Submission by the Australian Nursing and Midwifery Federation

Consultation Paper – Expansion of the National Aged Care Mandatory Quality Indicator Program

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Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 322,000 nurses, midwives and care workers across the country.

2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best-practice care in every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving the health of our national and global communities.

5. The ANMF appreciates the opportunity to provide feedback on the Consultation Paper – Expansion of the National Aged Care Mandatory Quality Indicator Program. We welcome the proposed expansion of the Quality Indicator Program to include key performance indicators for enrolled nurse (EN), Allied Health (AH) and lifestyle services.

6. The ANMF notes that the expansion of the quality indicator program, although welcomed by the ANMF is not a solution to the structural systemic issues facing the workforce in aged care outlined below. Addressing staffing and workforce issues to achieve quality care delivery requires government commitment to not only increase surveillance through the expansion of the quality indicators program but actually address the systemic deficits of the current workforce.

Overview

7. The ANMF response to this consultation will focus on the development of enrolled nurse (EN) quality indicators, and the broader care workforce as part of the National Aged Care Mandatory Quality Indicator Program. The need for Allied Health (AH) and Lifestyle service measures will also be addressed as part of the overall submission relating to the nurse and care worker workforce and care outcomes. However, the ANMF notes the specifics related to these professions are best placed to be addressed by these professions themselves.

Background

8. It is a core position of the ANMF that care delivered in the aged care setting, in nursing homes, in the home and community-based setting, is a context of health care. The health care delivered in these settings should not, and cannot, be considered separate from other health care contexts, such as mental health, primary care, community care or in-patient rehabilitation.

9. As identified by the Royal Commission into Aged Care Quality and Safety (the Royal Commission), the linkages and intersections between the aged and health sectors must be improved and acknowledged.[1] Nursing care delivered by registered nurses (RNs) and enrolled nurses (ENs) in the aged care setting must be considered as specialist contexts of practice, in the same way it would in the primary care setting. This care requires a broad skill set and vast experience to be delivered safely and efficiently. This, and the important contribution of nursing care, must be recognised in aged care through the development of specific workforce quality indicators and by mandating appropriate skill mixes across the aged care sector.

10. The increasing trend towards home-based care observed across the sector will continue, reflecting the desire of older people to remain in their homes for longer. With the increasing number of older people remaining in their homes with increasingly complex needs,[2] there is a need to implement timely reforms that ensure older people receive adequate levels of health care delivered by a trained and experienced workforce.

11. Further, the ANMF believes that aged care providers, policymakers, and government, have largely minimised the health care component of aged care over the past decade, resulting in older Australian's not receiving an adequate level of care and deteriorating at undue rates while in aged

care. This was recognised in the Royal Commission's final report 'Care, Dignity and Respect', which concluded that the aged care regulator and the Commonwealth Government Department of Health failed to demonstrate strong and effective regulation in the aged care space. [2] [3] Further, as indicated by the Committee for Economic Development of Australia (CEDA), Australia has failed to build an aged care workforce with the capacity and capability to meet community needs and expectations.[4] The ANMF highlights the need to solve these systemic issues present in aged care as a first step in increasing the level of nursing care available to older Australians.

Existing evidence

12. As has been well-documented staffing levels and skill mixes have been inadequate to provide the level of health care required for the reablement of older people. This issue has been particularly prevalent within residential aged care, where the bulk of care has historically been provided by care workers (CW). Results of the National Aged Care Staffing and Skills Mix Project Report 2016 identified aged care staffing and skill mix as deficient and not fit for purpose, resulting in high rates of missed care.[4,5] Based on empirical evidence the report makes a recommendation on the level of care required in residential aged care facilities, expressed as the duration of direct care per resident per day[4]:

    - An average hours of care per resident per day of 4.3 hours or 258 minutes.
    - A staffing mix of 30% RNs, 20% ENs and 50% CWs.

