ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

REGULATION OF QUALITY AND SAFETY IN AGED CARE AND HOW ASPECTS OF THE CURRENT SYSTEM OPERATE, DIFFERENT APPROACHES TO REGULATION (INCLUDING IN OTHER SECTORS) AND HOW REGULATION AND OVERSIGHT OF QUALITY AND SAFETY IN AGED CARE CAN BE IMPROVED

SUBMISSION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

INTRODUCTION

1. This submission concerns the operation of key legislation and regulation as it affects the provision of aged care services.

2. This submission is provided in response to the matters the Royal Commission will inquire into at the public headings to be held in Brisbane between Monday 5 August and Friday 9 August 2019. It addresses:

    - Regulation of quality and safety in aged care and how aspects of the current regulatory system operate
    - Different approaches to regulation, including in other sectors
    - How regulation and quality and safety in aged care could be improved.

3. We need a regulatory system that is informed by the underlying principle of ensuring that people who access aged care services are provided with safe, quality care. The assessment of any legislation, regulation or standard must be viewed through the lens of the quality of the care received by the individual.

4. The ANMF's position is that safe, quality care will only be achieved with mandated staffing and skill levels in aged care. There are many other matters that are subject to regulation that can impact the quality of outcomes, however, without the appropriate staff with the right skills to deliver direct care, all other measures will fall short.

THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION (ANMF)

5. The 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 275,000 nurses, midwives, and care workers across the country.

6. 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 each and every one of these settings, fulfil their professional goals, and achieve a healthy work/life balance.

7. 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.

8. Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

9. The ANMF represents almost 40,000 nurses and care workers working in the aged care sector, across both residential and home and community care settings.[1]

Key legislation

The Aged Care Act 1997

10. The *Aged Care Act 1997* (the Act) is the principal legislation used to regulate commonwealth funded aged care.

11. The object of the Act are to provide for funding of aged care that, amongst other things, takes account of the quality of the care.[2]

12. Chapter 4 of the Act requires approved providers 'to maintain an adequate number of appropriately skilled staff to ensure the care needs of care recipients are met'[3].

13. The Act does not address what an adequate number is or define appropriately skilled staff.

14. The ANMF has made many submissions, previously provided to the Royal Commission (see the annexures to Exhibit 1-16 (WIT.0020.0001.0001) and, in particular, ANM.0001.0001.0018 to ANM.0001.0001.0899 (inclusive)) which have argued that the lack of mandated staffing levels and skill mix is a flaw in the Act.

15. The Royal Commission has heard extensive evidence from families about missed care, failures in communication and preventable deterioration of health of residents of RACFs. The ANMF considers the evidence before the Commission supports the broader contention that the current regulatory scheme is inadequate, difficult to navigate and fails to ensure the delivery of safe best practice aged care.

16. A lack of mandated minimum staffing levels and skills mix means that:

- In the absence of an evidence based methodology setting minimum staffing levels, providers operate without guidance and in some instances, the clinical knowledge, to match staffing levels to care needs.
- There is no benchmark for determining what 'adequate numbers' are.

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[1] Care workers can be referred to by a variety of titles, including but not limited to 'assistant in nursing', 'personal care worker' and 'aged care worker'. In Australia, these staff are unregulated in contrast to registered nurses and enrolled nurses. For the purposes of this submission, workers who provide assistance in nursing care within RACFs are referred to as care workers.

[2] Aged Care Act 1997 s2-1(1)(a)(i)

[3] Ibid s54-1(1)(a)(b)

- There is no benchmark for determining what the appropriate level of skill is to ensure that care needs are met
- Providers may make staffing decisions that may be driven by factors such as budgetary considerations, rather than ensuring delivery of safe, quality care

17. The ANMF recommends in the strongest possible terms that the Act be amended to provide for evidence based benchmarks that ensure both the number and skills of staff are, at a minimum, adequate. The ANMF submits that the research and findings set out in its National Aged Care Staffing and Skills Mix Project Report 2016 (Exhibit 1-20 (ANM.0001.0001.3151)) provide the basis for establishing such benchmarks.

