SENATE INQUIRY INTO AUSTRALIA'S AGED CARE WORKFORCE

HANMAC PTY LTD

OVERVIEW

HANMAC Pty Ltd (HANMAC) is a Registered Training Organisation (RTO) located in Townsville North Queensland.

HANMAC specialises in Community Services Sector training particularly accredited training in aged care, home and community care, individual support, disability, community services and leadership and management focussing on the community sector. HANMAC has, in the past, also provided training in children's services, work health and safety and other supportive skill sets and units, however due to the lack of availability of quality trainers and assessors and/or price slashing and the market flooding of VET Fee Help these have not been offered for some months. Further to this HANMAC provides soft skills training to aged and community sector services.

All staff who are employed by HANMAC have qualifications and current industry experience in the courses that they train/ assess to ensure that their training and assessment is contemporary, enquiring, and planned to ensure ongoing validity of both training and assessment. Further to this all trainers / assessors have qualifications in language, literacy and numeracy and an understanding of the needs of the Australian Core Skills Framework (ACSF).

Retention and completion levels for HANMAC students are high compared to the national average and there is a steady flow of student enrolments to courses which run continuously throughout the year. All courses receive strong positive feedback and are reviewed and adapted to incorporate the changing needs of specific aged care/disability programs.

HANMAC has positive recognition, as an RTO, within the community services sector for its training outcomes and has high employment rates for graduating students. It is the RTO of choice for several services who openly acknowledge that the training and assessment of students prepares them for work placement which consolidates their theoretical and practice experience to ensure that the students are work ready at time of completion of their chosen course. These services inform HANMAC of their need for staff and ask for recommendations to fill vacancies. Recently HANMAC has had 2 services approach them to recruit students to be trained specifically for their upcoming service expansions under the NDIS (National Disability Insurance Scheme)

2 MANAGEMENT

Ms Leeanne Hanna initiated HANMAC Registered Training Organisation in response to a deficit in aged care training for those working in /and or wishing to join the Aged Care industry in the mid 1990's. Ms Hanna has a vast experience in aged care, community and disability services, including needs based planning and service establishment. She is a registered nurse, her post graduate qualifications include: Masters Of Business Administration, Nursing (Gerontology), Gerontological Rehabilitation, Management (Residential Aged Care Facilities, Nursing Homes), TAE training and assessment, Health Administration and Information Systems, Education (Tertiary Teaching),and Human Resource Management. Ms Hanna is a Consultant to the Aged Care Industry including re-establishment of services to meet accreditation requirements and acting in key roles for state wide organisations across Queensland and has in the recent past been contracted to Leading Aged Care Services (Qld) a peak body to aged care. She manages, designs and implements training sessions for HANMAC and at times contracts to other RTO's.

3 Submission

This submission is based on experience, feedback and anecdotal evidence provided by Aged Care providers, students and users of the services. HANMAC has chosen all those who have offered data for this submission to attend the inquiry to validate current aged care /disability the information provided, however due to commitments or preference for anonymity they have declined. HANMAC has one student present at this Inquiry.

4 Terms of Reference

The terms of reference are:

a. The current composition of the aged care work force

b. future aged care workforce requirements, including the impacts of sector growth, changes in how care is delivered, and increasing competition for workers;

c. the interaction of aged care workforce needs with employment by the broader community services sector, including workforce needs in disability, health and other areas, and increased employment as the National Disability Insurance Scheme rolls out;

d. challenges in attracting and retaining aged care workers;

e. factors impacting aged care workers, including remuneration, working environment, staffing ratios, education and training, skills development and career paths;

f. the role and regulation of registered training organisations, including work placements, and the quality and consistency of qualifications awarded;

g. government policies at the state, territory and Commonwealth level which have a significant impact on the aged care workforce;

h. relevant parallels or strategies in an international context;

i. the role of government in providing a coordinated strategic approach for the sector;

j. challenges of creating a culturally competent and inclusive aged care workforce to cater for the different care needs of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups and lesbian, gay, bisexual, transgender and intersex people;

k. the particular aged care workforce challenges in regional towns and remote communities;

l. impact of the Government's cuts to the Aged Care Workforce Fund; and

m. any other related matters.

4 Response to the terms of reference

a. The current composition of the aged care workforce:

The Australian Bureau of Statistics research provides a vast knowledge of the statistical make up of Australia's aged care workforce from non-registered carers to registered nurses. All this information is readily available online and through other Government sources. It is the intention of this submission to reflect on the practical composition of the aged care workforce that impacts on the provision of the 'bedside' care within residential and community services.

The Aged Care Sector needs a positive shift in the image of aged care. This will attract regulated workers who will promote and support person centred care resulting in quality care for all individuals in aged care or disabled residents and those receiving community care services

Currently there is an assumption that the composition of the aged care work force at entry, have the skills and knowledge to provide not only 'hands on care' but the ability to visually assess the person at the bedside, identify deviations from the norm and the resident/client health status and psychosocial needs. It puts a lot of responsibility on the worker who in many cases has only had a very short training that does not include in-depth information on health, physical or psychological /mental health needs and often the individuals "right to say no".

Organisations, owing to budget restrictions or lack of qualified aged care staff, resort to employing staff who have little knowledge of gerontology or healthy aging needs, chronic disease, mental health requirements or the changing needs of the resident/client. Those employed are disadvantaged as they cannot meet their own expectations in caring or those of the resident/client, therefore they are not long term employees nor do they advance their careers in aged care. This in turn leads to the requirement for agency or casual staff to be sought. These staff have minimal knowledge of the individuals under their care or the specialty field in which they are providing the care.

Highly honed skills are practiced and learned over a long period underpinned by a wide base knowledge of anatomy, physiology and aging that the regulated worker gains in their tertiary training. Aged care services require a competent level of care from regulated and unregulated workers. They expect that these workers will have a high knowledge base of the health ageing process that is evidence based. The unregulated worker will require basic knowledge of contemporary aged care needs to allow them to recognise and report these to the regulated worker who can adjust care/support to manage deviation as new complications arise. Infection control, pathways in palliative care, falls, dementia and dying must all be part of the workers knowledge base so that the individual person receives the care that provides the best health outcomes for them.

This highlights the need for an acceptable entry level for unregulated workers intending to enter the aged care industry. Some students will not have the capacity, nor do they want to progress beyond delivering care based on the daily needs of the resident/client such as bathing, dressing, groom, feeding and social support.

