currently has in place:

We have nurse unit managers, clinical nurse consultations and registered nurses providing clinical support. They are also linked into hospitals and can access the clinical services that are needed. The aged care industry does not have that. I think those are the sorts of things that would make the aged-care sector a bit more of an attractive service to come to.⁴³

3.38 Representatives of James Cook University agreed that a career structure for aged care workers would make the sector more attractive for people who want to pursue a career in nursing. Ms Jennifer Davis suggested a model which offers a graduate entry program into aged care, and pathway opportunities into higher qualification, such as upskilling to a nurse practitioner.⁴⁴

3.39 The Australian Council of Trade Unions (ACTU) were also supportive of establishing a career structure for the sector, suggesting that pathway options to undertake specialised training, such as in dementia or palliative care, mentoring new entrants and graduates and developing career pathways linked to wage progression should all be examined as options.⁴⁵

3.40 The Department of Health (department) has stated that consideration of initiatives to establish career opportunities for people in the aged care sector is a matter for service providers and the industry to manage, and further that:

The department's view is that setting minimum standards and having lots of rules about how people should be employed and what mix and all those sorts of things actually creates some problems due to the diversity of what may be required by a small community-based provider in a remote community versus a large commercial provider in an urban centre. So there is not a one-size-fits-all model here.⁴⁶

Committee view

3.41 The committee notes that career paths in the aged care sector are not clearly defined, and play a role in the inability of the sector to attract and retain staff. While some providers rely on their own career structure initiatives to attract workers, there is an inconsistent approach within the industry to career planning and succession, with other providers offering limited or no career and development opportunities.

43 Mr Graham Kraak, Queensland Health, *Committee Hansard*, 23 February 2017, p. 13.

44 Ms Jennifer Davis, James Cook University, *Committee Hansard*, 23 February 2017, p. 48.

45 Australian Council of Trade Unions, *Submission 254*, p. 4.

46 Ms Catherine Rule, Acting Deputy Secretary, Department of Health, *Proof Committee Hansard*, 13 June 2017, p. 3.

3.42 The committee commends those providers who have established their own career structures and continuing professional development models for their staff. The committee agrees that such models should be explored to identify best practice models that could be replicated nationally across the industry.

Remuneration

3.43 Aged care workers, both skilled and semi-skilled, are paid significantly less than similarly qualified workers in comparative sectors. The wage disparities between the aged and acute care sector, for example, cause many nurses and PCAs to feel undervalued and underpaid in their roles.⁴⁷

3.44 Submitters highlighted the low rates of remuneration as one of the key barriers to recruiting and retaining workers in the aged care sector.⁴⁸

Nurses and personal care workers

3.45 Individuals and organisations submitted that the remuneration rates for nurses and personal care workers in aged care are:

- less than wages paid in the health and disability sectors for equivalent roles;⁴⁹ and
- not reflective of the value and responsibility of the work.⁵⁰

3.46 Remuneration for nurses in the aged care sector is significantly lower than for nurses working in the acute care sector. The committee received evidence that RNs and ENs are paid about 100 dollars less per week in aged care than acute care.⁵¹ The wage disparity between the two sectors creates significant difficulties for aged care providers to compete for nurses, and undervalues the important work of nurses in aged care.

3.47 For example, the ANMF commented that the low remuneration levels undervalue aged care work:

47 Australian Nursing and Midwifery Federation, *Submission 225*, p. 19.

48 See, for example: Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 9.

49 See, for example: Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 7; Australian Council of Trade Unions, *Submission 254*, p. 3; Queensland Nurses' Union, *Submission 215*, p. 9.

50 See, for example: Quality Aged Care Action Group, *Submission 182*, p. 4; Australian Nursing and Midwifery Federation, *Submission 225*, p. 18; Mr Tim Jacobson, Health Services Union, *Committee Hansard*, 28 April 2016, p. 7; Professor Sara Charlesworth, RMIT University, *Committee Hansard*, 28 April 2016, p. 19; Professor Melanie Birks, James Cook University, *Committee Hansard*, 23 February 2017, p. 49.

51 Doctor Ann Harrington, School of Nursing and Midwifery, *Committee Hansard*, 7 March 2017, p. 43. See also, WA Primary Health Alliance, *Committee Hansard*, 28 September 2016, p. 12. The Australian Nursing and Midwifery Federation also submitted that the wage difference between a full time registered nurse level 1 in the public sector compared to residential aged care is 200 dollars, or 15 per cent per week calculated on a base rate. See: Australian Nursing and Midwifery Federation, *Submission 225*, p. 19.

The pay for the majority of aged workers, both skilled and semi-skilled, simply does not reflect the nature of the work and the level of responsibility required nor does it value the importance of providing the best care possible to Australia's frail elderly.⁵²

3.48 The NSWNMA agreed that aged care work is undervalued stating that aged care workers are paid significantly less than people working in other sectors that require comparatively lower skills and training:

...across all comparable types of jobs people at the checkout get paid better than assistants in nursing; people who are supervising a small division get paid better than an assistant in nursing with a certificate III who is termed a team leader.⁵³

3.49 Unions and employee representatives have raised concerns that the changing aged care sector will adversely impact on the pay and conditions of aged care sector workers. For example, unions have noted that in the scheduled 4 yearly reviews of the Aged Care and Social, Community, Home Care and Disability Services Industry awards by the Fair Work Commission, which are currently under way, some employer groups have made submissions seeking to:

remove the requirement for a regular pattern of hours. In other words, a part-time employee, if they are successful with their award change, would only need to be given a minimum number of hours that is less than 38 but could be expected to work fluctuations on that, week-in week-out, day-in day-out, without considering the needs of that worker and their own caring needs or family responsibilities.⁵⁴