    Using these findings, the apportionment of care minutes should be:

    - RNs = 77.4 care minutes per resident per day
    - ENs = 51.6 care minutes per resident per day
    - CWs = 129 care minutes per resident per day.

13. While the mandated care minutes introduced in October 2023 of 40 RN care minutes within a total of 200 direct care minutes per resident per day is supported by the ANMF, this is notably lower than what is recommended based on best-practice.[5] The ANMF emphasises that the current mandated care minutes are to be considered as an important starting point and the minimum. ANMF members understand the importance of these minutes being increased in October 2024 to 215 minutes per resident per day and reinforce that the current minimum care minutes requirements remain inadequate. The ANMF strongly advocates for the continued increase of care minute requirements,

as the needs of older people and rates of chronic conditions, acuity, frailty, and comorbidities continue to increase.

14. Despite the ever-increasing acuity and frailty of those older Australians across the aged care sector, the bulk of direct care (approximately 70% of all care delivered) continues to be provided by CWs. These workers provide essential personal care and are a critical part of the aged care workforce, however, they have a defined skill set that does not include delivery of complex health care.[6] The staffing and skills mix needs to meet resident's needs and to address the increase in co-morbidities, polypharmacy, and care complexity of residents going forward.

15. Research commissioned by the Royal Commission and undertaken by the University of Wollongong, indicated that residential aged care continues to be understaffed as compared to international and national benchmarks.[6] The report reveals that, based on 2016-17 star rating dates, over half of all Australian aged care residents are in homes with only a 1 or 2-star staffing levels and that only 2% of Australian aged care residents are in homes that provide the 22 minutes of allied health services per day recommended in the British Columbia system.[7] While the ANMF recognises that the essential reforms in recent years, such as mandatory care minutes and 24/7 RN have increased adherence, these reforms do not include allied health, which continues to be underdelivered to aged care residents.

16. Further, in nursing homes, there continues to be a lack of staffing to meet the complex care needs of residents, resulting in a systemic failure to provide quality care.[8] A 2021 review of the quality of care delivered in Australian residential aged care facilities based on adherence to best practice guidelines found that, across six conditions (skin integrity, end-of-life care, infection, sleep, medication, and depression) adherence to practice guidelines was less than 50%.[9] These findings suggested that vulnerable older people are frequently not receiving adequate levels of evidence-based care, with this dearth in care being attributable to several factors including the lack of staff capacity to meet the clinical care needs of the residents; reduction in the number of nurses and their replacement by less skilled care workers; poor staff renumeration leading to low rates of attraction and retention; and lack of access to medical and allied health skills in nursing homes. [10]

17. Staffing and skill mix levels directly influence quality of care and care outcomes in residential aged care [11][12][13] The ANMF highlights the inappropriateness of providers relying heavily on agency staff to

make up shortages. Agency staff utilisation negatively impacts quality of care as measured through complaints, reportable assaults, hospitalisations, and accreditation flags in the Australian context. [14] Further, as agency staff work intermittently, they lack familiarity with residents and their individual needs, greatly decreasing continuity of care, which has been identified as a key component in increasing health outcomes of older peoples. [15] [16] The sector must guarantee secure work to build a permanent, sustainable workforce.

18. Addressing staffing and workforce issues requires government commitment to address structural deficits of the skills and mix of the current workforce and recognise the unique contribution of nursing staff in the aged care context.

Enrolled nurses and care minutes

19. Enrolled nurses (ENs) are essential members of the aged care nursing team whose work contributes immensely to the care of many older people around Australia. However, this valuable resource is not only insufficiently recognised but, currently, is being actively eroded.[17]

20. The significant recent reduction in EN care minutes is widespread across the sector. Aged care providers must be held to account to ensure this reduction is stopped. The work of ENs is essential to providing safe and high-quality care for older Australians within residential care homes. Along with the current specified care minutes for RNs and ENs/care workers, the care minutes must be adjusted to include specified mandated minutes for ENs.

