Australian College of Nursing

ACN Response to the Aged Services Industry Reference Committee (ASIRC)

THE REIMAGINED PERSONAL CARE WORKER DISCUSSION PAPER

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General Comment

The Australian College of Nursing (ACN) welcomes the opportunity to provide feedback on the discussion paper prepared on behalf of the ASIRC, **'The Reimagined Personal Care Worker' (July 2020).** ACN acknowledges that the aged care sector has been facing significant challenges, as highlighted in recent findings from the Royal Commission, vulnerable Senior Australians including those in the community and those in residential aged care facilities (RACFs) are at risk of abuse and neglect.[1] Further, they are at increased risk of sub-optimal care due to an increased reliance on unregulated health care workers which includes the personal care workers (PCW). ACN's white paper (2019) on *'Regulation of the Unregulated Workforce across the Health Care System'*, outlines the issues related to this workforce being unregulated.[2] PCWs make up a considerable proportion of the aged care workforce (70%) contributing to a poorer skill-mix, where less hours of care are provided by skilled registered nurses (RNs). ACN has consistently expressed that this is of serious concern due to strong links with poor patient outcomes. For this reason, **ACN has been urging the Australian government to amend the Aged Care Act 1997 (Cth) to mandate safe RN staffing and skill-mix levels.**[3]

It is also concerning that an increasing number of elderly people entering the aged care sector are presenting with more complex care needs at the end of their life, and that PCWs have limited and varied training and preparation for the care of older people. ACN's white papers (2016) on *'The role of the RN in residential aged care facilities (RACFs)*',[4] and (2019) 'Achieving Quality Palliative Care for All: The Essential Role of Nurses',[5] outline the complex care needs of residents living in RACFs. Specifically, these complex care needs are due to significant cognitive and physical decline, co-morbidities, complex chronic disease, and the use of multiple medications, with 75% aged 85 years or older. ACN is aware that in aged care settings, PCWs are often working outside their scope of practice (i.e. role blurring); performing traditional nursing care elements (i.e. clinical care); and are unaware when to refer care to a regulated health care worker. While some tasks may be viewed as

[1] Royal Commission into Aged Care Quality and Safety 2019. Interim Report.

[2] Australian College of Nursing (ACN). 2019, 'Regulation of the Unregulated Health Care Workforce across the Health Care System – A White Paper by ACN 2019', ACN, Canberra. https://www.acn.edu.au/wp-content/uploads/white-paper-regulation-unregulated-health-care-workforce-across-health-care-system.pdf

[3] Australian College of Nursing (ACN). 2019, 'Regulation of the Unregulated Health Care Workforce across the Health Care System – A White Paper by ACN 2019', ACN, Canberra. https://www.acn.edu.au/wp-content/uploads/white-paper-regulation-unregulated-health-care-workforce-across-health-care-system.pdf

[4] ACN 2016. The role of registered nurses in residential aged care facilities Position Statement

[5] ACN 2019. Achieving Quality Palliative Care for All: The Essential Role of Nurses White Paper

'low risk', such as the delivery of meals or feeding, a PCW may not recognize the need to alert the RN on swallowing issues which is considered 'high risk' in terms of safety for the older person. For these reasons, **ACN has long been advocating for the presence of at least one RN on duty and available within RACFs at all times.** [6]

While the contributions of PCWs are valuable when utilised in a complementary model (i.e. alongside nurses), it is important to acknowledge that patient safety is significantly compromised as a result of PCWs not being sufficiently supported or supervised due to inadequate RN staffing. Given current legislation does not place minimum RN staffing requirements on aged care providers, there is no obligation to employ RNs who come at a greater cost to the provider compared to the less skilled PCW. ACN believes this is of concern, as clinical leadership and supervision which is necessary to patient safety, can only be provided by highly skilled and trained RNs.[7] For this reason, **ACN has been a strong advocate for clinical governance across Australia's health and aged care systems**. Clinical governance is an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms that are implemented to support safe, quality clinical care and good clinical outcomes for each consumer. If a 'reimagined PCW' is to be utilised in Australia's aged care system, ACN believes clinical governance is key to ensuring high-quality care is in place to deliver safe and effective services to older people.

Whether the scope and roles of PCWs is 'reimagined' or 'stepped up or re-defined', **ACN believes PCWs must first be regulated with nationally consistent nomenclature and titles, a code of conduct, professional standards and scope of practice, to ensure nationally consistent minimum education and ongoing continuing professional development (CPD) requirements**.[8] Without these fundamental changes and reform, the proposed 'reimagined PCW' only provides a band-aid solution to issues faced in aged care.