3.50 Further, Professor Sara Charlesworth of the School of Management at RMIT University argued that the introduction of CDC is being used by employer groups to argue for further eroding aged care workers' entitlements:

Aged Care Employers (ACE) argued in a submission to the Fair Work Commission that ACTU claims for some improvement of conditions for casual and part-time workers 'all run contrary to CDC in that they all reduce flexibility, increase regulation, increase costs and put significant barriers in the way of CDC'.⁵⁵

3.51 The committee has also heard about the growth in 'zero hour contracts', which seem to be increasingly used by aged care service providers instead of permanent, regular work contracts. United Voice, a union which represents a range of employee groups in the aged care sector, including personal carers, gardeners, cooks and cleaners, submitted that:

52 Australian Nursing and Midwifery Federation, *Submission 225*, p. 18.

53 Mr Brett Holmes, NSW Nurses and Midwives' Association, *Committee Hansard*, 3 November 2016, p. 54. See also: Mrs Anne O'Reilly, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 2.

54 Mr Robert Moore, Assistant State Secretary, Health Services Union Tasmania Branch, *Committee Hansard*, 31 October 2016, p. 19.

55 Professor Sara Charlesworth, *Submission 290*, p. 4.

Such contractual arrangements provide workers with no guaranteed weekly hours and thus no guaranteed weekly income. The employer is not obliged to provide the worker with any minimum working hours, and the worker is not obliged to accept any of the hours offered.⁵⁶

3.52 The committee heard that the impact of these kinds of contractual arrangements on both employees and the quality of care available to aged care service users can be significant. For employees, it can mean a high degree of uncertainty about income and hours to be worked, which in turn affects the ability to manage financial affairs and plan, placing 'particular strains on families'.⁵⁷ For people accessing aged care services, Professor Sara Charlesworth argued that:

Good quality care in both residential and community-case based settings requires a stable workforce, adequate staffing and an appropriate staff mix, as well as working conditions that allow workers the time to develop and maintain care relationships with the elderly and importantly to use their skills.⁵⁸

Allied health and medical professionals

3.53 The committee also received evidence from allied health and medical professionals that the aged care sector is not an attractive career choice due to the low rates of pay.⁵⁹

3.54 For example, at the committee's Melbourne hearing, the Royal Australian College of General Practitioners told the committee that general practitioners (GPs) receive higher pay when working in a clinic compared to an aged care facility, with estimates that 50 per cent of the work of GPs in residential care is unfunded.⁶⁰ The wage disparity between clinical and residential care, means that aged care work is often a last choice for AHPs and GPs.

Mechanisms to improve remuneration

3.55 To overcome issues regarding remuneration, submitters supported a strategic approach whereby the Australian Government works together with industry to develop a strategy to improve remuneration in the aged care sector.⁶¹ For example, Leading Aged Services Australia (LASA), a peak body for service providers, suggested that

56 United Voice, *Submission 247*, pp. 15-16.

57 Mr Robert Moore, Assistant State Secretary, Health Services Union Tasmania Branch, *Committee Hansard*, 31 October 2016, p. 23.

58 Professor Sara Charlesworth, *Submission 290*, p. 4.

59 Ms Jaci Armstrong, Guide Dogs Australia, *Committee Hansard*, 28 April 2016, p. 53.

60 Dr Beres Wenck, Royal Australian College of General Practitioners, *Committee Hansard*, 28 April 2016, pp. 34-35.

61 Australian Nursing and Midwifery Federation, *Submission 225*, pp. 19, 21; Australian College of Nursing, *Submission 285*, p. 16.

government should work with stakeholders to co-design a workforce strategy that includes a focus on remuneration.⁶²

3.56 The ANMF suggested that any future remuneration measure would need to ensure wage parity with the health and disability sector and be able to respond to indexation:

A mechanism which ensures the aged care sector achieves and maintains wage parity with the acute care sector must be developed. Such a mechanism must respond to changes in wage rates and accommodate an effective indexation system that provides employers with adequate funds when wage rises are negotiated. It must also incorporate a transparent and accountable process/framework.⁶³

3.57 IRT Group and the ACTU also suggested that portability of entitlements, such as accrued leave, would encourage mobility in the industry and help to attract people to the sector.⁶⁴

3.58 Submitters suggested that low remuneration is intrinsically linked to insufficient funding, and that government needs to increase funding in order for the sector to improve remuneration.⁶⁵

Committee view

3.59 The committee notes the inconsistency between the pay and conditions enjoyed by acute health care and disability workers compared to those available in the aged care sector. The committee also notes that aged care remuneration is often lower than less skilled jobs, or those with less responsibility, in other sectors.

3.60 The committee is concerned that pay and conditions for workers in the aged care sector are becoming more uncompetitive with other sectors. The committee considers that the move to 'zero hour' contracts, which are intended to provide flexibility for aged care service providers, but which have the impact of further marginalising aged care sector workers, is making the industry a less attractive alternative for workers.

3.61 Remuneration in the aged care sector will clearly affect the ability of the sector to grow to meet the needs of the ageing population.