Compliance, enforcement, sanctions, and penalties

21. Current compliance enforcement mechanisms for regulating minimum care minutes or RN 24/7, by both the Government and the Commission are seriously inadequate. Current regulatory mechanisms are not fit for purpose, they do not impose specific obligations on providers to ensure transparency regarding care minute compliance and have minimal direct consequences for providers not meeting identified legislated minimum staffing and skills mix standards in nursing homes.

22. These concerns must be addressed and require aged care providers to meet their care minutes and RN 24/7 requirements. Clear sanctions and penalties must be enforced by the Commission if these targets are not met. A weak enforcement mechanism will result in poor compliance and ultimately lead to poorer health outcomes for older people.

Transparent monitoring

23. Ongoing effective transparent monitoring is required to ensure that aged care providers are complying with their staffing and skill mix requirements. This should encompass clear mechanisms for reporting on compliance for both care minutes and RN 24/7 per resident AN-ACC profile. It should also mandate that providers actually report to, and engage with, their direct care workforce on minimum requirements for the nursing home, changes to care minutes, allocation of care minutes across the roster and the reporting of care minutes to the regulators. The reporting should also include an acquittal of the previous quarterly staffing and skill-mix requirements.

Workforce standard

24. The ANMF strongly advocates for the introduction of an Aged Care Quality Standard that is specific to, and addresses the systemic issues in relation to, the aged care workforce. A draft of this Standard has been included as Appendix A and is intended to describe the responsibilities and obligations of providers in ensuring that the direct and indirect workforce has the capability and capacity to deliver safe and high-quality care that meets the individual needs of older people. The introduction of this standard would be a positive step in addressing the significant and systemic workforce issues identified by the Royal Commission and provide a clear signal to providers and the Commission on the minimum workforce expectations.

25. While workforce planning is dealt with to some degree within the new Aged Care Quality Standards, the ANMF does not believe this goes far enough given the significant attention paid to staffing and skill-mix by the Royal Commission and the subsequent Government mandates for RN 24/7 and minimum care minutes. While this proposed standard is currently focused on nursing and carer workforce, there is no reason why it could not be expanded to incorporate allied health and lifestyle services staff.

Medication administration

26. It is the position of the ANMF that only RNs and ENs, by virtue of their knowledge, qualifications and demonstrated competency can safely manage and administer medications in the aged care sector. Given the prevalence of polypharmacy in residential aged care it is of critical importance that medications are managed by staff who hold appropriate training and qualifications,[18] such as the theoretical and training in pharmacology undertaken by nurses (both registered and enrolled) which

has been recognised by the Nursing and Midwifery Board of Australia. While unregulated care workers play an essential role in assisting with medications, the education and skills for CWs are not of a sufficient level to ensure safety with administration.

27. There is an increasing trend of aged care providers utilising unregulated care workers to undertake medication administration. The lack of clear guidance and consistency in a number of state and territory legislation regarding medicines administration by unregulated care workers further complicates the picture. It is the ANMF's position that personal care workers should only assist in medication administration if the resident/client's clinical record or care plan records an assessment by a medical practitioner, registered nurse or pharmacist that the resident/client has the capacity to self-administer their medications; and the resident/client is mentally competent to request assistance and personally requests that assistance.

28. Another key safety issue is the overuse of high-risk drugs in the aged care setting.[19] Due to the high risks of such medications if used in error, the administration and management of these medications require appropriate knowledge and skill by the administering clinician to ensure that this process is undertaken safely and to a high standard. RN and ENs are ideally placed to undertake this role to ensure that medicines are managed appropriately and safely prior to, during and following administration.

29. Supporting the ANMFs position that ENs play a key role in aged care medication management is complaint data from the Commission that identifies Medication administration and management as the top complaint issue reported to the Commission.[20] The ANMF suggests that the increasing use of care workers to administer, rather than assist with, medicines is a factor driving this complaint area.