Disclosure of ratios Bill and State legislation options.

18. At the time of preparing this submission a private member Bill to amend the Act has been tabled, titled Aged Care Amendment (Staffing Ratio Disclosure) Bill 2019. This Bill would result in approved providers being required to disclose the ratio of care recipients to whom residential care is provided to staff members who provide care. Legislation that provides transparency of staffing ratios is welcomed by the ANMF and may form a useful tool for consumers to make informed decisions about facilities. However, it is submitted by the ANMF that the Bill does not go far enough as it does not set minimum staffing and skills levels.

19. The Queensland government has recently announced it will introduce new legislation requiring all Queensland residential aged care providers to publicly disclose staffing ratios.

20. In Victoria, minimum numbers of nursing staff have been legislated for public sector aged care facilities under the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratio) Act 2015*. The legislation does not apply to private or not-for profit RACFs. Similar legislation exists in Queensland, the 2016 amendment to the *Hospitals and Health Boards Act 2011* will be further amended to enforce minimum nursing contact hours in public aged care facilities, set at 3.65 hours of daily nursing contact time per resident, per day.

21. The ANMF considers it should be the responsibility of the Commonwealth government to legislate mandated minimum staffing levels and skills mix.

The Aged Care Quality Standards

22. The Act requires providers to meet the Aged Care Quality Standards (ACQ Standards), which became effective on 1 July 2019. Prior to that providers were required to meet the Aged Care Accreditation Standards. Again, the evidence before the Royal Commission has demonstrated that even though providers were able to meet the standards for accreditation purposes, care provided was not always adequate.

23. The case study provided to the Royal Commission relating to Ms Bertha Aalberts on 15 July 2019 provided a clear example of the failings of the regulatory regime for residential aged care.

24. Ms Aalberts who was cognisant, continent and ambulant when she moved into Avondrust, a Dutch home on the Mornington Peninsula on 24 May 2018. On 31 May 2018, the RACF was reaccredited by the Aged Care Quality Agency for the maximum period of three years after meeting all 44 of the accreditation standards in an audit conducted in April 2018.[4]

25. Ms Aalberts had a number of falls and developed a leg wound which was not properly assessed or treated. Importantly, her daughter was not informed of the severity of the wound and only discovered it when her mother was admitted to hospital. Serious pressure sores were also discovered and the combined effect of the wounds resulted in Ms Aalberts' death on 19 August 2018. Ten days later sanctions were imposed on the RACF for failing to meet standards, with particular reference to the failure to assess and provide appropriate clinical care for Ms Aalberts. The Department of Health found the service provider had placed or may place the safety, health and wellbeing of 14 of its residents at serious risk.[5]

26. The ANMF considers this case study does indeed illustrate the failings of the accreditation scheme, in particular it demonstrates that meeting the former accreditation standards was no guarantee of the quality of care provided.

27. While the ANMF welcomes the introduction of the new ACQ Standards, it remains to be seen whether they are sufficiently robust to ensure care needs are met. As discussed in the ANMF's Quality of Life submission (ANM.0005.0001.0001), the standards make little reference to the standard of clinical care required across a range of components of care. In addition, they do not address staffing levels or skills mix.

28. In addition, the ACQ Standards are only as effective as their application and assessment. The Aged Care Quality Commission (ACQ Commission) has recently introduced unannounced visits. This may result in improved consistent adherence to the ACQ Standards. The qualifications and skills of assessors are also essential to ensuring the effectiveness of the ACQ Standards.

29. It should become apparent over time whether the new ACQ Standards have resulted in fewer instances of sub-standard care. They should be reviewed on a regular basis to ensure effectiveness and be strengthened in either or both content and as tools for assessment if positive results are not achieved. To this extent, it is important that providers and the ACQ Commission record and maintain results that allow for measurement against the ACQ Standards and that can demonstrate transparency around both improvement or deterioration in meeting standards.