There are career pathways available to unregulated workers to specialise in their chosen area of care provision however it is neither fair, nor reasonable to expect that unregulated workers, who are not willing or able to take on the higher skills, to be specialist practitioners or indeed to be part of a team where the leader is unknown to them. Often the regulated worker or team leader is only accessible by telephone off site and at times, at some geographical distance away hence requiring "assessment at a distance". To expect quality,

appropriate care for a resident/ client who is being diagnosed over the phone, from a distance by a practitioner who may be sketchy about the health status history or peculiarities of the individual is not fair to the resident/client or the unregulated worker and may at best be questionable under the duty of care to the individual by the service.

One particular issue is the current practice of prescribed PRN (when necessary) medications being administered using this 'assessment at a distance'. The Certificate III qualified worker who is expected to provide visual observations, measurement of vital signs reading (blood pressure, pulse, respirations and colour) to the regulated worker may well have not had this training in their studies. There is no allowance in the Certificate III level training for these observation related competencies and therefore, unless on the job competency has been undertaken, the unregulated worker does not have an in-depth knowledge of the implications of inexact measurement of vital signs or observation of the resident's signs and symptoms including previously unobserved reactions to medications. This lack of knowledge can result in unnecessary discomfort for the resident/client, inappropriate hospital transfer and administration of inappropriate medication.

It cannot be expected or assumed that Certificate III level workers will have the ability to recognise changes outside the parameters of healthy ageing, and therefore observation of signs and symptomologies of what may have manifested subtly over time is outside their scope (under competency based training as well as under the guidelines of the Nursing and Midwifery Council which clearly bases assessment in the scope of the regulated worker). Unregulated workers cannot competently recognize and report on visual assessment to Regulated Workers (Registered Nurses and Enrolled Nurses).

This expectation of assessment is an unfair and unreasonable assumption particularly where regulated workers may be spread across several work units within one facility or at times located remotely only providing phone based advice and instruction. The true reality of work in aged care facilities and community services is that should a health related incident occur there are no emergency signals to bring a team of doctors and regulated workers to provide assistance or lifesaving assessment, administration of medications/ treatments. These tasks left to Certificate III trained workers, often without the luxury of a regulated worker, except at the end of the phone, can cause misdiagnosis and distress to the resident/client as well as the worker. The question posed: Is this level of care something that you would be willing to accept for yourself or your loved ones?

Currently, in Queensland Aged Care Facilities there are no ratios for the number of care staff or regulated staff per resident or skill mix. Should this be so when those working in the aged care residential sector are caring for Australia's most frail and vulnerable persons?

The Commonwealth has mandated ratios and qualifications/skill mix in child care and after school care programs due to the vulnerability of babies and young children, however there is a reluctance to mandate ratios in centres dealing with the other end of the spectrum i.e. the frail aged and people who are ageing with a disability. Many aged people and people with a disability have an equal or greater vulnerability than children, they are often disempowered with an inability to voice their concerns, lack of advocates with personal interest in their welfare and treatment and support outcomes, with compromised communication skills, a learned reluctance to complain/comment for fear of retribution either real or perceived.

Owing to budget constraints and lack of understanding of the specialisation of aged care needs, shortages of regulated workers (Registered Nurses and Enrolled Nurses) are common. The public perception of aged care is low; both regulated and non-regulated workers wages are lower and it is not seen as a vital part of the 'nursing career' pathway. This shortage creates "role creep", which is contrary to the workers duty of care, and

perpetuates the reliance on Certificate III qualified workers to be the “eyes and ears” of the regulated worker who may be “on call” at a geographically distant location.

Certificate III level workers often show interest in competency based nurturing skill but this does not extend to clinical based skills. They do not have the depth of knowledge, insight or language skills to accurately interpret vital signs, recognise health changes or vocalise concerns. Therefore, there is reinforcement that non-visual assessment needs regulated workers (Registered Nurse or Enrolled Nurse) intervention and must not be outsourced to a practitioner off site or at a remote geographical location.

Aged care has two major impactors apart from the quality of training provided at Certificate III level, which is discussed throughout this paper. Firstly, the consistent use and over use of agency staff. These workers are employed on a day to day basis often with no knowledge of the ongoing and ever changing needs of the person centred care of the residents that they are caring for. Secondly the reluctance of the Aged Care Sector to maintain an adequate casual pool of unregulated/regulated workers to replace permanent workers in emergencies. This factor has potential to lead to worker fatigue, poor quality care and reduces individual’s health outcomes. This point will be discussed further under separate sections of the submission relating to barriers of entry to employment.

Agency staff play an important role in current care provisions within the aged care sector as they are often the only workers available to provide the care required by residents/ clients. It may be argued that the frequently reviewed care plan and assessment processes ensure that appropriate inputs are provided to residents/clients continuity of care. In practice however change over time does not allow agency staff to familiarise themselves at the beginning of a shift with the care and support that their allocated residents/clients may need. Accumulated with the fact that often changes communicated at ‘handover’ are lost once documented in the sequence of progress notes and/or not shared between shifts, this poses a significant risk to care causing gaps in medication effects, treatment reviews and other care services. Constant employment of agency staff erodes the budget and impacts on the number of permanent care staff that could be employed as well as quality and continuity of care for the individual.

As has previously been stated a more positive image of aged care coupled with remuneration that is “on par” with state run agencies, and improved career paths through specialisation and skill set training may lead to higher attraction of both regulated and unregulated workers to the aged care sector which in turn would support the client/ residents psychosocial security, person centred care and quality improvement within the sector.

Aged care is a sector with a high emphasis on funding structures that rely heavily on documented outcomes which requires honed writing skills and reporting processes to support assessment. This documentation is, at times, completed to support the funding requirements and as a consequence, is diluted according to subjective determination of the need to include certain factors of the daily care and support needs. This erodes the concept of exception reporting as a legitimate record of ongoing care as well as the individualised inputs to support true person centred care

The introduction of computer based programs has seen the documented process become increasingly ‘tick and flick’ and as such is, at times not reflective of the true person centred care needs of the client / resident. Pre populated responses ensure that the information meets the requirements of the funding tool mechanisms rather than reflect the true objective of exception reporting and requirements of a validated assessment.

It is essential that this inquiry recognises the diversity training within the Community Services Training Package. The package centres on the principles of diversity and emphasises the

need for training on key areas of diversity and minority groups but does not at any point emphasis the need for those from cultural diverse backgrounds to gain an awareness of older Australians. Australian Indigenous and migrants' culture are dealt with under Minority groups. Australian culture relating to generational change, expectations, past history of the 'larrikin' personality and informal way of dealing with challenges is not included in the package. This aspect of training and practice impacts, in practice, on the delivery of quality care and understanding of the definition of the Australian pioneer (for the want of a better phrase) that still exists.