30. The ANMF believes that the key role of ENs in medication administration and safety in the aged care context is a further compelling reason for EN workforce reporting. If there were sufficient RNs and ENs employed in the sector, there would be no incentive for aged care providers to require CWs to administer medicines, underscoring the ANMF's insistence on mandated care minutes for ENs in the nursing home direct care workforce.

Response to consultation questions

The lack of QIs focusing on ENs, allied health professionals, and lifestyle officers in the international context highlights an opportunity for Australia to lead in this area. Developing QIs for these professions could ensure a more holistic approach to assessing quality care and recognising the importance of a diverse range of staff roles in aged care. If we were to develop workforce QIs for these three professions based on the total case-mix adjusted hours per resident per day:
How do the varying levels of resident needs and care complexities in different residential aged care settings influence the staffing hours per resident per day provided by ENs, allied health professionals and lifestyle officers?

31. While there is undoubtedly variation in the level of acuity and care needs for those older Australians in nursing homes, this group of people are characterised by frailty, dependency, and often complex care needs. The National Aged Care Staffing and Skills Mix Project (2016) identified rising numbers of residents requiring high levels of activities of daily living (ADL), behaviour management and complex health care. This study cited research indicating that residents may have between 3.4 and 4.5 separate diagnoses, about 6 co-morbidities, and were likely to experience polypharmacy with, on average, approximately 8 medications prescribed.[4] The complex needs of older Australians who enter residential aged care, highlights the need for sufficient care, that beyond personal care also includes considerations for health care. This need is best addressed by aged care nursing staff (RNs and ENs) with multidisciplinary support by allied health professionals.

32. The ANMF contends that current care minute requirements, while a good start, have not effectively yet driven the level or amount of care provided in the nursing home setting. The Royal Commission found that on average those in residential care received 180 minutes of care, of which only 36 minutes was provided by RNs.[21] This is significantly less than the 77.4 minutes of RN care recommended by the National Aged Care Staffing and Skills Mix Project, and does not account for the recommended 51.6 minutes of EN care.[22] This highlights the significant dearth of nursing care provided to residents in nursing homes.

33. The lack of staff within nursing homes, has resulted in staff being forced to prioritise certain types of care with limited capacity to provide whole and holistic care. This has resulted in missed care as staff attempt to provide care to those in greatest need.[23]

34. The introduction of the Australian National Aged Care Classification (AN-ACC) in October 2022, to replace the no longer fit for purpose Aged Care Funding Instrument (ACFI), does provide a mechanism to classify and fund the care of residents based on their individually assessed care requirements, however, does not appear to account for all care needs. Care minute mandates of 40 minutes of RN care within a total care provision of 200 minutes of care on average have been incorporated into the AN-ACC model, and thus does not provide adequate funding to meet all care needs. While offering slightly more resources with which to provide care, the ANMF is concerned that there seems to be little evidence that these care mandates are empirically derived and there doesn't seem to be any clear pathway to do so. Indeed, a recent review of the AN-ACC funding model by PricewaterhouseCoopers (Australia) suggests that resident costs are $100 higher than that reflected in the AN-ACC model.[24] The ANMF outlines the need for a review of AN-ACC classification in relation to increased care needs and funding for an adequately sized workforce.

If we were to develop a single workforce QI for these three professions:
How might it impact a provider's current staffing profile?

35. The ANMF does not believe that the development and introduction of a workforce quality indicator for EN, AH and lifestyle staff would necessarily directly influence current staffing profiles. Aged care providers have, historically, resisted reform measures over many years, and it is optimistic that a requirement to report on the EN, AH and lifestyle workforce would have a positive impact on staffing profiles on its own merits. Indeed, feedback from ANMF members indicates that are care providers are currently:
    - Making EN positions redundant and reclassifying EN positions to care worker type positions, alleging that ENs are not funded under the AN-ACC model.
    - Reducing and reclassifying household, food services, and lifestyle/diversional staff to care worker positions while requiring direct care workers to pick up additional household, food service and lifestyle/diversional work as a method of 'adhering' to care minute requirements.