30. Equally, the effectiveness of the ACQ Standards and application of the ACQ Standards will be apparent from the number and nature of matters referred to the Department of Health for non-compliance with the ACQ Standards and sanctions that may be imposed.

31. The resourcing of the ACQ Commission is and will continue to be essential for the success of the current standards as a means of ensuring care recipients receive safe and effective

[4] Royal Commission 15.7.2019 P-3447-3448
[5] ibid

personal and clinical care that is best practice, tailored to their needs and optimises their health and wellbeing.

32. The ANMF refers to its previous submission on Quality of Life (ANM.0005.0001.0001) at ANM.0005.0001.0003 to 0004 in relation to concerns about the Aged Care Quality and Safety Standards.

33. The above objectives are significantly more likely to be met if appropriate staffing levels and skills mix are in place.

Serious Incident Response Schemes

34. In addition to external assessment of whether standards are being met, providers currently have a limited obligation to report adverse events.

35. The Aged Care Act requires reporting of a reportable assault or an allegation or suspicion of a reportable assault (Section 63-1AA(3)(3))

36. The Act defines reportable assault as unlawful sexual contact, unreasonable use of force or assault that is an offence under a Commonwealth, State or Territory law. Reportable assaults must be reported to police and the Secretary of the Department of Health. As has been identified in the *Strengthening protections for older Australians*[6] report, the current reporting scheme has a number of inadequacies. These include:

- The definition of 'reportable assault' may exclude certain serious incidents of abuse and neglect occurring in residential aged care.
- The exemption of resident-on-resident violence may not be effective in ensuring a violence and abuse-free environment for residents.
- The reportable assault obligations only apply to approved providers of residential aged care.
- There are no specific legislative requirements for the way providers need to respond to reportable assaults.
- Provider responses to reportable assaults are not adequately overseen[7]

37. The report puts forward options to expand the scope of reportable conduct beyond the current legislative requirement which is confined to reportable assault.[8]
The options include

- Reportable conduct should be defined to mean abuse and neglect by a staff member against a consumer, including:
- Physical, sexual or financial abuse.

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6 https://agedcare.health.gov.au/sites/default/files/documents/04_2019/23012019_proposal_for_a_national_aged_care_serious_incident_response_sch._.pdf Commonwealth Department of Health February 2019 in partnership with KPMG

7 Ibid p4

8 Ibid p36-

- Seriously inappropriate, improper, inhumane or cruel treatment.
- Neglect

- The definition of staff member should mean any individual who is employed, hired, retained or contracted by the service provider, directly or indirectly, to provide care or other services.
- A further option included a requirement to report resident to resident abuse (the ANMF would strongly recommend that resident to resident abuse be reportable).
- Expanding the requirement to report to all government subsidised aged care services
- Providers must report when they become aware of the reportable conduct and the obligation to report is extended to staff members, consumers, family members and other concerned persons
- Expand to include unexplained serious injury

- A reportable conduct scheme, should in broad terms set out how reports should be made and create obligations on providers to demonstrate how the incident has been investigated and responded to.
- There should be an obligation to retain records about the reportable conduct and the relevant statutory authority should collate, monitor and identify systemic issues and have the capacity to intervene when a provider has not responded adequately.

38. The ANMF considers the development of a reportable conduct scheme, with the ACQS Commission being the regulator for the scheme is an appropriate option to be explored. Such a scheme should have the safety and protection from risk of harm of aged care recipients as its primary objective, but must also ensure procedural fairness for employees.

39. The development of a regulated reportable conduct scheme would require extensive consultation with stakeholders and need to ensure there is an appropriate balance between protecting consumers from abuse and neglect and setting a reporting threshold the excludes trivial and negligible matters.