All the above mentioned issues need to be addressed if quality care is to be delivered throughout the Aged Care Sector. The introduction of a staffing ratio, skill mix, career paths promoted through specialisation through skill set training and appropriate wages for regulated and unregulated workers will improve the image of age care services and make them more attractive to all levels of staff. These measures will ensure the continuity of care that residents and clients deserve.

b. Future aged care workforce requirements, including the impacts of sector growth, changes in how care is delivered, and increasing competition for workers:

There is unprecedented growth in the aged care sector as with improved health services and preventative care people are living longer. This population growth impacts on the demand for increased numbers of workers under the National Disability Insurance Scheme (NDIS), health care sector, demanding aged care early interventions and ongoing care. Two important issues from these changes are:

1. the impact on wait times for admission to a facility and transfers to aged care facilities, admission from aged care facilities and services; and
2. the need for acute admissions for individuals with acute onset conditions as a result of existent chronic disease and comorbidities.

Whilst the employment of cheaper Certificate III trained workers with training specific to provision of personal care, dementia and palliative care provides the "freeing up" of regulated workers to provide higher level clinical care to others it must be recognised that these workers have limitations in the care they can provide.

There is an urgent need to overhaul the present structure and function of the organisational aged care system and provide an integrated approach to training outcomes for Certificate III level qualifications. The move to 'training residential focus and community focused' aged care workers as a combined outcome under the Certificate III in Individual Support is one step towards this integrated approach. It is important that this Certificate III level qualification remains targeted at the level of the nurturer/ carer who understands the basic requirements of the resident / client, so they have a strongly engrained understanding of the issues of ethical practice, advocacy including the completion of care and support at the bedside/ in home, personal care and grooming and the elements of substance of life. Self-actualisation as espoused by Maslow (Hierarchy of Needs), or a credibly researched alternative, must be used as a guideline in the Certificate III program so that the student is aware of the need to promote physiological support, safety, belonging, and esteem of the individual.

Current funding arrangements, within the aged care sector scream for a greater emphasis on the following issues: isolation, boredom and loneliness. These issues need to be captured and encapsulated into the training package and ongoing practice of Certificate III workers. This can be achieved with a more relaxed funding model, workable structures and improved documentation guidelines. Workers would have time to practice these activities and respect the aspects of person centred care that is being lost in the industry with the current funding tools and shrinking of staff budgets. As individuals enter the aged care sector they have a heightened need to be supported and reassured within their new surrounds and

routines. This can only be achieved by reviewing funding structures to allow more appropriate allocation of staff and properly integrated care models that place an equal emphasis on care and psychosocial needs

Many services have excellent therapy programs which support person centred care. However, they are rarely extended to the full work day and routines. There is often little recognition of the principles of personal psychological and strengths based support integrated into the general duties of the worker who is at the “bed side/ home” providing outside hours care and support. These supports are lost in the flurry of completing the duties that support the physical comfort of the resident / client and the associated need to be accounted in documentation to support funded outcomes. This onerous documentation requirement detracts from actual hands on care to include allowance for human comfort and belonging. This is frustrating for unregulated workers who see the need for this support but are unable to provide same due to time constraints of embedded routines

With the inception of the NDIS where a generous “bucket of funding” is allocated to the care recipient without the need for the level of documented scrutiny that aged care has, there is a potential and to date, anecdotal heightened interest in cross sectional leeching of workers. Aged care workers are seeing this disparity as an opportunity to be able to provide the client with the needs that they are unable to give to the aged clients under their care. Therefore workers providing service to clients with NDIS funding are experiencing a heightened satisfaction and sense of achievement in their days work and higher levels of remuneration.

The onerous documentation processes required in aged care are driving practitioners to reassess their willingness to enter and / or remain in the sector. All levels of regulated and unregulated workers, including therapists and medical practitioners are, at the coal face, discussing the unnecessary need for heightened monitoring of such things as medication, continence, nutrition, personal hygiene, and toileting management in the pursuit of funding. Surely the assistance levels for the support of these basic human needs should not need to be monitored by and reported to a funding agency.

The domains of medication management and assessment relating to pain management, behaviour and cognition have potential to change frequently thereby increasing workload of already stretched workers. If there was a baseline funding level that is then “topped up” to support the fluctuations in care this would allow for a return to exception reporting and provide more time at the bedside for workers. These actions would enhance the quality of life of residents/clients and in part alleviate the effects of isolation, loneliness and boredom experienced by them in residential facilities and socially isolated community locations as there would be more time for workers to provide psychological support to those in need of same.

The aged care sector currently has robust accreditation and complaints systems for example the Aged Care Complaints which ensures quality of care for residents and clients mainly in residential facilities and sporadically in the community sector.

These systems, at times, do not address the human resource deficits. Service rostering, skill mix, replacement, attraction and retention of staff, staff qualifications and experience/qualification of managers/leaders in the aged care sector. The implied requirement for higher level qualifications, including nursing has been removed from the management structure of aged care services. Aged Care Services are now being administered by accountants and managers with no exposure, let alone experience in providing care to the aged. Consideration of participation in a mandatory skill set to assist aged care sector managers to understand the needs of residents/clients would improve their understanding and ability to allocate funds where necessary. Managers do need to have a knowledge base of residents/clients with cognitive, behavioural and chronic disease issues,

and palliative care requirements, as these items take a bigger percentage of the budget to manage and are an important part of the core business of the aged care sector. An understanding of dementia and palliative care would enhance the importance of selecting, employing and retaining skilled regulated and non-regulated workers within their facility enhancing the outcomes of residents and clients and will in the long term increase the profit margins and returns to shareholders and / or stakeholders in the case of not for profits.

c. The interaction of aged care workforce needs with employment by the broader community services sector, including workforce needs in disability, health and other areas, and increased employment as the National Disability Scheme rolls out:

The aged care sector is vulnerable to employee number attrition and associated "lifeblood exsanguination" as the NDIS ramps up. The image of the disability sector is one based on support, a sense of personal interaction and "fun". The Aged Care Sector which has been poorly betrayed over time i.e. aged people being abused, neglected and poorly treated etc. needs to improve its image if it is to recruit and maintain workers in the future. The media appears to have an obsession for portraying this sector in the dimmest light possible. Very rarely is there a "good news story" apart from those portrayed in advertising for entry to retirement villages and RV villages, service competition and targeted media "lift outs". Occasional advertisements indicate that there is time to provide psychosocial supports however very quickly workers find that this is not the case and that they have little time for the "niceties" of caring for the aged. Tasks associated to residents' care is often rushed and the pressure is on to ensure that all work is completed according to, in the most, routines that are tailored to staff rosters rather than resident/ client preference. Of course there are exceptions to this, however experience has shown that these exceptions are not in the majority and are highly reliant upon the manager's knowledge of industry and the possibilities for timely care and support based on preference through the provision of a truly person centred care practice model.