Lack of funding

3.62 Several aged care providers argued that their ability to attract and retain workers would be enhanced if they received greater funding which would make them

62 Leading Aged Services Australia, *Submission 222*, p. 8.

63 Australian Nursing and Midwifery Federation, *Submission 225*, p. 21.

64 IRT Group, *Committee Hansard*, 6 March 2017, p. 21; Australian Council of Trade Unions, *Submission 254*, p. 4.

65 See, for example: Palms Aged Care, *Committee Hansard*, 23 February 2017, p. 2; Palm Island Aboriginal Shire Council, *Committee Hansard*, 23 February 2017, p. 25; Australian Council of Trade Unions, *Submission 254*, p. 3.

more competitive.⁶⁶ Submitters expressed concerns that reductions in funding to the for-profit sector, in particular, has increased competition for workers, and hindered their ability to attract a workforce.⁶⁷

3.63 For example, at the committee's Bunbury hearing, Hall and Prior Health and Aged Care Group told the committee that the loss of payroll tax funding for for-profit providers has made it harder to compete for staff with not-for-profit providers, such as churches and charities who can utilise tax deductibility status for salary-sacrificing options which reduce wage costs.⁶⁸

3.64 Juniper also told the committee that the successive reductions in funding across a range of programs have impacted their ability to support staff to seek to 'improve their skills, knowledge and qualifications'.⁶⁹ At the committee's hearing in Broome, Mrs Raelene Siford, the Executive Manager, Residential, at Juniper told the committee that:

The funding that is allocated to aged care is really designed around services that operate in the metro or rural areas of Australia. It certainly does not take into account costs associated with the remoteness of services in the Kimberley. A number of examples of those costs are employing staff. The cost of transferring them from a metro site to the country can be up to \$12,000 just to get them up there. That is the cost of flights, transferring their furniture—all their goods and chattels—and you do not have that cost in the metropolitan areas or the rural areas. But there is no recompense designed to meet the needs of the Kimberley for anything like that in the funding models.⁷⁰

Committee view

3.65 The committee acknowledges concerns that reductions in funding have impacted the sector's ability to recruit and retain workers, and offer higher rates of remuneration.

3.66 The committee notes that the Government committed in its 2017-18 Budget to provide funding to assist providers in rural and regional areas, in particular, to grow their workforce. The committee is of the view that this is an important first step to addressing the impact previous reductions in funding have had on the sector.

66 See, for example: Ms Joanne Christie, The Bethanie Group Inc, *Committee Hansard*, 28 September 2016, p. 1.

67 Mr Graeme Prior, Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, p. 25.

68 Mr Graeme Prior, Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, p. 25.

69 Mrs Margaret Antonucci, Juniper, *Committee Hansard*, 27 September 2016, p. 9.

70 Mrs Raelene Siford, Executive Manager Residential, Juniper, Proof Committee Hansard, 9 June 2017, p. 2.

Staffing ratios

3.67 Several submitters expressed concerns that the ratio of registered nurses, personal care attendants and clients leads to poor quality of care and stressful working conditions. To overcome this issue, some submitters supported the introduction of mandatory staffing ratios.

3.68 However, the committee also heard evidence from a number of submitters who were not supportive of mandated staffing ratios, mostly because they considered it would not resolve issues and would impose unnecessary regulatory burden and expense on the sector.⁷¹

3.69 The committee understands that mandated staff ratios in the aged care sector are not currently government policy.

3.70 ⁷²This section examines the various arguments presented to the committee for and against government regulation of mandatory minimum staffing ratios in aged care.

Mandated staffing ratios: the case for

3.71 Some submitters supported the introduction of mandatory staffing ratios due to concerns that staff and clients are not adequately supported. In particular, the committee heard that there are not enough nurses in some facilities to provide appropriate medical care.⁷³

3.72 The ACTU was supportive of mandated ratios on the basis it would improve the quality of care delivered, and reduce unsafe work practices:

We are concerned that high [patient to staff] ratios are creating unreasonably high workloads, leading to unsafe work practices that compromise both patient and carer safety. Consideration should be given to requiring aged care providers to publish minimum staff/patient ratios which, which will enable older Australians to make informed choices about their care and support.⁷⁴

3.73 The ANMF suggested that mandated ratios would lead to better outcomes for patients, and reduce health costs, as has been observed in the acute care sector:

In the acute setting, the implementation of safe mandated minimum staffing has been shown to prevent adverse incidents and outcome, reduce mortality and prevent readmissions thereby cutting health care costs. It is widely

71 See, for example: Jewish Care Victoria, *Submission 109*, p. 4.

72 Ms Catherine Rule, Acting Deputy Secretary, Department of Health, *Proof Committee Hansard*, 13 June 2017, p. 1.

73 See, for example: Name withheld, *Submission 117*, p. 1; Name withheld, *Submission 260*, p. 1; Name withheld, *Submission 66*, p. 1; Australian Council of Trade Unions, *Submission 254*, p. 3; Australian Nursing and Midwifery Federation, *Submission 225*, p. 23; Australian Medical Association, *Committee Hansard*, 3 November 2016, p. 13; Combined Pensioners & Superannuants Association of NSW Inc, *Submission 295*, p. 15.

74 Australian Council of Trade Unions, *Submission 254*, p. 3.

agreed that the same improvements could be achieved in the aged care sector.⁷⁵

3.74 The HWU agreed, submitting that the aged care sector should have mandated staff-to-patient ratios as is the case in comparable health and community sectors, such as hospitals and child care centres.⁷⁶

3.75 The committee also received evidence from some submitters that mandated staffing ratios would assist to retain workers who can become too stressed by high workload pressures, and consequently choose to leave aged care for sectors with better working conditions.⁷⁷

Mandated staffing ratios: the case against

3.76 The committee received evidence from several aged care providers who did not support mandatory staffing ratios. Providers argued that ratios could stifle innovation. Providers also suggested that mandatory ratios are incompatible with consumer directed care which is expected to change the role of rostering and service provision to be customer, rather than industry led.⁷⁸

3.77 For example, LASA, submitted that a mandatory staff ratio is a 'blunt instrument' that does not take into account changing care needs or acknowledge the broad-ranging skills of the workforce.⁷⁹

3.78 JewishCare Victoria agreed stating that it does not support mandated staffing ratios as it considers quality 'care is achieved through adequate training and competency...and not through additional staff'.⁸⁰

Alternative model: mandated minimum nursing numbers

3.79 An alternate approach to mandated staffing ratios is mandatory minimum nursing numbers.

3.80 Prior to July 2014, all designated 'high care' facilities in NSW were required to have an RN on duty at all times. Following changes to Commonwealth legislation which resulted in the removal of that requirement, the NSW Government agreed to maintain mandated minimum nursing requirements for facilities formerly designated

75 Australian Nursing and Midwifery Federation, *Submission 225*, p. 23.

76 Health Workers Union, *Submission 248*, p. 43.

77 See for example, Health Workers Union, *Submission 248*, p. 43; Queensland Nurses' Union, *Submission 215*, p. 12.

78 See, for example: Resthaven, *Submission 140*, p. 6; HammondCare, *Submission 209*, p. 4; JewishCare Victoria, *Submission 109*, p. 4.