40. The intersection of a reportable conduct scheme with professional regulatory schemes (AHPRA) and the National Code of Conduct for Health Care Workers would also need to be considered.

41. It would also be desirable for greater sharing of information, for example a report to the Secretary should be shared with the ACQS Commission and vice versa. It is important that all regulatory bodies share information in order to ensure problems are identified and addressed early.

42. The benefits of a reportable conduct scheme have been identified in other jurisdictions such as the NSW Disability Reportable Incident Scheme, for example, the NSW Ombudsman noted in 91% of matters 'action has been taken to improve the support and circumstances of the victim'[9].

[9] Elder Abuse- A National Legal Response (ALRC Report 131) p116

43. The NSW Ombudsman described the level of neglect that warrants treatment as a serious incident as:

    - Intentional or reckless failure to adequately supervise or support a client that involves a gross breach of professional standards, and has the potential to result in death or significant harm; or
    - Grossly inadequate care that involves depriving a client of the basic necessities of life.[10]

    The ALRC considered that examples of advanced pressure sores said to be caused by failures in wound care would meet the above threshold of reportable neglect.[11]

44. Adequate numbers of nurses and appropriate skills mix in health and aged care environments are critical for early identification of warning signs to implement timely interventions to mitigate the risk of elder abuse.

Regulation of use of chemical and physical restraint and quality indicators

45. The *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* creates requirements for the use of and recording of physical and chemical restraint within residential care or short-term restorative care settings.

46. The amendment to the Quality of Care Principles to regulate the use of restraint is a welcome improvement.

47. From 1 July 2019, it will be mandatory for residential aged care service providers to provide data on three quality indicators, including use of physical restraint, to the Department of Health.
48. Again, the collection of data is a welcome initiative. It will assist in identifying patterns of concern and should lead to earlier intervention where the use of physical restraint appears to be excessive or unwarranted.

49. A further area of concern is the distinction between the use of psychotropic medication as a form of restraint and prescribing for mental health purposes. The use of prescribed psychotropic medication, where it is not clinically justified, may be a de-facto form of restraint that escapes regulation. This must be addressed from a clinical point of view.

50. The ANMF considers the use of restraint must only be in exceptional circumstances. The primary means of reducing the use of restraint will be by ensuring adequate staffing levels so that people in aged care facilities can be monitored, assessed and alternative interventions engaged before the need for restraint arises. This has the additional benefit of reducing the risk of harm to other residents and staff.

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[10] Ibid p122
[11] Ibid

51. The other mandatory quality indicators to be recorded are the occurrence of pressure injuries and unplanned weight loss. The collection of this data will assist in measuring quality outcomes. The new Quality Indicator Program will need to be continually assessed to establish whether it is sufficient to improve care.

Drugs and Poisons legislation

52. Each state and territory has its own primary legislation dealing with drugs, poisons and medication administration. This creates inconsistency in the level of protection afforded to care recipients and workers. It creates particular difficulty for aged care providers and employees who operate and work across state and territory boundaries. Registered Nurses and Enrolled Nurses find it particularly challenging in ensuring they meet professional requirements and obligations. The absence of appropriate and consistent regulation of carers' role in medication administration gives rise to professional conduct risks for registered and enrolled nurses and confusion as to responsibility and permitted functions related to administration.

53. Registered nurses are qualified and legally authorised to administer medicines under the *Health Practitioner Regulation National Law 2009* and the relevant state and territory legislation and regulation. Enrolled nurses work under the direction and supervision of registered nurses. Under the *Health Practitioner Regulation National Law 2009,* enrolled nurses may administer medicines except those who have a notation on the register against their names that advises they do not hold Board approved qualification in administration of medicines.

54. From 2010 the NMBA required all nurses, including enrolled nurses to complete detailed theory and practice in pharmacokinetics, pharmacodynamics, quality use of medicines, and inclusion of national evidence-based resources to enable them to administer and monitor medicines outcomes safely.