The NDIS allows clients to self-direct care and to flexibly choose providers to meet their needs. Some of these clients have the assistance of agencies that manage their funds while others self-manage, often with the assistance of parents, siblings and advocates. The luxury of such support, with the exception of advocates, as NDIS offers is often not available to the aged resident/client and their carers, who are entering or have reached old age. The NDIS funding models are in stark contrast to those in the aged care sector where there is a basic means test and then user pays model to access services.

Traditionally carers of the aged are exhausted by the demands of a lifetime of struggles, or are entering the phase of life where they are now free from dependent children and have plans to live their life to the fullest unencumbered by the demands of caring for parents and siblings.

This aged cohort has never been as vocal as the disability sector. They are seen to be less able than younger people with a disability and in reality have far less options for community support and family advocacy. Very few older people would freely choose to go into residential care if they had the choice and the luxury of generously funded support within the community. The recipients of the NDIS have access to funding that is not means tested for care, social support, transport, training etc. including the freedom to choose care according to preference, not short regulated visits at times that "fit in" for agencies. It is understood that there are shifts toward client directed care for aged persons, however will the outcome of this be unmeanstested similar to the NDIS? Will aged care residents/clients have the ability to move from provider to provider? The answer to these two questions is no as the means test / user pays model will remain for the aged seeking services as will an exit fee for those choosing to change service providers. The question that must be debated is why there

is a disparity in the funding models for each of these groups and what makes the aged devalued in consideration for fee funded services? This new model has potential to bring changes within the sector, as has been seen in the shift or funding strategy for the NDIS, however exit fees may inhibit the fluidity movement, which can be seen as yet another barrier for the aged accessing appropriate services. http://www.afr.com/news/policy/health/how-the-disability-sector-is-being-uberised-20161005-grvz08

People with a disability have the un-means tested option of living in clustered housing, using residential respite centres, choosing services that they feel best suit their needs and then as a final need entering residential aged care services, or more appropriately and more recently disability residential centres such as Young Care https://www.youngcare.com.au/ . It is to be noted at this point that admission to residential aged care short term respite and long term admission requires a Centrelink assessment and hence assets testing and lengthy and complex collection and submission of information, plus ACAT approval and then ongoing scrutiny of daily care routines and intimate support needs.

The two models described could be duplicated for the aged in order to decrease isolation, boredom and loneliness and the reality of the trauma of repeated assessment and diminishing assets that the aged have accumulated over time. This could further cut carer stress levels through the increased availability of respite and support services in the home and may, in fact strengthen the carers ability to provide ongoing care. The success of the chosen model would however be reliant upon an easing of means testing, better funding and a review of pensions to better allow ongoing affordability within the aged care sector.

The final issue to be highlighted is employment in the aged care sector compared to the health sector provides further challenges in that the health sector has higher wages, better conditions and the availability of supported career path planning and achievement. These factors draw those trained in the Certificate III in Individual Support and the Certificate IV in Aging Support away from aged care and into the general health sector as Assistants in Nursing (AIN). AINs within the health sector have access to further training and have job tasking that includes assisting with hygiene, transport and monitoring of those patients with dementia, reassurance for post-operative patients and the dying and patients with terminal illness, without the requirement for documentation to support ongoing funding mechanisms that retract from the provision of care. These roles are far less pressured with added bonuses as mentioned above and hence far more attractive to workers.

Commentary on possible career path options to support workers and quality care in aged care appears below

d. Challenges in attracting and retaining aged care workers:
e. Factors impacting aged care workers, including remuneration, working environment, staffing ratios, education and training, skill development and career paths

Challenges include: lack of career paths, wage disparity, day to day expectation of workers and sector image have been discussed formally.

Three burgeoning issues in aged care include

- The requirement for medication training prior to employment in the Community Sector
- The requirement for six months experience prior to employment
- Employment of graduates from courses that have insufficient training inputs to ensure work ready outcomes

The following are additional factors

- Limited career paths
- Lack of ongoing career path opportunities
- Lack of parity in pay and conditions

There is a trend in North Queensland for community services employers to insist upon the inclusion of medication management as a unit in the Certificate III in Individual Support. Two immediate barriers are:

- The downsizing of the number of units required to qualify for this qualification from 14 to 13 and
- transferring CHCPAL001 deliver care using a palliative approach to an elective unit
- disparity of the stand alone accredited units relating to medication and the requirements of skill set training

In transferring CHCPAL001 to an elective unit there is no opportunity to provide the medication unit in a provider preferred dual specialisation outcome (CHC33015 Certificate III in Individual Support (Ageing, Home and Community). This dual qualification is tailored to meet the best employment prospects for potential workers in the aged care sector both residential and community care sector.

Consultations with Industry (residential care in particular) identify that they have advocated loudly that Palliative care is an essential component of the outcome of an aged care qualification. This is particularly obvious in the care of the resident/client with chronic disease requiring palliative (non-curative) care and care of the resident/client approaching death (terminal care) which are core business in the Aged Care Sector.

Community providers have validated the requirement for an understanding of both dementia and palliative care and support the outcome of a dual qualification to provide better employment prospects within a highly casualised work sector.

The disability sector has advocated for the inclusion of dementia as a unit of the Certificate III in Individual Support (Disability) as there is a higher prevalence of dementia as a diagnosis as people with a disability age.

A clear issue that must be examined within aged care is the attainment of HLTHPS006 Assist clients with Medication (a unit of the CHCSS00070 Assist with medication skillset) can be completed as a unit of competency within the CHC30115 Certificate III in Individual Support qualification with no reference to the fact that there is a requirement for the student to be working within the sector where as in the CHCSS00070 Medication Assistance Skillset where there is a clear requirement for students to be “people working in various care and support roles in the community services industry”. The incongruence between the requirements of the unit and the skill set is causing distress to students who have not had this unit included in their training course. Services are refusing employment to students who do not have this unit of competency and will not accept students for assessment against the required practical outcomes for assessment. Where then do the students get the practical assessment to have the competency required to attain employment? This is a vicious circle and one that could be easily remedied if the single unit held the same provision as the skillset and required employment within sector in order to undertake the unit of competency and / or the unit was removed as an elective within the CHC33015 Certificate III in Individual Support. These same services that are demanding competency in this unit are not willing to accept students during the practical phase of the assessment thus providing a barrier to the completion of the unit and in turn excluding new entry to employment within community care services. The feedback from students is that they are refused employment until they achieve competency, and therein starts the vicious cycle of where to obtain competency.