79 Leading Aged Services Australia, *Submission 222*, p. 10.

80 JewishCare Victoria, *Submission 109*, p. 4.

as 'high care'.⁸¹ In October 2015, an inquiry into RNs in NSW nursing homes, conducted by the NSW General Purpose Committee No. 3, recommended that the requirement for all aged care facilities to have a RN on duty at all times be reintroduced in legislation, and extended to all facilities with residents with high care needs.⁸²

3.81 Submitters to the NSW inquiry highlighted the success mandatory minimum nursing requirements have had in NSW in ensuring the provision of quality care, and improving health outcomes for patients.⁸³

3.82 Ms Jan Barham MLC, former Chair of the General Purpose Committee No. 3, submitted to this inquiry that the mandatory nursing requirement should be implemented across the Commonwealth.⁸⁴

3.83 Ms Jennifer Davis from James Cook University was supportive of establishing a mandatory minimum nursing requirement, stating that if the Commonwealth government does not introduce mandated ratios it should:

At least establish a minimum...It does not necessarily have to dictate numbers, as such, but I think there needs to be an established minimum where you can actually demonstrate that there has been someone with a critical clinical eye who knows the clients and what their health needs are.⁸⁵

3.84 The NSWNMA was also supportive of the viewpoint that residential aged care facilities should be required to have nursing staff rostered at all times.⁸⁶

3.85 A representative of the Health Services Union (HSU) indicated support for an examination of ratios or some other means to ensure appropriate staffing levels in residential aged care facilities:

There are a couple of different models, and ratios is certainly one that I think has some merit, because we are seeing a severe lack of staff in residential aged care, and we would certainly support a model that would see better and safer staffing.⁸⁷

81 The removal of the distinction between high and low care from the *Aged Care Act 1997* in July 2014 rendered the NSW requirement under the *Public Health Act 2010* to have a RN in 'high care' facilities at all times inoperable, as it applied to 'high care' facilities as defined by the *Aged Care Act*. See: NSW Nurses and Midwives' Association, *Submission 134*, p. 30; Ms Jan Barham MLC, *Submission 245*, p. [4].

82 NSW Legislative Council, General Purpose Standing Committee No. 3, *Registered nurses in New South Wales nursing homes*, recommendation 7, pp. 77-78.

83 NSW Legislative Council, General Purpose Standing Committee No. 3, *Registered nurses in New South Wales nursing homes*, pp. 69-70.

84 Ms Jan Barham MLC, *Submission 245*, pp. [3] and [5].

85 Ms Jennifer Davis, James Cook University, *Committee Hansard*, 23 February 2017, p. 49.

86 NSW Nurses and Midwives' Association, *Submission 134*, p. 7.

87 Mr Robert Moore, Assistant State Secretary, Health Services Union Tasmania Branch, *Committee Hansard*, 31 October 2016, p. 18.

3.86 The committee heard that the Australian Health Ministers' Advisory Council (AHMAC) agreed in February 2017 to ask the government to consider, in its development of a single aged care quality framework, 'the inclusion of a standard that requires that clinical care provided in residential aged care be best practise and provided by a qualified clinician'.⁸⁸

3.87 The Australian Law Reform Commission (ALRC) in its recent report commissioned by the Attorney General, *Elder Abuse – A National Legal Response*, made the following recommendation:

Recommendation 4-7 The Department of Health (Cth) should commission an independent evaluation of research on optimal staffing models and levels in aged care. The results of this evaluation should be made public and used to assess the adequacy of staffing in residential aged care against legislative standards.⁸⁹

Committee view

3.88 The committee is concerned that the ratio of workers to patients in some aged care facilities is too low and risks compromising the quality of care delivered.

3.89 The committee acknowledges concerns expressed by residential care providers that mandatory staffing ratios may not resolve current issues and could stifle innovation and impose greater regulatory burden and expense on the sector. The committee also acknowledges, however, the AHMAC agreement to consider a clinical care standard in its development of the aged care quality framework and more particularly the ALRC recommendation to evaluate optimal levels of care and make use of and publish the results of this analysis.

3.90 The committee considers that a compromise position may be to mandate a minimum number of nurses working at any one time and that there should be a registered nurse present at all times. The committee considers such an approach may be less burdensome for employers than mandating a nurse-to-patient ratio.

3.91 The committee notes that the sector may require additional funding and support from governments in order to meet such a mandatory minimum requirement.

3.92 The committee also considers that a mandated requirement for residential aged care facilities to publish their staff to client ratios should be explored.

Training personal care workers

3.93 Training for personal care workers is provided by Australia's vocational and education training (VET) system and delivered by registered training organisations (RTOs). Students can gain aged care specific qualifications through VET including Certificate III in Aged Care and Certificate IV in Aged Care.

88 Ms Amy Laffan, Assistant Secretary, Department of Health, *Proof Committee Hansard*, 13 June 2017, p. 1.

89 Australian Law Reform Commission, [Elder Abuse – A National Legal Response](#), ALRC Report 131, May 2017, p. 11.

3.94 This section examines the quality of training currently provided to personal care workers (PCWs), areas for improvement, and the potential for greater regulatory oversight including the establishment of a national register of workers and setting of mandatory minimum training standards.