55. Care workers, who are not subject to the *Health Practitioner Regulation National Law 2009,* may be subject to relevant state and territory legislation and regulation or may be unregulated with regard to medication administration. Delegation and supervision policies of RACF's will be relevant as to the extent that care workers administer medication.

56. Residents in RACF's are increasingly entering care with greater levels of complex care needs. In conjunction with this, the proportion of residents who use five or more medicines is high. A 2010 study identified 91.2% of RACF residents as having polypharmacy requirements, with the average of 9.75 medicines per person.[12]

57. The risk of medication administration error is high, particularly with polypharmacy and residents who may not have capacity to self-administer medication or convey information

[12] Sommers m, Rose E, Simmonds A, Whitelaw C, Calver J & Beer C (2010. Quality use of medicines in residential care. *Australian Family Physician,* 2010, 39(6):413-416

about their condition. Errors in medication administration can result in negative health outcomes.[13]

58. The ANMF submits there are a number of concerns with the current legislative scheme with respect to administration of medicines and the associated risks.

59. The existence of different legislation in each state and territory increases the scope for error, particularly for RACF's that may operate across a number of jurisdictions. This may arise because of inconsistent knowledge of legislation, implementation of policy and training in each jurisdictions' requirements. Consideration of a unified mechanism to deal with inconsistencies in drugs, poisons and medication administration laws would be a measure to reduce the risks associated with the current disparate legislation.

60. Delegation and supervision of medication administration may also be inconsistent and due to inadequate staffing numbers may not be able to be properly implemented. Medication administration requires ongoing assessment of the health of the resident and knowledge of how medications interact. Registered nurses are qualified to conduct this complex assessment process. While it is a requirement for enrolled nurses to be supervised in medication administration, there is an absence of regulation with respect to care workers' requirement for supervision.

Registration of the nursing profession

61. Nurses are subject to regulation via the *Health Practitioner Regulation National Law* 2009.

62. This regulatory scheme's primary objective is the protect the health and safety of the public by ensuring only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered.

63. Nurses are subject to the *Health Practitioner Regulation National Law* 2009 and their registration is administered by the Nursing and Midwifery Board of Australia (NMBA). A dedicated professional Board is a feature of the registration scheme that ensures the profession is meeting standards expected of the profession.

64. This form of regulation operates to ensure practitioners are suitable to practice on a range of levels. Graduates must demonstrate that they have met minimum standards of

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[13] Pharmaceutical Society of Australia (2019). Medicine safety: take care. Canberra, PSA.

Ferrah, H; Lovell, J; Ibrahim, J (2016). Systematic review of the prevalence of medication errors resulting in hospitalization and death of nursing home residents. *Journal of the American Geriatrics Society*, 65 (2): 229-454

education and practice before being granted registration. To maintain registration, nurses must continue to demonstrate recency of practice and attaining ongoing professional development requirements.

65. The scheme further protects the public by providing for notification of concerns about a practitioners fitness to practice or a health impairment. Notifications can be investigated and outcomes, including restrictions on registration – such as requiring education or supervised practice, or cancellation of registration can be imposed. Outcomes that impact on a practitioners' registration are recorded and are capable of being viewed by the public.

66. This form of regulation of the nursing profession provides a high level of confidence in the practitioner. Obtaining and maintaining registration with the NMBA is a robust method of ensuring the nurse has the necessary skills and qualifications to provide appropriate care.

67. The ANMF considers the regulatory scheme administered by AHPRA is an appropriate scheme to ensure that nurses engaged in aged care are capable of delivering safe, best practice quality care. Where a concern about that capacity arises, there is an appropriate regulatory scheme in place to manage that concern to address the risk of harm to people in aged care.