If this skillset was stand alone, and therefore, not completed until workers were employed and in a position to have had supervised visual oversight of the medication administration process it would ensure appropriate completion of competency is available to all participants. The spinoff is that it may also decrease the number of medication errors which occur due to inappropriate administration as is the case now. The inception of employment requirements would ensure that there is ongoing practice of competency after completion, rather than completion and then waiting an unknown period of time for employment. It is possible that during this period, contemporary practice may have changed or skills and knowledge are less easily recollected.
https://training.gov.au/Training/Details/CHCSS00070
, https://training.gov.au/Training/Details/HLTHPS006

Many aged care and community services now require six months experience prior to employment in an aged care service. This creates a huge barrier to graduates who are keen to put their skills to use and gain employment as soon as possible. Industry feedback is that the need to have this experience is related to the fact that students are not work ready when they complete their competency based training at Certificate III level. These students will, in most instances, require on the job mentoring to hone their skills and knowledge learned during training, simulated practice and 120 hours of work placement. It is impossible to ensure that every graduate will be work ready. It is widely recognised that practice reinforces skill and assists in the retention of knowledge and therefore employment soon after completion of the qualification is optimum for retention of skills and knowledge and support of lifelong and incidental learning.

If the Aged Care Industry did not support short courses (5-9 weeks) and online training conducted without adequate practical skills training, students would gain a better understanding of the tasks to be completed and the skills requirements of industry. This six months experience is a case of the RTOs with students who are prepared for workplace being penalised along with graduates from RTOs who do not adequately prepare their students.

Anecdotally one service that demands this pre entry requirement actually partners with an RTO which runs short courses and provides onsite training only to then refuse employment as the students do not have appropriate skill levels to participate in the workforce.

One solution to this “mistrust” of employability may be through a mentoring program such as is available to Registered Nurse upon graduation. This would ensure that the students get the reinforcement of skills that Industry is expecting but are unwilling to provide under the six month experience requirement.

HANMAC is privileged to be the RTO of choice for community services and Indigenous services (all of whom have waivered the six months experience expectation for our students) which means that these providers call and request our students when they have a vacancy. For those students who are superfluous to these needs gaining employment is challenging.

The lack of career paths in Aged Care Industry has been discussed previously. However it is timely to point out that there could be career paths “put in place” through heavier emphasis on the use of skill sets to provide incentive for workers to follow a specialty stream and hence provide a career path within the Certificate III / Certificate IV role. An overview of the CHC Community Services Training Package can be found at https://training.gov.au/Training/Details/CHC . This overview contains a list of available skillsets. Additionally and overview of the HLT Health training Package and skillsets can be found at https://training.gov.au/Training/Details/HLT . These skill sets also impact on the provision of specialist skills and practice within aged care.

Examination of this information indicates that there is real opportunity for workers to upskill to follow career paths for those who wish to pursue further training as a regulated worker This upskilling would extend the capacity for employers to provide targeted specialised training and competency in many areas of clinical care. Skill sets are not generally promoted in Industry unless through free training opportunities as they arise through government funded programs, the exception to this would be the medication assistance skill set.

Pay and conditions of workers in aged care are at the lower end of the spectrum. Aged care is a job that is physically and mentally taxing. It involves manual handling, cleaning, cooking, meal delivery, psychological care, social support as well as lengthy documentation. Tasks include the ability to observe and document natural processes and recognise deviations to, personal care such as continence, feeding, socialisation and other interventions as they arise from time to time for individual clients and residents. Specifically the aged care worker role is complex and involves dealing with bodily fluids and functions: including incontinence and management of other secretions, supporting personal hygiene, grooming and personal choice with routines, confusion and dementia related symptoms, care of the dying and death, personal rituals and idiosyncrasies. Further to this there are the requests and, at times, unrealistic expectations of relatives, employers and other stakeholders. All of this combines to ensure that mental and physical fatigue / stress is a real component of the job. Workers in this field have added aspects of fatigue, not only from dealing with the "people" aspects of the job but also fatigue from the demands of shift work including the effects of working double shifts on a regular basis due to non-replacement of staff

Aged Care is an unglamorous career choice and requires dedication and fortitude to remain committed to the care outcomes of the residents and clients. There must be recognition given to the fact that the Aged Care Sector, inclusive of other sectors within the Community Care Industry, have an enormous role to play in the support of other workers and consumers of the services. Without these devoted workers this Industry would not be able to attend to their jobs with the certainty that their loved ones, children, and aged and disabled relatives and friend are being provided with competent care while these workers go about their own business. This is particularly evident through the support of parents through childcare and carers through the provision of respite and in home / residential care. The government has not openly considered this "underpinning sling" when considering such things as skills recognition and support for the economic pillars or other economic reforms including the impact of worker attrition from the sector and through acknowledgement of the work done by workers in sustaining the economy through the provision of this "sling".

Recognition of the range and demand of work and support that is undertaken in this sector needs to be seriously considered with a remuneration review of funding, documentation process demands, pay scales in line with residents/clients needs and increased worker's satisfaction recommendations of the Inquiry to Aged Care Workforce. Attraction and retention issues will prevail and have the potential to worsen if this is not undertaken with a minimum, and in addition to those outlined above, parity between employers; State, Private and Not for Profit being addressed

f. **The role and regulation of registered training organisations, including work placements, and the quality and consistency of qualifications awarded**

Registered Training Organisations (RTOs) are tightly regulated by an every changing system. In Queensland there are two sets of Standards, one for the Australian Skills Quality Authority (ASQA) and another under The Department of Education and training (DET) for organisations providing training under Pre Qualified Supplier arrangements. These are at times conflicting in their requirements for competence determination. This is however out of the scope of this inquiry.

RTOs feel the brunt of an education system that has ineffective language, literacy and numeracy (LLN) programs. It is the expectation of the rules of training packages that students are at a level that is appropriate to the LLN needs of the work role. There is no additional funding available to providers to bring these expectations into line unless through formalised foundation skills training, an option that is seen by some as shameful and demeaning. In HANMAC's experience many students are hesitant to engage in training due to their own perceptions of their capabilities and associated low self esteem; however once a trust based relationship has developed they are open to individualised programs to develop their skills. They are reluctant to be referred to other providers for formalised assessment and if supported "in house" develop, over time to be confident potential workers within the aged care sector.