Quality and consistency of training

3.95 Many submitters expressed concerns that VET training programs do not adequately equip PCWs with the necessary theoretical and practical skills and knowledge for work in the aged care sector.

3.96 Key concerns expressed by submitters regarding the quality and consistency of training programs included:

- inconsistency of program quality across RTOs;
- varying length of programs offered by RTOs with some being too short to develop adequate skills and experience;
- non-compliance with national training standards;
- limited work placement opportunities in aged care offered during training; and
- lack of training on dementia and palliative care.

Consistency of training

3.97 The committee heard that the quality and consistency of training provided by RTOs varies considerably, with courses varying in length, entry requirements, and opportunities for on-the-job training:

In the various RTOs, courses range from four weeks to six months full-time. There is no national consensus on what is an acceptable time frame, and many RTOs unfortunately have little or no practical experience embedded into that certificate in aged care.⁹⁰

3.98 Many submitters expressed concerns that the length of courses provided by some RTOs are inadequate to ensure students receive the level of training in skills and competencies required to work in the aged care sector. The NSW Nurses and Midwives' Association also raised concerns about 'training delivered online with no safety checks on how much they have learnt or whether they can apply learning to practice'.⁹¹ The concern in relation to aged care training delivered online was echoed by the Western Australian Primary Health Alliance.⁹²

3.99 A 2013 report by the Australian Skills Quality Authority (ASQA), the national regulator for Australia's VET sector, found that 70 per cent of RTOs who offered a Certificate III in Aged Care ran the course for a period of less than one year,

90 Miss Stacey Kafkakis, *Gratis Recruitment*, *Committee Hansard*, 7 March 2017, p. 14.

91 NSW Nurses and Midwives' Association, *Submission 134*, p. 25.

92 Ms Krystal Laurensch, Aged Care Representative, Regional Clinical Commissioning Committee, WA Primary Health Alliance, *Committee Hansard*, 28 September 2016, p. 10.

despite the fact the Australian Qualifications Framework (AQF) guidelines set a benchmark of one to two years as an appropriate course length for a Certificate III.⁹³

3.100 The Australian Centre for Evidence Based Aged Care (ACEBAC) at La Trobe University submitted that there is 'a lack of standardised education' in the aged care sector. ACEBAC further noted that despite the fact that there are national standards for these courses, 'there can be a great deal of variance in delivery standards between training organisations and States' resulting in 'large differences in skills and knowledge between workers'.⁹⁴

3.101 Many submitters highlighted concerns that some RTOs do not provide students with the necessary skills to work in aged care, resulting in many graduates not being job ready.⁹⁵ For example, Jewish Care Victoria noted:

Experience has shown that quality and job readiness of personal care workers varies from RTO to RTO. Those RTOs with more stringent selection criteria seem to provide workers better suited to an aged care environment. Acceptance into a course should be made on genuine desire to work in the industry...⁹⁶

3.102 The Salvation Army Australia (Aged Care Plus) also noted concerns that 'many Certificate III holders come with little or no knowledge of critical topics like manual handling, infection control and basic understanding of what personal care involves'.⁹⁷

3.103 A number of witnesses and submitters have indicated that service providers do not hire people who have obtained their Certificate III through certain RTOs:

We are targeting relationships with [training] providers that we have confidence in because they provide the right levels of training, and we are eliminating a number of providers out of our employment where we can. I know that there has been a lot of work done around cert III training into improving that standard, but we are still getting people applying or coming to do work experience with us who have only just got the piece of paper, and we are then expected to teach them.⁹⁸

93 The same report found that over 'one-third of RTOs offered the Certificate III in Aged Care in less than 15 weeks'. Australian Skills Quality Authority, [Training for aged and community care in Australia](#), p. xi.

94 Australian Centre for Evidence Based Aged Care, *Submission 174*, p. [1].

95 Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 1; Wami Kata Old Folks Home Inc, *Committee Hansard*, 7 March 2017, p. 2; Gratis Recruitment, *Committee Hansard*, 7 March 2017, p. 14; Resthaven Inc, *Committee Hansard*, 7 March 2017, p. 14.

96 Jewish Care Victoria Inc., *Submission 109*, p. 4.

97 The Salvation Army Australia (Aged Care Plus) *Submission 183*, p. 6.

98 Mrs Linda Jackson, Manager of People and Risk, Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, p. 21; see also: Mrs Deanna Maunsell, Manager, Aged and Disability, Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 11; Ms Jenny Semple, Chief Executive Officer, Southern Migrant and Refugee Centre, *Committee Hansard*, 28 April 2016, p. 58.

3.104 Catholic Care in the Illawarra region in New South Wales argued that a national standard that meets the needs of the industry is desirable, as in the current system 'there are some RTOs that have only a nine-week program and they may as well have just cut it off from a Weet-Bix box'.⁹⁹

3.105 The committee notes that a number of the concerns highlighted by submitters were also raised in ASQA's 2012 inquiry into aged care VET courses.¹⁰⁰ Many submitters supported the implementation of ASQA's recommendations to improve VET quality training in its 2013 report of that inquiry (see Box 1.1).