In terms of minimum educational requirements for PCW, ACN strongly recommends that: [9]

- **Anyone working in Aged Care must have education at the Certificate III level in dementia and palliative care and infection control.**
- **It will not support a single Certificate III course being developed which includes Aged Care and Disability, as there are different skills required for care of these different groups and separate skills training is required.**

ACN's Key Messages and Position:

1. Regulation of PCW is a priority
2. Clinical Governance essential
3. RN on duty and available 24 hours a day in RACFs
4. Minimum legislated RN staffing and skill-mix to be mandated in RACFs

[6] ACN 2016. The Role of Registered Nurses in Residential Aged Care Facilities - Position Statement. https://www.acn.edu.au/wp-content/uploads/position-statement-role-rn-residential-aged-care-facilities.pdf

[7] ACN 2016. The Role of Registered Nurses in Residential Aged Care Facilities - Position Statement. https://www.acn.edu.au/wp-content/uploads/position-statement-role-rn-residential-aged-care-facilities.pdf

[8] Ibid

[9] Ibid

5. A single Certificate III course for Aged Care and Disability Care is strongly opposed due to different skill set requirements.
6. PCWs working in Aged Care must have education at the Certificate III level in dementia and palliative care and infection control.

Response to selected questions in the discussion paper

Section 1:

Recipient Expectations: Diversity and Inclusion

Q 1. While every person is an individual and at different stages of the life journey:

a. ***What are the core needs that cut across diversity and stages?***

Regardless of living at home or is residential care, the core needs of older people include:

- Being treated humanely with dignity and kindness at all times
- Being cared for with sensitivity to personal and cultural needs
- Having individual choices respected
- Encouraging open communication
- Permitting involvement of individuals and their family/carer(s) in all stages of care, with a focus on health, comfort and quality of life

b. ***What are the core needs that address key elements of diversity?***

There is not a one size fits all approach to meet the diverse needs of individuals and families; hence there is a need to shift towards value-based health care (VBHC) models to address key elements of diversity. The VBHC model can target core issues in our health and aged care settings to ensure that the **right incentives** are in place to provide the **right care** at the **right time** for the **right price**, in the **right place** by the **right provider**.[10]

Further, given there is no 'typical' older person, policies should be devised to improve the functional ability of all older people, whether they are robust and/or care dependent.

Overall, the key elements of diversity must address personal and cultural values to ensure a sense of belonging within their environment at home or in residential care. For individuals and families this can be achieved by:

- Being treated with respect, listened to, and valued
- Having basic care needs met
- Having open communication and expectations clearly conveyed by the clinician

[10] Global Access Partners (2019). 'Ensuring the sustainability of the Australian health system: Australia's Health 2040 Taskforce Report | GAP TASKFORCE REPORT 2019'. Accessed at: https://www.globalaccesspartners.org/AustraliaHealth2040_GAPTaskforceReport_Jul2019.pdf

- Being understood to build and maintain trusted relationships
- Being afforded opportunities to contribute to society for a sense of identity and belonging

c. ***What are the core needs specific to the three key life stages of healthy ageing, re-ablement and palliation?***

ACN's membership provided the following feedback:

- There must be access to services that provide older-person-centred and integrated care.
- The ageing person must be afforded choice around where they want to live according to social activities of daily living (ADL's) and health determinants.
- Palliative care symptom management, the place of dying and death should be determined by the individual person and supported by the clinician as best practice service provision.
- Wellness and reablement should be linked to the Aged Care Quality Standards.[11]
- There should be purposeful engagements that improve physical and mental health; and aim to empower older people to improve their quality of life. This can be achieved through targeted care such as an exercise plan, equipment that enhances living, social activities, creative activities (art, music therapy), and cooking activities.

Q 2. How critical is it that reimagined Personal Care Workers are able to interact with and respond to the needs of recipients and co-workers in a culturally familiar, safe and sensitive way?

ACN believes culturally sensitive and safe care is vital at all levels of care. It is important that aged care employers and education providers promote approaches to improve the knowledge and competencies of the reimagined PCW workforce.