68. An issue of concern arises for nurses to work within their scope of practice and maintain the professional standards required to meet the regulatory requirements of registration. Where RN and EN staffing numbers are inadequate in relation to the number and care needs of residents the risk of professional error that may jeopardise registration standards increases. This is unacceptable and scapegoats nurses for the failure to properly staff RACFs.

69. The ANMF notes also that section 136 of the *Health Practitioner Regulation National Law* makes provision for corporate directors or managers to be fined if they are found to incite their registered health practitioner employees to practise in ways that would constitute unprofessional conduct or professional misconduct.

70. To the ANMF's knowledge, this provision has not been utilised at all in relation to nurses. The ANMF considers AHPRA should review its compliance role in respect of the provision and should be supported in its capacity to prosecute breaches of this provision and that the fines for breaches should be increased in line with comparable offences under the Health Practitioner Regulation National Law and Corporations Law.

71. Prosecution under the above provision could be a useful deterrent tool for providers who require registered and enrolled nurses to practise in ways that would constitute unprofessional conduct or professional misconduct. This may arise in situations where there are inadequate numbers of registered and enrolled nurses available to ensure safe and quality care is provided.

Options for regulation of care workers

72. The majority of aged care workers are not subject to a professional registration scheme. There are a range of options to be considered.

73. The evidence of Ms Lisa Backhouse, given to the Royal Commission on 11 July 2019 articulated the shortcomings of an unregulated workforce in aged care after her mother was assaulted by a care worker.

'I have proceeded with pressing an assault charge against the carer, not because I'm vindictive but because I don't want her to work again in the aged care sector, and this is my only choice. There is no regulation for care workers in Australia. No national register to guard against this type of behaviour, not even a blue card or equivalent. Without any way to check employment history and dismissals, this carer can walk into another centre tomorrow with no record of the event to follow her.'[14]

National Code of Conduct

74. In 2015, the COAG Health Council approved the National Code of Conduct (NCC) for Health Care Workers. The NCC sets standards that apply to all unregistered health care workers and regulatory powers to deal with complaints about health care workers who breach the code of conduct.

75. The NCC has limitations in its effectiveness, as identified in the A Matter of Care Report- Australia's Aged Care Workforce Strategy. They include:

- It is up to the states and territories to implement the NCC and not all states and territories have done so.
- There is not a single register with details about prohibition orders (meaning for example that a person may have a prohibition in one jurisdiction that is not detected in another)
- It does not impose minimum training standards or require continuing education[15]

76. The NCC also highlights the issue of the question of whether aged care workers are health care workers. Where aged care is not recognised in a jurisdiction as health care, the NCC is not effective.

77. A National Code of Conduct for aged care workers should be considered. To address the concerns with the current NCC, all state and territory jurisdictions should be encouraged to adopt the code and a single register created to capture prohibition orders. This could be a task of the ACQS Commissioner.

Screening

78. In addition to or as an alternative, screening of unregulated workers in aged care is an option. This has recently been put forward in the *Aged Care Quality and Safety Commission Amendment (Worker Screening Database) Bill 2019*. This Bill, for example would require state and territory jurisdictions to make an assessment as to whether a person who works, or seeks to work with aged care consumers poses a risk to such people. The outcome of any assessment would be stored in a Commonwealth database administered by the ACQS Commission.

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[14] ROYAL COMMISSION 11.7.19 P-3201 L.M. BACKHOUSE XN MS HUTCHINS

[15] A Matter of Care Australia's Aged Care Workforce Strategy, Aged Care Workforce Strategy Taskforce, June 2018 p41

79. This proposal is dependent on state and territory jurisdictions adopting legislation which provides for screening of aged care workers and ensuring information gathered is provided to a Commonwealth body (such as the Commission) to establish a central data base.

80. This would provide a useful tool for employers and members of the public to screen potential employees for any history of misconduct.

81. Consideration could be given to a screening scheme, but notes it must balance safeguards for individuals privacy and any assessment and negative finding be capable of review.