Box 3.1 – ASQA review of aged and community care VET training courses

In 2012, ASQA initiated a review of aged and community care VET training programs. The key findings of the review set out in its 2013 report included:

- training programs offered by RTOs are 'largely too short' and do not include sufficient time for 'satisfactory skills development';
- RTOs delivering high-quality programs face unfair competition from RTOs offering cheaper, shorter programs;
- most RTOs offering training were not compliant with the national standards; and
- RTO leadership and staff had poor knowledge and understanding of the national standards.¹⁰¹

Representatives from ASQA told the committee at its Melbourne hearing that there has been 'good progress' on addressing the review's 10 recommendations, including revisions to the VET training courses for aged care and introduction of workplace requirements.¹⁰² However, ASQA remains concerned that around 25 per cent of courses offered are 'still too short for people to get properly skilled' and that no changes have been made to minimum course length requirements.¹⁰³

Compliance with national training standards

3.106 Under section 22 of the *National Vocational Education and Training Regulator Act 2011*, it is a condition of registration for RTOs to comply with the VET

99 Mrs Deanna Maunsell, Manager, Aged and Disability, Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 11.

100 Australian Skills Quality Authority, *Training for aged and community care in Australia*.

101 Australian Skills and Quality Authority, *Opening statement and report*, 2016, p.3 (tabled 28 April 2016).

102 Ms Bronwen Griffiths, Australian Skills and Quality Authority, *Committee Hansard*, 28 April 2016, p. 72.

103 Mr Christopher Robinson, Australian Skills and Quality Authority, *Committee Hansard*, 28 April 2016, p. 70.

quality framework, including the national training standards.¹⁰⁴ The purpose of the standards is to ensure that training programs delivered by RTOs 'meet the requirements of training packages or VET accredited courses'.¹⁰⁵

3.107 The ASQA's 2013 report, found that 87.7 per cent of RTOs offering aged and community care training were not compliant with at least one of the training standards.¹⁰⁶

Committee view

3.108 The committee is deeply concerned that the significant issues associated with the provision of aged care workforce training are undermining, the development of the aged care workforce, and will continue to do so until they are addressed.

3.109 The committee is concerned by evidence that RTOs are providing inconsistent standards of training and that many RTOs are offering programs that are too short to ensure students gain the necessary skills and practical training to ensure they are job ready.

3.110 The committee acknowledges that quality rather than duration of courses is paramount, but considers that the length of some courses offered is far too short to cover all the necessary skills and competencies required for aged care work. The committee is particularly concerned by reports that some RTOs are offering courses that range from as little as four weeks, which falls well below the AQF guidelines.

3.111 The committee considers that greater regulatory oversight of RTOs in regard to the duration, curricula, and on-the-job-training for courses they offer is urgently required. The committee is of the view that current national training standards do not go far enough to achieve this, and more needs to be done to ensure that RTOs are providing quality training to give students the best possible training and work outcomes.

Changes to regulatory framework

3.112 The VET system is regulated by the Commonwealth, state and territory governments through the Council of Australian Governments (COAG) Industry and Skills Council.¹⁰⁷ VET training packages are developed and approved by the Australian Industry and Skills Committee.¹⁰⁸

104 The latest iteration of the national training standards was agreed to by the Council of Australian Governments (COAG) on 26 September 2014 – the [Standards for Registered Training Organisations \(RTOs\) 2015](#). See: Australian Skills and Quality Authority, [Standards for Registered Training Organisations \(RTOs\) 2015](#), (accessed 23 May 2017).

105 Australian Skills and Quality Authority, *Standards for Registered Training Organisations (RTOs) 2015*.

106 Australian Skills Quality Authority, *Training for aged and community care in Australia*, p. ix.

107 Department of Education and Training, [About the Skills Sector](#), (accessed 18 May 2017).

108 Department of Education and Training, [Australian Industry and Skills Committee](#) (accessed 18 May 2017).

3.113 As mentioned, the ASQA is responsible for registering RTOs, monitoring compliance with national standards and investigating quality concerns.¹⁰⁹ In Victoria and Western Australia these roles are undertaken by the Victorian Registration and Qualifications Authority and the Training Accreditation Council Western Australia.

3.114 Submitters supported more 'nationally consistent' training standards for RTOs, Some submitters offered suggestions on how to improve the existing regulatory framework, including:

- review of quality and accreditation processes for RTOs and training courses;¹¹⁰
- consideration of student outcome and feedback in ASQA audits of VET courses;¹¹¹
- public reporting by government on effectiveness of training programs;¹¹² and
- increased role for industry in ASQA auditing process (such as development of 'companion manuals' for auditors).¹¹³

3.115 Some of these same suggestions and concerns were raised during an inquiry by the Senate Education and Employment References Committee (EEC) in 2015 (see Box 1.2).

109 See: Australian Skills Quality Authority, *About ASQA*, <https://www.asqa.gov.au/about> (accessed 18 May 2015).

110 Australian Human Rights Commission, *Submission 243*, p. 4; Catholic Health Australia, *Submission 211*, p. 3.

111 See, for example: HammondCare, *Submission 209*, pp. 10-11; Southern Migrant Resource Centre, *Submission 38*, p. 3.

112 Australian College of Nursing, *Submission 285*, p. 16.

113 Australian Nursing and Midwifery Federation, *Submission 225*, p. 26.

Box 3.2 – Education and Employment References Committee – VET inquiry

In October 2015, the EEC reported on its inquiry into the operation, regulation and funding of private VET providers. The EEC made 16 recommendations aimed at reforming the VET sector, including:

- ASQA conduct a review of RTOs to ensure they are complying with national standards, enforce adherence to the AQF learning standards, and remove non-compliant RTOs as VET FEE-HELP providers; and
- ASQA be given the 'powers to take swift and strong action' against RTOs 'found to be providing inadequate training to their students'.¹¹⁴

In response to the EEC's report, the government noted that they key concerns had already been addressed through a range of reforms to the VET sector introduced throughout 2015, including:

- introducing new standards for RTOs
- providing a further 68 million dollars to fund ASQA
- introducing the National Training Complaints Hotline and supporting the Australian Competition and Consumer Commission's investigation into complaints; and
- measures to strengthen the VET FEE-HELP scheme.¹¹⁵

National registration and minimum training standards

3.116 As noted above, PCWs do not have regulated minimum training requirements or ongoing professional development obligations, and are not subject to a registration or licensing system. The lack of quality oversight of PCWs means that consumers, families and employers cannot be sure that a prospective PCW is suitable for employment or to provide care to a loved one.¹¹⁶

3.117 To ensure greater oversight of the unregulated PCW many submitters supported the introduction of national minimum training standards and requirements for continuing professional development (CPD), and establishment of a national register of PCWs.