ACN has consistently expressed its commitment to bringing together health professionals and community representatives to address systemic barriers to access associated with cultural and linguistic diversity (CALD). ACN recognises that people from migrant and refugee backgrounds face significant physical and mental health challenges through experiencing hardships and inequities; and must therefore be cared for in a culturally familiar, safe and sensitive way. The physical, psychological and social health needs of individuals from migrant and refugee backgrounds may be affected by physical hardship, stress, and legal, economic, and social exclusion. [12] [13] They may experience *"discrimination, violence, exploitation, long-term detention, limited or no access to education, human*

[11] Aged Care Quality and Safety Commission 2019. Guidance and Resources for providers to support the Aged Care Quality Standards. Viewed 15th July 2020. https://www.agedcarequality.gov.au/sites/default/files/media/Guidance_%26_Resource_V9.pdf

[12] Bronstein L & Montgomery P (2011), "Psychological distress in refugee children: a systematic review". Clinical Child Family Psychology Review, 14(1):44-56

[13] ICN (2016), Position Statement: Health of migrants, refugees, and displaced persons.

trafficking, malnutrition, and limited or no access to both preventive and essential health services". [14]

As a member of the Migrant and Refugee Women's Health Partnership, ACN believes all refugees and migrants should receive quality holistic health care that addresses their physical and mental health needs, and which includes health promotion and illness prevention. ACN promotes enhanced flow of information to migrant and refugee persons with credible and authoritative guidance on key issues for preventive health and informed treatment. ACN recognises that improvements in the health and health literacy of migrant and refugee persons have a directly positive impact on family care and community.[15]

ACN strongly supports the recommendations outlined in the International Council of Nurses (ICN) position statement (2016) on the health of migrants, refugees and displaced persons to: [16]

- *"Provide respectful, culturally-sensitive, and dignified care to migrants, refugees and displaced persons (MRDPs) and their families that acknowledges the intersectionality of their physical, psychosocial, and social needs and challenges."*
- *"Engage in research to contribute to evidence that expands understanding of issues that relate to MRDP health and can improve healthcare service delivery."*
- *"Participate in and/or support dedicated local, national, and international organisations in their efforts to address MRDP rights, socio-economic, health, and healthcare needs."*

Cultural sensitivity also extends to people from Aboriginal and Torres Strait Islander background and individuals who identify as LGBTIQ+. If PCWs are to be utilised as a reimagined workforce, they must receive guidance on how to care for these individuals in aged care settings. The national *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health;*[17] *the CATSINaM framework for promoting and embedding cultural safety in the Australian Healthcare system (2018);* [18] and the *Cultural Competency Implementation Framework: Achieving Inclusive Practice with Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) Communities (2013)* [19] can be used to develop, implement and evaluate cultural awareness and cultural competency strategies.

[14] Statement by the UN human rights mechanism on the occasion of the UN High Level Summit on large movements of refugees and migrants [press release]. Geneva, Switzerland 2016

[15] ACN (2017), Media Release: ACN Attends 3rd Migrant And Refugee Women's Health partnership Meeting. Available at: https://www.acn.edu.au/publications/media-release/acn-attends-3rd-migrant-and-refugee-womens-healthpartnership-meeting

[16] ICN (2016), Position Statement: Health of migrants, refugees, and displaced persons.

[17] Department of Health 2019. Cultural Respect Framework 2016-2026. https://www1.health.gov.au/internet/main/publishing.nsf/Content/indigenous-crf

[18] CATSINaM 2018. Framework for promoting and embedding cultural safety in the Australian Healthcare system https://www.catsinam.org.au/online-store-1/partnering-for-equity-framework

[19] National LGBTI Health Alliance (October 2013) Cultural Competency Implementation Framework: Achieving Inclusive Practice with Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) Communities Sydney. National LGBTI Health Alliance https://www.lgbtihealth.org.au/sites/default/files/Cultural%20Competancy%20Implementation%20Framework.pdf

Q 3. How should a PCW meet both the social and health needs of care recipients?

The importance of clinical and social care delivery for aged care service recipients and the need for PCWs to have an understanding of these aspects of care is well recognised. This is a foundational contribution that PCWs make to the aged care workforce. However, ACN does not support the provision of clinical care – or more complex social care - by an unregulated, non-clinically educated/trained workforce. A range of regulated, appropriately qualified health and social care professionals already exist to provide this care.[20] This includes registered nurses (RNs) and enrolled nurses (ENs) who are regulated with the Australian Health Practitioner Regulation Authority (AHPRA). Greater use of this skilled workforce within aged care is recommended. More extensive use of such personnel would help better meet the increasingly complex needs of aged care clients. It would also provide much needed opportunities to supervise and mentor PCWs, health professional students and other aged care staff/trainees.