82. This sort of screening could operate in a way similar to Working With Children Check schemes. A person who demonstrates through a centralised checking system that they do not have any adverse findings against them (criminal history, or reportable incidents) can provide a level of assurance to consumers as to their suitability to work in aged care.

Licensing

83. The ANMF considers there is scope to develop a licensing scheme for direct care aged care workers. Such a scheme should be designed:

- to protect the public from harm and the risk of harm.
- To set minimum qualifications for working in the sector – Cert III or recognition of prior experience/learning
- Set minimum communication skills for working in the sector
- Require ongoing skills training
- Have a notification scheme that identifies individuals who may pose a risk and that investigate notifications and can impose restrictions to ensure safety- including prohibiting work in the sector.
- Has information about individuals working in the sector that is capable of being viewed by the public and providers on a national basis

84. There are models of licensure in other jurisdictions that may be worth consideration. For example in the United States, assistants in nursing are certified and licensed and are titled Certified Assistants in Nursing. The scheme requires applicants to have completed an accredited course and to complete a competency exam before commencing work in designated health care roles. A minimum number of hours per renewal cycle are required to be completed to maintain licensing. States have legislated scopes of practice for certified nursing assistants and codes of ethics. Certified Assistants in Nursing work under the supervision of registered nurses.

85. The primary objective of any new regulatory scheme must be to ensure safety and quality care for consumers of aged care services in all aged care settings. Any scheme that sets benchmarks for working in the aged care sector, encourages ongoing development of skills and creates safeguards for identifying unsuitable workers will promote a more engaged, educated and skilled workforce.

86. This in turn should result in improved safety and quality of care. It will support a framework of ensuring appropriate numbers of staff and skills mix are engaged in aged care. A scheme that acknowledges and identifies a skilled workforce is an essential component of meeting a minimum staffing and skills mix workforce model.

Education and Training

87. Evidence before the Royal Commission has identified that there is a lack of aged care specific content in health care education. This is particularly the case with respect to dementia care (See ANM.0003.0001.0001)

88. The ANMF supports a review of content of courses to ensure that aged care specific content is included in all general degrees, diplomas and certificates and that opportunities for further learning are available.

89. If aged care workers become subject to a licensing scheme that includes demonstrating appropriate qualifications and ongoing learning then courses must be developed to meet those requirements. There are regulatory implications with regard to education and training and the ANMF would welcome the opportunity to participate in the development of training programs that ensure aged care workers are equipped to work in the sector.

90. Providers have a role to play and many offer 'in house' training. The standard of in house training offered to employees or potential employees should be subject to quality standards.

91. If mandatory minimum qualifications are to be introduced, provision must also be made for recognition of prior experience and learning and a reasonable transition period offered to allow the current workforce time to meet new requirements. Employers should be encouraged to support staff to meet new standards.

92. The Australian Nursing and Midwifery Accreditation Council (ANMAC) is appointed by the NMBA as the accrediting authority for nursing and midwifery programs that lead to registration. They provide profession specific accreditation for programs being delivered in Australia that lead to registration as a registered nurse and enrolled nurse. ANMAC is responsible for the development of accreditation standards for the Bachelor of Nursing and Diploma of Nursing programs. The standards are developed in the interest of public safety and provide minimum requirements for program delivery such as theory, clinical placement, program entry criteria including minimum English language skills. ANMAC accredited and NMBA programs leading to registration are usually accredited for five years and monitored by ANMAC to ensure they are meeting the requirements of their accreditation and professional specific standards.

93. ANMAC work closely with the education regulators including Tertiary Education Quality and Standards Agency (TEQSA)- Higher education and the Australian Skills Quality Authority (ASQA) – vocational education and programs leading to registration as a registered nurse and enrolled nurse must meet the regulatory requirements of both the profession specific accrediting authority- ANMAC and the education regulator – TEQSA or ASQA.