Minimum training standards

3.118 As Australia's ageing population grows and clients' care needs become more complex, it is expected that pressure and demand for quality training, particularly in

114 See recommendations 6 and 11. Education and Employment References Committee, *Final Report – Recommendations, Getting our money's worth: the operation, regulation and funding of private vocational education and training (VET) providers in Australia*, October 2015.

115 See: Coalition Senators' Minority Report, *Getting our money's worth: the operation, regulation and funding of private vocational education and training (VET) providers in Australia*, October 2015. See also: Department of Employment, *VET FEE-HELP REFORMS*, <https://www.education.gov.au/vet-fee-help-reforms> (accessed 24 May 2017).

116 Australian Nursing and Midwifery Federation, *Submission 225*, p. 22.

the areas of dementia and palliative care, will only increase. However, quality of training is hindered by the fact there is no national minimum standardised training requirements for aged care.

3.119 The committee heard overwhelming support for nationally consistent training standards.¹¹⁷ For example, the ACEBAC submitted that there is a major need for 'standardisation of education requirements and clearly defined competencies' for each level of worker in the aged care sector.¹¹⁸

3.120 Submitters argued that standardised training, particularly of the practical components of aged care courses, would ensure graduates have received the same level of training and are work ready.¹¹⁹

3.121 The ANMF recommended in its submission that minimum training standards for PCWs 'should be linked to the Australian Qualifications Framework and include a requirement for a recognised level of training to at least Certificate III level'.¹²⁰

3.122 The Corporation of the City of Port Augusta suggested that training standards and CPD requirements could be linked to a national register of carers.¹²¹

National register of personal care workers

3.123 Some submitters suggested that a system of registration, similar to the National Registration and Accreditation Scheme (NRAS) for health care workers, would increase accountability of workers and provide an important safeguard for consumers against abuse.

3.124 For example, the NSWNMA submitted that a registration system would improve quality safeguards and raise standards of care.¹²²

3.125 The Aged Care Guild also argued that a national register would improve administrative efficiencies for employers by providing easily accessible background checks and employer reviews.¹²³ Ngaanyatjarra Health Service agreed suggesting that a review mechanism, such as a website where employers can provide comments about

117 See, for example: RDA Illawarra, *Committee Hansard*, 6 March 2017, p. 6; Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 11; and Yass Valley Aged Care Ltd, *Committee Hansard*, 6 March 2017, p. 33.

118 Australian Centre for Evidence Based Aged Care, *Submission 174*, p. [1].

119 Southern Cross Care for Facility Pearl Supported Care, *Committee Hansard*, 6 March 2017, p. 11.

120 Australian Nursing and Midwifery Federation, *Submission 225*, p. 23. The ANMF estimated that around 30 per cent of assistants in nursing and personal care workers do not have formal aged care qualifications.

121 Mrs Anne O'Reilly, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 4.

122 NSW Nursing and Midwifery Association, *Submission 134*, p. 23. See also: Association of Private Nursing Services, *Submission 189*, p. 4; Australian Nursing and Midwifery Federation, *Submission 225*, p. 22.

123 Mr Cameron O'Reilly, Aged Care Guild, *Committee Hansard*, 3 November 2016, p. 5.

an individual contractor's performance, would assist employers to recruit adequately qualified and reliable staff.¹²⁴

3.126 Mrs Anne O'Reilly, Director of Community Services at the Corporation of the City of Port Augusta, also suggested that a national register would capture undesirable workers who may otherwise 'slip through' the gaps, and boost the accountability and standing of the PCW workforce:

...there are some workers that do go from facility to facility. You can try and do background checks. We all do our criminal history assessments and check with referees but we all know that there are people who can slip through the gap in that process as well. Secondly, I also think that it may be an opportunity to give some more credence to personal care attendants if there was some training and some continuing professional development attached to that to try and improve the standing of personal caring carers in the workforce community'.¹²⁵

3.127 St Ives Home Care agreed that a national register would improve quality safeguards and help to ensure patients are cared for by well performing workers.¹²⁶

3.128 These views were also reflected in the ALRC report, *Elder Abuse – A National Legal Response*, which recommended that 'unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers'.¹²⁷

3.129 Other submitters did not support a national register of carers, suggesting that the National Code of Conduct (NCC), and various state codes of conduct, for unregistered health care workers is sufficient to regulate the PCW workforce.¹²⁸

3.130 For example, Aged and Community Services Australia argued that a national register is not required as 'there are sufficient checks, balances and measures in place to ensure that quality aged care is delivered'.¹²⁹

3.131 The NCC was approved by the Council of Australian Government (COAG) Health Council in April 2015. The NCC does not impose minimum training standards

124 Ngaanyatjarra Health Service, *Committee Hansard*, 26 October 2016, p. 7. See also: St Ives Home Care, *Committee Hansard*, 27 September 2016, pp. 19 and 21.

125 Mrs Anne O'Reilly, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 4.

126 Ms Liza Michelle De Ronchi, St Ives Home Care, *Committee Hansard*, 27 September 2016, pp. 19 and 21.

127 Australian Law Reform Commission, [Elder Abuse – A National Legal Response](#), ALRC Report 131, May 2017, p. 11.

128 See, for example: Ms Emma Patton, Leading Age Services Australia, *Committee Hansard*, 3 November 2016, p. 5. New South Wales, South Australia and Queensland have established Codes of Conduct for unregistered health practitioners.