36. Unless there are specific steps to address this restructuring of the workforce by providers, the ANMF believes this dysfunctional reshaping of the aged care workforce, which is clearly against the intention of the aged care reform, will continue.

37. While this submission focuses primarily on ENs and the nursing workforce, the ANMF is also concerned about reductions in AH services in the sector. Allied Health Professionals Australia has raised the alarm many times regarding reductions in AH services with the average AH care per resident reduced to approximately 5 minutes per day and significant numbers of AH practitioners stating an intention to leave the sector.[18] Since the introduction of AN-ACC, AH workers identify issues such as loss of roles, redeployment, reductions in hours and increased referrals as factors impacting in their roles. The loss of allied health workers, as part of the aged care multidisciplinary team, not only impacts the quality of care provided to residents, but also increases the workload placed on nurses and CWs, resulting in more instances of missed care.

38. These negative changes, instigated by providers, clearly indicate that minimum nursing, AH, and lifestyle workforce mandates are required to maintain the momentum of aged care reform.

Are there other professions that would need to be considered to ensure a comprehensive assessment of care quality in residential aged care settings?

39. Given the current workforce practices of some aged care providers reported by ANMF members, the ANMF believes that aged care providers must be compelled to provide comprehensive data on their entire workforce. This reporting must not only include those who provide direct care, it must also include those in support and indirect care positions. There is a need to increase transparency and accountability in the reporting of care minutes, with measures in place that disincentivize providers from ‘gaming’ the system.

40. Members employed by multiple providers indicate that not only are workers in support services such as household and food services being reduced in number or being reclassified as CWs, there is also the expectation that direct care workers will now undertake household and foodservice roles in addition to the impossible workloads they often experience. The ANMF reiterates that the development of a workforce standard is essential to provide clear expectations and signal to providers expected workforce management requirements, with sanctions in place should they not comply.

Australia already has mandatory care minutes targets for total direct care delivered by registered nurses, enrolled nurses, and personal care workers/assistants in nursing (and a specific registered nursing target) and a QI for staff turnover, how might QIs for ENs, allied health professionals and lifestyle officers influence the availability and/or volume of service provided by these professions?

41. Given that the bulk of funding received by aged care providers is derived from public funding, the ANMF believes that the Government has the right and obligation to direct providers on how these funds are expended, both for workforce and other purposes. The ANMF believes the best use of funds is investing in a skilled, qualified, and diverse workforce. A multidisciplinary team approach is the mainstay of health and aged care and must be enforced in the aged care sector. The reductions in EN, AH, and other support roles are to the detriment of older Australians. Consideration must be given to the following:
    - In addition to RN 24/7 and RN care minutes mandates, specified EN care minute mandates must be developed for the reasons already outlined above.
    - The parlous reductions in AH presence in the sector must be reversed. Research to establish AH requirements, beyond just performance indicators, and incorporating these requirements in the AN-ACC funding model is imperative.
    - Standards around the level of support services such as household and food services must be developed. These services contribute significantly to the quality of care provided and must not be left to the discretion of individual aged care providers, who are often driven by cost-saving rather than service quality.

As part of the Quarterly Financial Report (QFR), providers are required to report on care minutes by allied health professionals, allied health assistants and diversional/lifestyle/ recreation/ activities officers. Are the QFR definitions for these professions suitable for use in the QI program?

42. Allied health professionals and diversional/lifestyle/ recreation/ activities officers are best placed to provide specific recommendations on this question.