94. If a form of licensing scheme for care workers is introduced, it will be necessary to ensure there is appropriate accreditation of courses that are required for licensing recognition. It is important that training standards are consistent and support delivery of quality care.

Funding and Accountability

95. The funding of RACF's is determined by the Aged Care Funding Instrument. This resource allocation instrument is currently the subject of review and considerable research and consultation has advanced for a replacement model under the Resource Utilisation and Classification Study (RUCS).

96. The ANMF largely supports the proposed RUCS model. Annexed and marked **ANM.0006.0002.0001** is the ANMF response to recent consultation. The proposed funding model more closely aligns funding with delivery of care that improves or maintains the health and wellbeing of the person receiving care.

97. Of greater concern to the ANMF is the lack of accountability for government subsidy of RACF's. This has been addressed in the All in the Family: Tax and Financial Practices of Australia's Largest Family Owned Aged Care Companies report[16] which examines the lack of transparency of private family owned facilities.

98. Any allocation of additional funds must come with a clear mandate of accountability and transparency. A level of funding that is directed towards, and confined to, payment of wages is key to ensuring staff with the appropriate education, skills and experience are attracted to and are retained in the aged care workforce.

Linkages

99. ANMF has submitted to the Royal Commission that minimum staffing levels and skills mix must be mandated for RACFs. The question of staffing demands consideration of a range of other features of a complex and inter-related aged care system. This includes all the matters addressed in this submission. For example:

- the new ACQ Standards do not address staffing levels or skills mix in any direct way;
- the reportable assaults regime and current proposals adopt an individual incident focus and do not adequately address systemic contributors, including staffing, to incidents;

[16] https://apo.org.au/sites/default/files/resource-files/2019/05/apo-nid236126-1358731.pdf

- recent initiatives concerning the regulation of the use of chemical and physical restraints are not a substitute for adequate numbers of appropriately skilled staff to deal with challenging resident behaviour;

- the safe administration of medications requires sufficient numbers of qualified staff;

- the identification of staff appropriately qualified to work in RACFs requires in turn the identification of appropriate courses of education;

- the various proposals for the regulation of carers (e.g. National Code of Conduct; Screening; Licensing; minimum educational preparation) must meet the fundamental requirement of ensuring that staff can be identified and engaged who meet appropriate minimum requirements; and

- the targeting of funding to the provision of direct resident care and the accountability for those funds by proprietors is an essential element in securing the observance of minimum staffing and skills mix.

Industrial and WHS legislation

100. The industrial and work health and safety legislative regimes form part of the regulatory framework for aged care providers. The ANMF will address workforce issues in detail in subsequent submissions. It is noted here, however, that the sector needs to encourage recruitment and retention of a suitable calibre of staff to provide quality care.

101. Over many years enterprise bargaining has not been a sufficiently effective means of improving wages and conditions for aged care workers, who are consistently paid at lower rates than their counterparts in acute health settings. The Royal Commission could make recommendations that would encourage providers to improve wages and conditions for aged care workers.

102. Similarly, WHS legislation, which creates obligations on both employees and employers to ensure a safe workplace, must be emphasised as key to retention of staff. The Boland report recommendation to develop regulatory standards for psychosocial work hazards, is for example, a welcome proposal that will provide a framework for dealing with complaints and management of harassment, bullying and psychological distress in the workplace, which is all too often viewed as a normal part of the job.

Conclusion

103. The ANMF submits that there are a range of areas where the regulatory framework in aged care could be improved. These include:

- Introducing mandated minimum staffing levels and skills mix
- Improving reporting and transparency requirements for providers across a range of areas, including ratios, how funding is spent and disclosure of adverse events and quality indicator data
- Strengthening the regulatory environment for care workers in aged care
- Ensuring all standards, regulation and legislation operates from the premise of ensuring safe, quality care and protecting the public from the risk of harm
- That the complex regulatory aged care framework be reviewed to identify where better coordination and reduced complexity can be achieved.