129 Mr Trevor Lovelle, Aged and Community Services Australia, *Committee Hansard*, 27 September 2016, p. 2. See also: Leading Age Services Australia, *Committee Hansard*, 3 November 2016, p. 5.

or CPD requirements. It is the responsibility of states and territories to implement the NCC.¹³⁰

3.132 However, the Aged Care Guild (ACG), which represents private providers, submitted that the NCC does not go far enough to ensure aged care workers are adequately trained and 'would not meet the requirements and full intent of a national registration process'.¹³¹

3.133 The ALRC report, *Elder Abuse – A National Legal Response*, has recommended the introduction of a new serious incident response scheme for aged care, with oversight from an independent body with investigative powers, and a national employment screening process which would be based on relevant incidents under the new serious incident response scheme, criminal record checks and relevant disciplinary proceedings or complaints.¹³²

Committee view

3.134 The committee notes the same issues around training standards and registration for personal care workers were examined in depth in relation to the disability service sector during the committee's 2015 inquiry into violence, abuse and neglect of people with a disability.¹³³ Three key recommendations were made in that report regarding national workforce and workplace regulation of the disability service sector:

- Establishment of a scheme to ensure national consistency in disability worker training;
- Establishment of a disability worker registration scheme, including requirements for ongoing professional development; and
- A national approach to State, Territory and Commonwealth service delivery accreditation programs.¹³⁴

3.135 The committee is of the view that the same recommendations must apply to the aged care sector, to ensure that consistent standards are met across both sectors which are responsible for the direct care of vulnerable Australians.

130 See: Council of Australian Government Health Council, *A National Code of Conduct for health care workers*, 2015.

131 Aged Care Guild, *Submission 220*, p. [8].

132 Australian Law Reform Commission, *Elder Abuse – A National Legal Response*, ALRC Report 131, May 2017, pp. 10-11.

133 Community Affairs References Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, November 2015.

134 See recommendations three, four and five.

Training nurses and health professionals

3.136 The committee heard concerns that training courses for nurses, medical professionals and allied health practitioners do not include adequate experience and exposure to the aged care system.

3.137 For example, Doctor Deirdre Fetherstonhaugh, Director of the ACEBAC, told the committee at its Melbourne hearing that of the six Victorian universities that offer an undergraduate degree in nursing, only one of those offers a unit on aged care nursing as part of the degree.¹³⁵

3.138 Many submitters representing nurses, medical professionals and allied health professionals supported the introduction of initiatives to give students the opportunity to rotate through aged care placements during training, together with placement opportunities for graduates.¹³⁶

3.139 For example, the Australian Medical Association submitted:

Offering appropriate and accredited medical training places in aged care facilities would educate the next generation of doctors about caring for the aged as part of routine medical practice. These places need to be supported by appropriate incentives.¹³⁷

3.140 The Australian Nursing and Midwifery Accreditation Council (ANMAC), is the independent accrediting authority responsible for developing accreditation standards for nurses and midwives. Doctor Jo-Anne Rayner, Senior Research Fellow at the ACEBAC, suggested to the committee that ANMAC should have a role in ensuring that aged care becomes a core subject of the curricula for undergraduate nursing degrees.¹³⁸

3.141 At the committee's Wollongong hearing, the committee received evidence from representatives of TAFE Illawarra and IRT Group; both of which have developed training and placement initiatives to ensure students can gain experience in aged care.

3.142 For example, Ms Belinda Mackinnon from TAFE NSW described to the committee TAFE Illawarra's workforce development initiatives, including the Young@Heart Program, which is specifically targeted at encouraging young people to undertake training in aged care, and various partnership initiatives with universities that are aimed at building educational pathways into careers in aged care.¹³⁹

135 Dr Dierdre Fetherstonhaugh, Australian Centre for Evidence Based Aged Care, La Trobe University, *Committee Hansard*, 28 April 2016, p. 27.

136 Australian Medical Association, *Submission 210*, p. 5; NSW Nursing and Midwives' Association, *Submission 134*, p. 8; Royal Australian College of General Practitioners, *Submission 281*, p. 10; Allied Health Professions Australia, *Submission 208*, p. 4.

137 Australian Medical Association, *Submission 210*, p. 5.

138 Dr Jo-Anne Rayner, Australian Centre for Evidence Based Aged Care, La Trobe University, *Committee Hansard*, 28 April 2016, p. 28.

139 Ms Belinda Mackinnon, TAFE NSW, *Committee Hansard*, 6 March 2017, p. 16.

3.143 IRT Group also explained some of its training and development initiatives that are provided by the IRT College (a RTO operated by IRT Group), such as a school based apprenticeship and trainee program under which students have to complete a minimum of 700 hours of paid employment, and a pathways program that is in partnership with the University of Wollongong.¹⁴⁰

Committee view

3.144 The committee acknowledges concerns that current training courses for the medical profession do not offer adequate practical training in aged care.

3.145 The committee is of the view that a nationally consistent curriculum for aged care specific courses should be considered for people who wish to specialise in this area, and that a general overview course of aged care should be included in all general nursing degrees to increase exposure to the sector. The committee also considers that it is crucial that nursing students are given greater opportunities to undertake placements in aged care.

3.146 The committee considers that ANMAC, as the national accreditation body, should take a lead in developing and implementing such reforms.

140 Mr Campbell McGlynn, IRT Group, *Committee Hansard*, 6 March 2017, p. 17. The committee also had a site visit at IRT College, where it had the opportunity to learn about and see in practice some of the College's training initiatives.