A number of students only require support and become frustrated and aggrieved at suggestions that all students are required to undertake formalised testing, particularly those who have worked for many years in other industries. Other RTOs require students to undertake large pre entry testing and mandatory literacy training regardless of need or consideration of former work roles, skills etc. (see attachment A)

LLN funding is available through Foundation Skills (FSK) Programs which target general literacy and numeracy at an appropriate level, meet the requirement of the course, and allows for contextualisation for the work role. HANMAC has experienced students being told by other providers that "they are not wired to learn", and as such "should not even try". Many of these students given the right support and guidance have been quiet capable of learning and have the caring attitude required to succeed in the aged care and community services industries. The expectation of training authorities must be mindful of taking the nurture out of the nurturing role and replacing it with expectations of higher level skills, while conversely providers must remember that the Certificate III is entry level training and cannot be expected to produce workers with assessment and high level literacy skills. To this end appropriate skill mix and workplace mentoring will, if utilised and when in place, ensure that Certificate III trained staff grow into the higher expectations of the role.

There is a tendency for the general population to place all non-government (private RTOs) into the same basket. There is a perception that RTOs with the exception of TAFE do not have government endorsement, and are subjected to different regulations and are profit driven. This is a false hood and could be remedied by the use of RTO in lieu of TAFE as terminology when applied cross sector.

Students who wish to change RTOs complain that other RTOs do not provide resources, "give you a USB and you are on your own" and are unsupportive and trainers are uncontactable. This information is supposedly captured in surveys completed at the completion of training, however random sampling of students during and after completion of courses may provide a better insight into these problems. These poor practices have led to Registered Training Organisations being "tarred with the same brush" in the aged care and community services due to poor training and/or assessment practices which results in a lack of job ready students.

There are barriers in North Queensland through facilities not extending placement opportunities to RTOs other than TAFE. This is due to the perception that TAFE as a government agency, with government endorsement and are by default better. Governments when speaking of the VET sector should be, in all fairness, referring to RTOs not TAFE. This coupled with programs such as "rescuing TAFEs" which provided multi millions of dollars across the states to provide second chance funding for people wishing to change careers, providing unfair advantage within what is supposed to be a level playing field for those wishing to access funding with private RTOs Please see attachment A Statement by Student

Many students are poorly equipped to undertake the physical and psychological demands of the aged care workplace, unprepared for the realities of the stress that accompanies working with people who, at times have disinhibited thought processes or are behaviourally challenged. Entry level qualification is prescribed for training in these areas. However unless the trainer/ RTO is current in contemporary industry needs and has sufficient experienced there is a misconception of the demands of the work role. The inclusion of the ability to utilise training from industry experts on a regular basis would assist in this dearth of knowledge for students as it would facilitate the "story telling" that makes the work role real.

Currently industry experts, although highly trained specialists in particular fields, require a training skill set or supervision to train. This is a barrier, as previously discussed, to real grass roots knowledge exchange within the aged care sector for training relating to such specialties as palliative care and dementia, where experts do not have these skill sets.

ASQA has begun to screen and deregister the small percentage of unprincipled providers. This process is often "turned back" on the funding guidelines of associated government funding agencies, with the true reason not publicised in the public domain therefore the general community is unaware of the consequences of the deregistration of these organisations which results in suspicion for all RTOs. The outcome of the ASQA processes and closures promote the integrity and ethics of all RTOs who are compliant with standards and outcomes and it is only fair that the real reason for closure should be available to public record. In a recent case the RTO ceased trading due to "funding not being forthcoming" but the RTO remains registered on the ASQA site. This closure was well publicised and yet has not been captured by the regulator.

One of the greatest difficulties encountered in attracting and recruiting students to the Aged Care Sector is the media's coverage of bad news stories relating to aged care and the community sector. The sector is not seen as an accepted work area with ongoing prospects of further advancement in contemporary terms.

Random questioning of school graduates (10 in total) about whether they would follow a career path into aged care identified the following issues:

- I don't want to wipe butts", "
- why would you want to work with old people?",
- "I visit my grandmother in a nursing home and it smells", "
- If I got paid enough", "
- yer, sure why not, but I am going on a holiday first", "
- will I get paid ok?", "
- yep I have enrolled in a course to do just that", "
- uuummm no"
- the remainder were undecided.

The eleven students in the Certificate II in Health Support trained through the VET in Schools program last year were offered placement in an aged care facility, 1 student undertook the placement but failed to engage with the residents, regardless of the promotion of the opportunity to learn from stories and reminiscence and the residents willingness to share experiences. There seems to be a general lack of insight into the knowledge of older people and their worth to society generally

Students undertaking CHC33015 Certificate III in Individual Support must participate in a minimum of 120 hours of work place experience. This number of hours equates to 16 days in a facility that rosters at 7.6 hours per day. This requires a placement of 3 weeks and one day, while other services and facilities roster shorter shifts the requirement to meet the hours required increases to 5 or 6 weeks of work placement. Students who are taking annual leave

from other jobs are often disadvantaged as they do not have the annual leave allocation and therefore must take leave without pay or long service leave. This is a deterrent for potential students with many choosing not to pursue this avenue of career change due to the length of placement, when greater than 3 or 4 weeks is required as it erodes their personal leave time and necessitates leave without pay and associated financial hardship.

To note under CHC30212 the vocational placement (now called work placement) requirement was up to 80 hours. The need to increase the hours of work placement is understood and recommended however it would be better to introduce a day allocation over an hours based allocation that does not account for the casualization of the aged care industry for example a 3 or 4 weeks work placement. This correction would allow for the variation in hours between facilities and services in the casualised aged care industry

g. Government policies at State, Territory and Commonwealth level which have a significant impact in the aged care workforce:

The Government policy on reducing pensions, tightening assets and the general devaluing the pensioner as a life-long contributor to Australia's economic and social history is perceived by many as having an impact on the value of working with the aged. Anecdotally conversations around the difficulties working within the sector, job security associated with perceived cuts to services related to the pension changes and continuing fatigue considerations of staff on a day to day basis are barriers to those wishing to enter into the aged care sector and workforce. A more positive picture of the aged care industry as a whole, as well as previously discussed recommendations, are essential to the attraction and retention of workers

Federal and State Governments provide funding for subsidised training in Queensland. This is an excellent way of supporting entry level learners to access the skills and knowledge required with in the sector. The fact that learners have to pay to receive the training spurs them on to get value for money in the majority of cases. There are no caps on the charges that can be made to enter courses in Queensland. This allows providers to offer cheap (as low as $10, $20 and $50) courses over very short timeframes i.e. 5-6 weeks. Feedback from students who have transferred from these providers is that training is non-existent, assessments are completed by the group in class time, they do not receive adequate resources and / or they are poorly informed of the realities of working in the aged care industry. There has been discussion with ASQA regarding these timeframes and the parameters for volume of learning, i.e. the number of hours to complete the course competency outcomes, with the response, during a public forum being "if the assessment strategies are supportive of knowledge and skill outcomes, the course can be conducted over any time frame". Students undertaking these short course without prior knowledge or training in the Aged Care Sector are not qualified to work effectively or efficiently in the system.