The standards found in countries like the USA, Canada and New Zealand can inform the development of similar standards in Australia, especially for ENs and allied health professionals. Adapting these standards to the Australian context could help in setting optimal staffing ratios that ensure quality care. Should individual QIs (e.g. hours of care per resident per day) be established to monitor the volume of service provided by ENs, allied health professionals and lifestyle officers?

43. Yes. The ANMF believes that each of these workforce groups should be dealt with individually, but within a broader and comprehensive workforce reporting framework. It is important to note, however, there is a fundamental difference between these professions, in that the nursing presence

in aged care is continuous over 24 hours per day, while care by AH and lifestyle offices is episodic. The ANMF highlights that AH and lifestyle care minutes must consider this, and be considered distinct and separate from, and not reduce, the provision of nursing care.

What alternative QIs should be considered to monitor the availability of ENs, allied health professionals and lifestyle officers? *Examples include number of full-time equivalent staff and number of current allied health assessments*.

44. As outlined previously in this submission it is the ANMF's position that developing QIs for the enrolled nurse is essential. However, the impacts on the EN workforce are multi-faceted and are influenced by aged care provider behaviour as outlined throughout this submission. Therefore, the ANMF recommends that the following QIs are implemented to provide a complete picture of the care workforce going forward. This monitoring will be a significant contribution to ensuring aged care delivery in nursing homes is high quality, safe, and provided by a staffing and skills mix that meets the assessed needs of residents.

45. The new QIs proposed by the ANMF include:
    - QI for ENs outlining a value and percentage of ENs per shift divided by the number of residents in the facility times 100.
    - QI for RNs outlining a value and percentage of RNs per shift divided by the number of residents in the facility times 100.
    - QI for an CWs outlining a value and percentage of CWs per shift divided by the number of residents in the facility times 100.
    - QI outlining per shift the number of CWs who are or have been previously qualified as an EN.
    - QI outlining the number of CWs per shift who have a qualification as a Certificate III in Individual Support or equivalent.
    - QI outlining the number of AH, AH assistants, Lifestyle officers, cleaners, Laundry and Kitchen staff rostered per shift.
    - QI separately outlining the episodes of care per resident per day for a General Practitioner, Nurse Practitioner and AH professionals and
    - QI outlining the type of staff who administer medicines per shift.
    - QI outlining the type of staff who assist with the medicine administration per shift.

What are the potential challenges providers might face in adopting minimum standards for ENs, allied health professionals and lifestyle officers? What factors would need to be considered in establishing minimum standards for ENs, allied health professionals and lifestyle officers?

46. There is a range of potential challenges and factors that need to be considered in the development of minimum standards. These include:
    - In the ANMF's experience with aged care providers, a "carrot and stick" approach must be used to drive change in provider behaviour. Incentives without sanctions, and vice versa, will not achieve lasting change and improvements that can ultimately be normalised in the sector.
    - Both the Government, the Department of Health and Aged Care, and the Commission must provide consistent signalling to providers and other stakeholders regarding the expected outcome of any indicator program.
    - While workforce shortages are an issue in some areas, they must not be used as an excuse for inaction or delay.
    - Realistic lead-in times must be developed to reduce provider resistance and support recruitment and retention strategies to meet any workforce growth strategies.
    - Any workforce standards must be reflected in the AN-ACC funding model in a timely manner and reflect the actual cost of care, and workforce providing that care.
    - Government intervention, for example by subsidising nursing and AH undergraduate training to reduce specific workforce shortages, must be considered as part of the broader workforce support measures.
    - Further work needs to be done to ensure that there is ongoing evidence to support RN and Care Minute mandates to ensure they are meeting quality care needs. An aged care workforce research program should be undertaken by the Independent Hospital and Aged Care Pricing Authority, as well as supporting research institutions, to underpin aged care workforce standards. Ultimately, the ANMF believes that the aged care workforce must provide care in the amount required (not just available), at the time required, and by the appropriate aged care worker.
    - Workforce standards must be part of the aged care legislative and regulatory framework. Simply making them guidelines would defeat the purpose of developing these standards and offer no incentives (both of a negative or positive nature) for aged care providers to comply and will undermine the aged care regulators capacity to drive and enforce minimum standards.