ACN has previously recommended that PCWs should be regulated with nationally consistent nomenclature and titles, a code of conduct, professional standards and scope of practice to ensure nationally consistent minimum education and CPD requirements.[21] Relevant education and training for PCWs is recommended as a useful first step towards this. The level at which such vocational education should occur is a joint matter for the VET sector and industry. From a health professions education perspective, ACN recommends that minimal knowledge requirements of a PCW include a solid understanding of:

- Health care consumer directed approaches
- Specific issues of ageing including frailty dementia and palliative care
- Nutritional requirements and feeding issues
- Mobility issues
- Scope of the PCW role
- Communication: when and how to communicate with/implement instructions from health and care professionals
- Infection control.

In the wake of COVID-19, infection control has become even more pertinent in aged care settings. It further underlines the need for greater employment options for health professionals in aged care. Health professional education and training deeply embeds such knowledge within everyday practice so that it occurs as a matter of course. Health personnel not only model this practice in their regular work but are also on hand to teach other staff so that good practice is integrated across the workforce – not just provided as an "add-on" in times of crisis.

The paper also suggests that the aged care sector *"…cannot wait for regulation to ensure that PCWs have the skills demanded in a consumer-directed system…".* ACN has previously presented evidence

[20] "Appropriate" refers to relevant health/social care qualifications provided across the tertiary education sector in both VET and Higher Education.

[21] Australian College of Nursing 2019. Regulation of the Unregulated Health Care Workforce across the Health Care System – A White Paper by ACN 2019. https://www.acn.edu.au/wp-content/uploads/white-paper-regulation-unregulated-health-care-workforce-across-health-care-system.pdf

about the benefits of learner-development approaches in addressing aged care workforce issues. These approaches involve supervised opportunities in aged-care settings for all learners (students and staff) to learn the skills, knowledge and attitudes that provide high-quality and safe services to older people. Learner-development approaches build safe learning environments and allow for career pathways to be embedded in aged-care workforce development. The path begins with a learner at the beginning of their journey and then supports them towards competence and independence in aged-care service delivery. Evidence suggests multiple benefits of this approach to aged care health consumers, service providers, students and staff.

Such an approach would go a long way to upskilling PCWs and others while issues of regulation were determined. To deliver this approach, policy support is required to enable:

- Greater employment options for health and social care professionals in aged care; and
- Higher education-service provider partnerships and flexible industry approaches to building learner-development cultures in aged care services.
- Continuity Between Home Care and Residential Care

ACN's membership provided the following feedback. PCWs need to:

- be educated, respectful and provide safe communication, with empathy and advocacy being vital
- encourage individuals and their family to be involved with care as required
- escalate the need for increased support and resources as required
- be involved in the provision of ADL's as required
- demonstrate a commitment to best practice care as set down by the RACF or care providers
- provide all home and health care, and wellness activities in a caring and respectful manner.
- demonstrate respectful working relationship, observing confidentiality and boundaries.

Q 4. What are the main differences between the needs of recipients living independently and those living in residential care?

Recipients who live independently can make decisions about how they live and who provides their services. In residential care, it is the nurse, family and care staff who make those decisions with the residents if the resident is not involved in the decision-making process it can leave residents feeling disempowered and can lead to physical and mental health deterioration. Another difference is severity of illness, with increased level of acuity in RACFs.

Q 5. How do you think service can or should combine both support and care needs?

ACN members provided the following feedback:

- empathy plays a key role

- involving people in their own care needs wherever possible
- social and rehabilitative care (i.e. walking and talking to residents/the person even when combined with toileting and care needs)
- Nail care, mouth and dental care and footcare to be included with other care.

Q 6. How can we align health care imperatives and considerations with these customer service needs and expectations?

ACN members noted that this can be achieved by:

- A clinical governance framework led by a registered nurse.
- Encouraging conversations and discussion between care givers, residents and family during the assessment and care planning process (as required).
- Clearly documenting each individuals' needs, preferences, goals as well as tasks to be performed
- Ensuring there are enough resources in place
- The development of a trusting relationship with the person to enhance quality of care, wellbeing, and continuity of care.

Section 2:

The range of skills required

Q 1. What should be the scope of the role of the ideal reimagined PCW?