New South Wales has capped fees policies in place and therefore could be the basis of a national model that may outlaw the unscrupulous providers as students will then make a decision on quality not price or length of commitment to training (which they see as a fast track to employment) for further information on this fee structure see Smart and Skilled Price Fees for 2017 at https://www.training.nsw.gov.au/smartandskilled/prices_fees.html

As has been previously discussed retraining government funded programs, often inconsistent, is available in some states. HANMAC fields many enquiries from people wishing to change career paths, particularly since the downturn in the mining industry and

redundancies at Queensland Nickle. These people were able to access funds under the "Rescuing TAFE" programs however this funding was inconsistent and not available to all RTOs thus removing the element of choice for those wishing to train under a particular provider unless the potential student was informed and empowered. Refer to attachment A statement by student
and http://www.education.vic.gov.au/about/department/Pages/tafenetwork.aspx, https://backtowork.initiatives.qld.gov.au/for-jobseekers/#1467124949340-5beb9bc6-48ff

h. Relevant parallels or strategies in an international context;
Not applicable to HANMAC operations

i. The role of government in providing a coordinated strategic approach for the sector;

Government has a role to play in the equity of recognition of RTOs. There is a need for appropriate terminology to be used when referring to training providers. Reference to TAFEs when referring to accredited training providers does not present a true picture of the industry. There are many RTOs providing great outcomes to the industries that they train within. Mindfulness of the use of the all-encompassing terminology will enhance legitimacy of RTOs meeting standards and providing appropriate outcomes for students nationwide. Negative publicity such as that espoused by the Greens in their http://greens.org.au/save-tafe. These claims are false and misleading regarding the operations and interests of the majority of RTOs and while we have governments/ parties willing to make these unfounded claims and provide separatist funding for elements of the sector because there is a downturn in enrolments, the sector will remain divided and inequitously funded. If groups wish to make these claims they should be called upon to substantiate same through public forums. I am aware that this is not something that can be addresses overnight, however blanket statement and untruths must be addressed by governing agencies in order to address misconceptions by consumers.

The Government, through ASQA, has commenced and must continue the fight to close "dodgy operators" and call them to account for the real reason for closure. Representations to the public that RTOs who have been closed down for many reasons, but mainly noncompliance, must be identified as such in the public eye and not allowed to "hide " behind statements such as "funding was not forthcoming", when the reality is that funding was not forthcoming because it wasn't earned legitimately. The consequence of the closure of RTOs is devastating to its students and to the trust that has been built up within communities generally.

The promotion of a more positive picture of ageing and aged care, relaxation of the continual targeting of the sector as a source of budgetary support, and more positive media representation of the sector will enhance the image of aged care and will have a spinoff of being more attractive to younger people as a career of choice.

The perceptions of ageing and the aged as negative and undesirable, needs to have a reversal to promote their wisdom, contribution and worth to this nation. We need a positive and timely intervention to break the perceptions that people have that ageing and aged care are unglamorous. People relate to younger people with a disability because they see an " it could be me " scenario, however very few aged care policy makers and community advocates realise their mortality until well retired from the role of influencers.

Aged care and the training industries, alike, need strong and informed representatives, and sector champions to advocate at Government level. Currently these representatives are strongly influenced by a bureaucracy and peak bodies that are made of policy makers, some of whom have not experienced life at the "coal face". The sector needs strength in its advocacy and realism in its promotion. The grass roots issues must be identified in the real world and not as perceptions of policy makers. This Inquiry will enhance this recognition.

j. Challenges of creating a culturally competent and inclusive aged care workforce to cater for the different care needs of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups and lesbian, gay, bisexual, transgender and intersex people;

The challenges related to creating a culturally inclusive workforce need not be any more difficult that creating a generally inclusive culture which is respectful of all stakeholders need, preferences, values and beliefs as advocated in the person centred model of care.

Community services sector training advocates person centred and client directed care approaches. RTOs must be mindful of the fundamentals and principles that are prescribed under these approaches as well as the establishment of trust based relationships and subsequent service provision based on the needs and preferences, values and beliefs of the individual in order for this to flow through. Only once this has been firmly rooted in training throughputs with the culture of organisations and services move to become truly inclusive as workers are employed and engaged.

One option the Government could contemplate is to advocate person centred care in practice as the basis of quality service provision for the aged so that when program guidelines and funding are developed it includes guidelines for minority groups. Through strengthening the objectives of programs to include the values, beliefs, routines and preferences of program participants, it would negate the need for segregated programs and reigned in the administration costs of the provision of care and support as the individual uniqueness of clients/ residents would be forthcoming, considered and catered for within mainstream practice.

Governments fund specific target group services, viewed at times by the general population as exclusive and suspicious, as those on waiting lists are unable to gain entry to these services due to their lack of cultural heritage/ nationality. In the main people from multi cultural backgrounds can see admission to mainstream services where it is seen to be discriminatory to refuse this admission. Why is it that a person can go into services targeted at migrants of a particular nationality, where 457 visas have been approved for the employment of staff who speak the particular language when so many Australian aged care workers remain unemployed? Surely access to interpreters working with in the facility on each shift could bridge this gap, provide equal opportunity for admission and employment while at the same time meeting the requirements of person centred care. This model would broaden the understanding of workers and allow for extension of the person centred model when workers moved to another service.

The above "selective" employment practice should, in keeping with policies of equity, be extended to all facilities including "mainstream" English speaking Australians. Presently this group are faced with the reality of entering facilities and services that are predominately staffed by people who have English as a second language, do not understand the "larrikinism" of "grass roots Australians" and therefore workers without proper training in this cultural norm are subjected to misinterpretation and feelings of discrimination while residents/clients experience difficulties in communicating, especially those who are 'hard of hearing', mentally confused or have cognitive challenges and therefore can become isolated through language barriers and misinterpretations within their homes.