How might we acknowledge and measure the significant contribution of lifestyle officers to residents' quality of life?

47. Allied health professionals and diversional/lifestyle/ recreation/ activities officers are best placed to provide specific recommendations on this question.

What types of roles should be included in the category of lifestyle officer?

48. Allied health professionals and diversional/lifestyle/ recreation/ activities officers who are best placed to provide specific recommendations on this question.

Conclusion

49. The ANMF welcomes the opportunity to provide feedback on the Consultation Paper – Expansion of the National Aged Care Mandatory Quality Indicator Program. We support the proposed expansion to include key performance indicators for ENs, AHs and lifestyle services. However, addressing staffing and workforce issues to achieve quality care delivery requires government commitment to not only increase surveillance through the expansion of the quality indicators program but actually implement policy that addresses the known systemic deficits of the current workforce, including the implementation of specified EN care minutes and a workforce standard as part of the quality standards that is effectively regulated by the Commission.

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Appendix A

Standard 8: The Workforce
Intent of Standard 8
Standard 8 describes the responsibilities and obligations of providers for ensuring that the direct and indirect care workforce has the demonstrated capability and capacity to deliver safe and quality care that meets the individual care needs of older people.

Standard 8 expectation statement for older people:
The workforce that provides my care has the appropriate number and skill-mix of staff to meet my planned care needs effectively, safely and to a high standard.

Standard 8 expectation statement for employees:
I am treated as a valued member of the organisation and this is demonstrated by:

- feeling physically, psychological and culturally safe
- having clear lines of communication and feedback for work related issues and concerns
- being supported and encouraged to identify and report issues and concerns relating to
- the work
- a work environment that supports me to provide personal, clinical and health care that complies with relevant laws, regulations and professional standards.
- organisational systems that support me to identify and meet my learning and development needs.

Standard 8 expectation statement for the provider:
The organisation is provided with clear and timely feedback regarding the workforce planning and management and the capacity and capability of the workforce to provide safe, quality care, a professional practice work environment, and works with relevant regulatory bodies to ensure that workforce standards are met.

Outcome 8.1: Workforce planning
Outcome statement:
The provider understands and manages its workforce needs and plans for the future.

Actions:
8.1.1 The provider demonstrates that they have developed, implemented and regularly reviewed a workforce strategy and plan that:

a) provides evidence that the strategy and plan is based on gap analysis of current and anticipated future workforce needs and risks.
b) identifies the number and skill-mix of direct and indirect care workers to manage and deliver safe, quality care and services.
c) specifically identifies the number and skill-mix of health practitioners (nursing and allied-health) required to meet the clinical and health care needs of older people cared for by the nursing home or service and to meet regulatory requirements.
d) Identifies the skills, qualifications and competencies required for each role.
e) Identifies strategies and processes for engaging suitably qualified and competent workers.
f) Is based on a permanent workforce model and identifies strategies to minimise the use

of indirect employment workers wherever possible.
g) Identifies strategies to mitigate the risk of workforce shortages, absences , vacancies or staff turnover.
h) Identifies and demonstrates strategies to for supporting the physical, psychological and cultural safety of the workforce including work-life balance.

Outcome 8.2: Workforce utilisation
Outcome statement:
The provider ensures that the workforce is fit for purpose to meet the individual care and clinical needs of older people receiving care provided by the service.
8.2.1 The provider demonstrates that sufficient numbers and mix of suitably qualified and skilled staff are employed to meet the care needs of older people cared for by the nursing home or service to meet regulatory requirements:
a) Best practice rostering optimises the skills, knowledge and abilities of staff to meet care needs of residents and clients
b) Staff work-life balance requirements are considered in all deployment decisions
c) Business planning is demonstrated to match workforce capability and capacity to service demand.
8.2.2 Direct care workers are provided in sufficient numbers and skills-mix to meet the needs of the resident or client cohort but not less than those number required through direct care minutes funding and any other relevant legislation or regulation:
a) Rosters clearly identify average minutes of care per resident and registered nurse minutes of care in the residential setting on a daily basis so that these metrics can be easily accessed by
staff.