ACN considers it is essential that PCWs work within their scope of practice. PCWs are increasingly undertaking activities that fall within nursing work, leading to a blurring of scope and accountability. This lack of consistency and clarity regarding the PCW role is concerning. Firstly, it is concerning for PCWs who may be working beyond their scope of practice and thus potentially putting their own careers and their patients' well-being at risk. Secondly, it is concerning for RNs who are supervising them and responsible for the tasks undertaken by PCWs. [22]

To begin, the reimagined PCW scope of practice and role must be embedded in basic skills provided by the Certificate III in Ageing. Elective and Core units studied must be appropriate to provide the fundamental skills for job roles in aged care. ACN believes infection control, palliative care and dementia care should be core units. Core units vary across education providers and jurisdictions and examples of core units include:

CHCAGE001	Facilitate the empowerment of older people
CHCAGE005	Provide support to people living with dementia
CHCCCS011	Meet personal support needs
CHCCCS015	Provide individualised support
CHCCCS023	Support independence and well being
CHCCOM005	Communicate and work in health or community services
CHCDIV001	Work with diverse people
CHCLEG001	Work legally and ethically
HLTAAP001	Recognise healthy body systems
HLTWHS002	Follow safe work practices for direct client care

The scope of the reimagined PCW role should also embrace technology given the increasing digitisation of society; the availability of tablets, laptops, computers, and smartphones amongst most populated areas; and the demand by Australians. In fact, the uptake of telehealth during

[22] Duffield, C, Twigg, D, Pugh, J, Evans, G & Dimitrelis, S 2014, 'The Use of unregulated staff: Time for regulation?', Policy, Politics, and Nursing Practice, vol. 15 (1-2), pp. 42-48, doi: 10.1177/1527154414529337.

COVID-19 was significant in the community and primary health sector. Since the introduction of the *COVID-19 Temporary Medicare Benefits Schedule (MBS) Telehealth Service*[23] in March 2020, there has been increased use of this service from health care consumers of all ages. In April 2020, it was reported that 4.3 million health and medical services had delivered telehealth services to more than three million patients.[24]

Effective use of technology can enable self-confidence that in turn sustains independence. Independence in this context means independence in any living environment from the family home to supported environments. In addition, technology can help track health and wellbeing through personal electronic health records that can be selectively accessible to family and health professionals. Non-invasive wearable devices can be used to monitor basic health indicators such as blood pressure, body temperature, respirations, blood sugar, pulse and wellness indicators such as activity and social connectedness.

Q 2. What do you think is the range of skills a reimagined PCW will need to meet a recipient's individual or particular needs or requirements at every stage of the ageing journey?

a. ***How diverse do you think this range of skills should be?***

The range of skills should not overlap with traditional nursing care elements (i.e. clinical tasks should all be supervised).

There is growing evidence that Senior Australians are coming into aged care settings at a more advanced stage of their illness and that their length of stay from admission to death is reducing. Whilst this is highly positive in enabling people to stay at home longer, it nevertheless indicates that when many people are admitted to an aged care setting, they are coming in for End of Life (EOL) care. Skilled and dignified EOL care requires precision symptom management, careful titration of pain management, and compassionate management of family and loved ones.[25] This requires specialised nurse input, supervision and support. In the aged care setting, this is not necessarily the case and Senior Australians are increasingly receiving EOL care by PCWs with no training in dignified EOL care that respects the wishes of these individuals (i.e. advanced care directives).

ACN has previously suggested increasing the number of core units of the Certificate III Ageing course from 10 to 16 to reflect the changing landscape of the aged care sector. ACN understands that the suggested 120 hours for completion of the course may not be

[23] Department of Health. COVID-19 Temporary COVID-19 MBS Telehealth Services [Internet]. Australian Government; MBS Online Factsheet; Last updated 2020 May 8 [cited 2020 May 4]. Available from: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/0C514FB8C9FBBEC7CA25852E00223AFE/$File/COVID-19%20Temporary%20MBS%20telehealth%20Services%20-%20Overarching%2008052020.pdf

[24] Department of Health 2020. Australians embrace telehealth to save lives during COVID-19. Viewed 22 June 2020. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/australians-embrace-telehealth-to-save-lives-during-covid-19

[25] Becker, R. (2009) Palliative care 3: Using palliative nursing skills in clinical practice. Nursing Times; 105: 15.