The question must be asked, will a change to include the philosophy of setting up inclusive person centred based services, recognising the values and beliefs, needs and preferences of all individuals equally, provide a positive change to the way that aged care services are funded and delivered in the future?

k. The particular aged care workforce challenges in regional towns and remote communities;

Challenges to training and employment in areas as little as 2 hours from major centres include distances and costs involved when trainers must travel on a regular basis to provide face to face training, access to suitable qualified staff and the demands of aged and community care service delivery to individuals, carers and other health service providers. Relocating to/ from rural and regional areas may not be an option for all workers. Trainers are reliant on the ability of local workforce to reinforce training objectives for continuity of education for students in outlying areas. Some aged care and community services although not remote are often not serviced by regular public transport options which is an equally difficult barrier to geographical isolation.

The cross pollination of hospital staff and aged and community services presents a series of challenges in its transitions. Hospitals function under a medical model, services the needs of post-acute essentially well and usually active patients, aged care and community services on the other hand service older people undergoing the ageing process and often with chronic disease and co morbidities. The two caring scenarios are worlds apart, one supports and sustains life while the other supports death with dignity considering preference, social and family impactors. Both could be easily aligned through the availability of skillsets (as previously outlined) to ensure an understanding of the needs of the aged cross sector.

There are multipurpose centres, which function well, in some centres. Others have acute and aged care services that run in parallel universes rarely touch bases except for the admission of the resident for acute episodes, fractures and opinion and /or the discharge of short and long term admissions to aged care facilities and community services.
Other impactors relate to accommodation and transport issues where rural and remote pricing structure are in place and/ or there is a lack of available and suitable accommodation.

Staffing in rural and remote services require orientation and training tailored to the specific needs of the region to meet their specific populations. Some of the challenges for trainers when training diversity and then for workers are listed below

- working with past farmers and graziers, understanding their routines, personalities and expectations;
- working in Indigenous Communities and understanding cultural norms, dialects and deviations from mainstream care provision; working with older people who have specific communication and cognitive challenges and considering cultural differences, challenges and perceptions including the intricacies of clan and tribe interrelations.
- Working with older migrants in rural settings, who have not been exposed to the Australian culture and remain fixed in time and culture.

l. Impact of the Government's cuts to the Aged Care Workforce Fund;

The workforce development fund provided accessible, cost effective and quality training to rural and remote centres. The cost to provide services to rural and remote locations particularly for equipment and resources, is inhibitive for small providers and inflates training cost to the point of unaffordability.

The impact of reductions in this fund include a decrease in the volume of training provided / requested, participants being charged higher fees to attend the training and a lower rate of professional development.

The workforce development fund would be useful to employ support the training and development needs of workers through general information sessions on the realities and expectations of the aged care sector through the delivery of positive information sessions to schools and community centres (a national recruitment drive)

And

m. Any other related matters.

N/A

Recommendations :

- An urgent review of the qualifications required to manage an aged care service, including at least one member of the management team having qualifications in gerontology or having completed a skill set related to management in aged care
- Develop, clear accessible career paths for workers with the introduction of care associated skills set training to provide skilled and competent input into care outcomes from unregulated workers where regulated workers are not available on site
- An urgent review of the perceptions of aged care as an industry including the positive image of aged care as a worthwhile career, wages and conditions for aged care workers and addressing the fatigue that the current workers are suffering due to the lack of relief workers although there remains reasonably high unemployment of graduates
- Meaningful incentives be provided for aged care services to provide mentoring programs such as the Graduate Nurse Programs for both regulated and unregulated workers of at least six to twelve months on the job practice
- Ability for new graduates to consolidate their skills and knowledge including the opportunity for continuity of study in aged care courses and skillsets
- The use of the reference to TAFE be replaced by the generic term Registered Training Organisation (RTO) when Governments are referring to sector wide issues, funding and incentives.
- Capped fees for funded courses be implemented for funded programs to ensure that students are attracted to the Registered Training Organisation after considering the quality of training rather than being influenced by low cost, short courses
- A campaign to positively support the worth of the aged care industry and Australia's ageing population to support and attract workers in the Aged Care Sector.
- The identification of sector champions with firsthand experience and contemporary knowledge of the aged care and training sectors in order to bring positive recognition and advocacy. This should be as important as engagement of peak bodies in consultation and review processes.
- Greater recognition of the role that is played by the aged and community services sector in supporting workers from other industries to meet the requirements of their jobs.

ATTACHMENT A – Statement by student

I prefer to have my identity withheld a former student of HANMAC Pty Ltd for submission as support for the HANMAC Pty Ltd's appearance as a witness at the Inquiry into the future of Australia's aged care sector workforce.

After being made redundant as a trades person at my former employment I decided to take an alternative path to my future employment. I sought a career in aged care as I had been exposed to this through members of my family being employed and experienced in the care of the aged person and I knew that this was a growing sector and therefore would have solid employment opportunities as well as further study opportunities.

I made an informed decision to choose aged care over a fly in fly out position where I would have earned much more money, to be a bigger part of my young children's lives. Money is not everything but in my opinion aged care workers are extremely underpaid!!

I sought advice from my Job Service Agent (JSA) to ascertain whether I had access to funds to support my transition. I had heard of a small RTO (HANMAC) and was keen to commence the CHC33015 Certificate III in Individual Support (Ageing, Home and Community) as soon as possible in order to re-enter the workforce.

I was advised by my JSA that I should go to TAFE but I disagreed because the class sizes were big and they were unable to guarantee a place in the class. I also felt very uneasy about having to take entrance exams to get into the TAFE course at 34 years of age , having been a solid employee for 17 years and a qualified tradesman.

My JSA continued to push TAFE and the JSA became increasingly difficult to deal with, it was hard to get the money to pay for my course, my uniforms etc. The JSA gave me the run around and made it very difficult at a trying time in my life. All I wanted to do was move into a new career and get a job.

HANMAC supported me all the way and worked with my JSA to ensure that I received the training even though my JSA was stalling. It was a very positive training experience

I have secured a job in a home and community care service and find aged care extremely satisfying and far more rewarding than the mining sector could ever have been

The only down side for me is that I feel empathy for the aged people that I work with and feel that the aged are getting a pretty bad deal considering that they have made huge sacrifices to get Australia to where it is today.

Thank you for taking this statement.

CA TVL