Outcome 8.3: Workforce development
Outcome statement:
The provider demonstrates that a planned, communicated and continuously evaluated strategy, plan and process is in place to support the role, and professional and personal developmental needs of the workforce.
8.3.1 Staff receive the appropriate support, training, professional development, supervision and personal performance and development relevant to their job description.
8.3.2 Staff are supported, enabled and encouraged to obtain further qualifications relevant to the role they perform within the organisation.
8.3.3 Employees are enabled to undertake training and education needs which:
a) Is consistent with the assessed needs of the resident or client cohort
b) Includes both mandatory and non-mandatory learning opportunities
c) Enable health practitioners to comply with their continuous professional development requirements
d) Enables career progression and meets individual learning needs.
8.3.4 Priority training areas are encouraged and supported within the organisations workforce plan:
a) The health service organisation provides access to supervision and support for the workforce providing:
- end-of-life care, including palliative care
- dementia care

- skin integrity care
- behaviour management
- nutritional support.

Outcome 8.4: Workforce regulatory requirements
Outcome statement:
The provider demonstrates that the organisation enables and supports Health Practitioners registered with the Australian Health Practitioner Regulation Agency (Ahpra), or Self Regulating Allied Health Professions, to meet the standards of practice and code of conduct requirements of the relevant professional regulator.
8.4.1 Care staff including health practitioners and unregulated care workers are enabled to identify situations that compromise their professional standards of practice or codes of practice.
There is a system in place to support staff to report concerns or situations that compromise their capacity to meet their professional standards or codes of practice.

a) Reported concerns or situations are responded to by the provider in a timely manner (where possible within 24 hours).
b) Staff are supported to meet continuing professional development or credentialing requirements for registration or membership of a professional body.

Outcome 8.5: A positive workplace environment
Outcome statement:
The provider demonstrates that the organisation enables and supports the physical, psychological and cultural safety of staff.
8.5.1 The provider has effective systems in place for the identification, reporting and escalation of safety and quality issues and operational and professional decisions.

a) Contemporary policy and procedures in relation to physical, psychological and cultural safety are in place.
b) Processes are in place to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems.
c) Systems are in place for workers to raise concerns regarding staffing and skill-mix, incidents, complaints and workplace health and safety issues.
d) Whistle-blowing policies and procedures are in place and known to employees and they are enabled and supported to raise concerns in good faith and protected against reprisal.
e) Direct care workers are provided the opportunity to raise issues of concern relative to staffing and skills mix, resident and client safety and quality and workplace safety with the relevant regulatory authority and a workforce representative.

8.5.2 Health professionals are provided access to, and receive clinical supervision and mentoring.

a) Orientation and transition to practice programs are individualised to the learning needs of individual practitioners.
b) Health practitioners are supported to connect with external healthcare providers and any other entity deemed appropriate to maintain and update their clinical knowledge and skills.

8.5.3 Worker rights in relation to association and membership of industrial bodies are acknowledged and supported in the workplace.

a) Employees are enabled, without disadvantage or adverse consequence relative to

their employment, to engage a workplace representative for industrial and or other matters including professional advice, undertaking a union position, or being a union member in the workplace, including Health and Safety Representative role, and through education, networking and advisory groups.

8.5.4 Professional reporting lines are clearly identified within the organisation to support the practice of health practitioners in relation to:

a) role responsibilities and accountabilities
b) scope of practice issues
c) supervision and delegation
d) professional advice, direction and performance