Bolton Clarke 2019, Taking social isolation one street at a time, <https://www.boltonclarke.com.au/tackling-social-isolation-one-street-at-a-time/>

sufficient if the core units are to be increased. However, ACN considers it essential to incorporate more 'hands-on' core units so that individuals have the required skills to perform effectively in their roles. Within RACFs specifically, ACN recommends the addition of the following elective units as core units:

HLTINF001 (Comply with infection prevention and control policies and procedures)

CHCAGE002 (Implement falls prevention strategies)

CHCMHS001 (Work with people with mental health issues)

CHCCCS021 (Respond to suspected abuse)

CHCCCS017 (Provide loss and grief support)

CHCPAL001 (Deliver care services using a palliative approach)

This is because people living in RACFs are more commonly experiencing some form of dementia, require high-level care and have a mental health condition indicating a growing pattern of frailty, disability, dependence and complexity of care. Elder abuse is increasingly being reported in the media, however there is still a culture of under-reporting within RACFs. Safeguards against elder abuse are directly linked to quality of care and as such the aged care workforce must be educated to appropriately and efficiently report cases of abuse and neglect.

b. ***What's the extent of expertise or proficiency a reimagined PCW should have in any particular area or skill set?***

PCWs working in Aged Care must have education at the Certificate III level in dementia and palliative care and infection control.

c. ***How broad do you think PCWs' knowledge of other skills and roles should be?***

The breadth of skills and knowledge necessary for PCWs are provided in the responses above (Q1, Q2a, Q2b). This be articulated alongside regulation of PCWs with nationally consistent nomenclature and titles, a code of conduct, professional standards and scope of practice, to ensure nationally consistent minimum education and ongoing continuing professional development (CPD) requirements.

d. ***Are there any specific additional skills a PCW needs to work with a culturally diverse or other minority group?***

ACN considers it essential that the aged care workforce is educated to be more liberal and sensitive about culturally sensitive issues. ACN recognises the unique needs of

Aboriginal and Torres Strait Islander peoples. Equally, due regard must also be given to the unique needs of culturally and linguistically diverse (CALD) groups and lesbian, gay, bisexual, transgender and intersex (LGBTI) people in order to provide appropriate, safe and individualised care.

Interestingly, roughly one-third of Senior Australians are born overseas with limited English proficiency.[26] As diversity within Australian society increases there will be no standardised approach that fits all, therefore the educational needs of the aged care workforce will always be determined by the communities in which they serve. ACN also recognises that PCWs working in aged care are increasingly being recruited from the CALD community, which is not a problem in itself, however appropriate professional oversight, guidance, training, support and supervision is required.

Q.3. In addition to skills, what aptitudes, traits and attitudes ('soft skills') should the ideal PCW possess, and should we screen to ensure candidates have these characteristics prior to assuming PCW roles?

It is widely known that interpersonal skills matter to people receiving care, and especially to vulnerable populations. Empathy and working with dignity and respect are ideal traits. While ACN acknowledges that most PCWs will seek to undertake work in aged care with the best of intentions, they are not regulated so there is no method to screen or track these individuals. Tracking is a necessary mechanism to hold workers accountable for their behaviour. As highlighted in the Royal Commission into Aged Care Quality and Safety, vulnerable people are at risk of abuse including elder abuse. The inability to track or hold workers accountable, means that even if an PCW is dismissed due to poor behaviour, there is a risk of those employed individuals moving unnoticed onto other employers and continuing the elder abuse or unsafe practices.

Q 4. What autonomy and responsibility do you think reimagined PCWs should have? Should this autonomy and responsibility be dependent on their level of experience?

Autonomy and collaboration are essential to an RN's scope of practice. As described by the World Health Organization (WHO) *"Nursing encompasses **autonomous and collaborative care** of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people"*.[27]

Given the increasingly complex clinical and social needs of aged care residents however, an autonomous role for PCWs is not supported by ACN, especially while they remain an unregulated entry level workforce with no minimum qualification or ongoing staff development requirements. In such circumstances it is recommended that PCWs continue to work as part of a multi-disciplinary

[26] Australian Institute of Health and Welfare 2018, Ageing, AIHW, viewed 02 December 2018. Available at < http://www.aihw.gov.au/ageing/>.

[27] World Health Organisation 2020, Nurses, WHO, viewed 25 January 2020 <https://www.who.int/topics/nursing/en/>

aged care workforce team under the supervision of suitably qualified and experienced health care professionals.

If PCWs were to become regulated, autonomy within their scope of practice could be considered and would potentially provide an attractive career pathway opportunity for those seeking work in aged care. In addition, this could potentially boost the recruitment and retention of PCWs in the aged care sector. Autonomy should also be complemented through extended opportunities to work within a transdisciplinary team, where PCWs can provide meaningful contributions and learn from other team members.

Q 5. How do you think we should build skills around continuity of care and the transition of care from one setting to another, regardless of the model of care, such as:

a. ***Metro versus regional, rural and remote areas (RRRAs)?***

- In terms of continuity of care, PCWs could be provided with training around telehealth so they can utilise the technology to receive mentorship and escalate concerns to regulated health providers when necessary. The recent COVID-19 pandemic has illuminated the benefits of telehealth in ensuring continuity of care as it can allow health care providers to provide services across a number of locations (which may overcome some staffing issues particularly in RRRAs).
  - Telehealth is not a new concept and has existed since 2011, affording individuals living in RRRAs with the opportunity to gain access to healthcare delivery through phone or video conferencing calls.
  - There has also been a demand for telehealth services to continue post COVID-19 in metropolitan areas where busy lifestyles can serve as barriers to accessing care and continuity of care.
  - Telehealth with specific specialties can promote care provision at home where appropriate (based on assessment, evaluation and care requirements) and keep health care consumers at home for longer. PCWs could use technology to alert the nurse and/or medical team of wound care requirements/medical changes identified during a home visit.

Many aged care staff work casually and in multiple care homes. This casualisation of the workforce comes with its own set of issues.

Transition of care from the community to residential aged care should be seamless and should be accompanied by an in-depth handover.

If there is an overall Clinical Governance system in place led by an RN and the PCW working to scope of practice under the guidance of the RN, the care should continue to be of a high standard.

Rotating the staff through the community and aged care setting would be an advantage.

b. ***General duties versus more specific duties (such as palliative care, swallowing and meal assistance, disability services and dementia care)?***

- It is unclear if this question is referring to building such skills in PCWs or in general in the aged care workforce. If the former, ACN reiterates its view that *clinical and/or complex social care must be provided by appropriately qualified health professionals such as an RN*; or where health professional students/trainees are involved, under appropriate health professional supervision.

- PCW's need to be able to liaise with the nursing team when they identify social and health issues that need to be addressed. Changes in behaviour need to be escalated to ensure symptom management and ensure health care consumers are kept out of hospital in the environment of their choice.

c. ***Home & community care versus residential care?***

The skills required in home & community care involved forward planning and organising equipment ahead of time so that when PCWs are in homes and community care settings, they bring with them the necessary documentation, equipment and supplies. PCWs must maintain good record keeping and a high standard of adherence to care plans. This is essential as health care consumers transition from receiving home or community care to receiving care as residents in residential care. Furthermore, good stakeholder engagement skills would also be beneficial as PCWs engage with different elements of the health care system to ensure an appropriate and timely transition from home or community care to residential care.

Q 6. What technological skills are required by PCWs in their roles as carers?

a. ***Using a tablet or mobile phone to record clinical notes?***

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- Yes, ACN believes this would be an extension of how PCWs currently record notes within aged care. ACN wishes to highlight that recording of notes by a PCW must not replace the clinical notes provided by RNs; and it would be beneficial if embedded within the PCWs scope of practice. As a strong proponent of the National Digital Health Strategy, ACN supports digital innovation that empowers health professionals to provide best practice care and enables individuals to have greater control of their health and health care options.[28] [29] [30]

[28] ACN 2017. Feedback to the Australian Digital Health Agency on the National Digital Health Strategy https://www.acn.edu.au/wp-content/uploads/2018/03/20170203_final_digital_health_strategy_with_kw_signature.pdf

[29] ACN 2018. Submission to the Pharmaceutical Society of Australia (PSA) on the consultation for My Health Record – Guidelines for pharmacists https://www.acn.edu.au/wp-content/uploads/2018/02/20180216_PSA-Submission_My-Health-Record.pdf

[30] ACN, HISA & NIA 2017. Joint Position Statement: Nursing Informatics. https://www.acn.edu.au/wp-content/uploads/joint-position-statement-nursing-informatics-hisa-nia.pdf

b. ***Enabling a recipient to use FaceTime or other communicative technologies?***

Yes, as per Q6a above. In addition, PCWs should provide patients/residents with opportunities to use Facetime, Skype, Zoom or other communicative technologies to prevent distress around not being able to communicate with family and other loved ones. COVID-19 has highlighted that Senior Australians experience higher levels of social isolation and anxiety with many demonstrating a reduction in mental health particularly during social distancing restrictions. Regardless of COVID-19, ACN is concerned that in an increasingly digitised world, many Senior Australians still have poor digital health literacy which may impact their ability to not only communicate with loved ones but also to access digital health services such as telehealth. PCWs could be utilised to encourage and teach older people about communicative technologies to enhance overall mental health.

c. ***Administering and operating an enterprise- wide software system in aged care?***

No, a wide software system in aged care would contain confidential personal and health information. This should be the responsibility of someone in management as there is potential for security and confidentiality breaches. RNs in clinical leadership roles would be ideal candidates for operating the software as they are trained in patient confidentiality. This should be clearly articulated within the clinical governance guidelines in aged care.

d. ***Administering and operating remote monitoring or intelligent health information systems?***

No, as per Q6c above

e. ***Operating robotic mobility, dexterity or socialisation devices?***

They should have the knowledge in how to operate the various devices which assist with daily living or be able to obtain that knowledge through research, reading manuals or asking others for assistance.

However, ACN believes this is clinically focused and within the scope of practice of the RN and EN; not the PCW. The PCW could assist but not have the overall responsibility.

f. ***Something else – and if so, what?***

Note:

Assistive technology (AT) plays a critical role in the lives of people with disability by facilitating independence and participation in everyday activities. Screen reading software, mobility aids,

electronic communication devices and prosthetic aids are all examples of AT and should also be considered.

Q 7. What skills, knowledge or capabilities would be required of a PCW in regard to assistive technology in supporting a recipient's daily living activities?

A PCW should have the research and analytical skills to research assistive technology for daily living areas, including new products on the market. They should have the knowledge in how to operate the various devices which assist with daily living or be able to obtain that knowledge through research, reading manuals or asking others for assistance.

Q 8. What do you think Telehealth and other remote communicative and diagnostic health technologies might play in aged care, particularly for chronic conditions or in the event of an epidemic?

Telehealth has been invaluable for reducing the spread of COVID-19 and protecting vulnerable Australians from infection, including the elderly, individuals with chronic diseases, those who are immunocompromised and those from Aboriginal and Torres Strait Islander (ATSI) backgrounds. In June 2020 the Australian Medical Association (AMA) President Dr Tony Bartone, stated that *"the temporary expansion of telehealth, driven by the need to reduce the risks of transmission of COVID-19 and to protect vulnerable patients, had presented the opportunity to trial telehealth in the Australian context and achieved positive results… [and] about 20% of all Medicare-funded consultations with a doctor were now being provided by telehealth, either via phone or video, since the temporary Medicare telehealth items were introduced in March in response to the coronavirus crisis"*.[31]

Some of the clinical activities that can be supported by telehealth include:[32]

- Pre-emptive health care management
- Managing chronic disease before acute attacks with targeted care for health cohorts (e.g. chronic disease, aged care, mental health)
- Promoting wellness amongst the community including preventative health
- Diagnosis, pre-treatment and post-treatment care
- Team based health care service provision

In addition, ACN applauds regulatory changes implemented during COVID-19 to encourage access and supply of medicines via non-traditional methods, namely facilitated through telehealth consultations (i.e. without the need to obtain a hard copy prescription from their GP prescriber and then present this to a pharmacist). Prescribing options during COVID-19 were extended through electronic prescribing and temporary COVID-19 digital image prescribing.[33] This has meant that individuals in the community can have a prescription prescribed during a telehealth consultation and

[31] https://anmj.org.au/telehealth-must-remain-an-integral-part-of-health-system-beyond-covid-19/

[32] https://www.racgp.org.au/running-a-practice/practice-resources/medicare/medicare-benefits-schedule/new-items-for-covid-19-telehealth-services

[33] Pharmaceutical Society of Australia – 19th June 2020. Summary of COVID-19 regulatory changes. Viewed 22 June 2020. https://www.psa.org.au/coronavirus/regulatory-changes/

can then collect medications directly from the pharmacy whilst by-passing the need to consult the prescriber face-to-face. For many Senior Australians this has also meant having their medication delivered to their home via the pharmacy, without requiring travel to the GP surgery or pharmacy.

Telehealth can be used to enable new models of health care such as the Health Care Homes (HCH) Program which focus on connecting individuals with their primary care team made up of a range of health providers including nurses. This model can significantly improve access and equity, reducing pressure on acute and specialist services and ensure continuity of care. For individuals currently enrolled in HCH, telehealth consultations relating to their existing chronic disease conditions or the shared care plan part of HCH are covered by the HCH bundled payment and not the new-COVID-19 temporary telehealth MBS items. [34]

ACN acknowledges that telehealth may be problematic in some locations due to a lack of suitable networks/internet connection; however, this can be addressed with the adequate deployment of Government resources. For example, the vast geographical distribution of Australia means that there are challenges in providing equitable access to health care, particularly for populations who live in rural and remote areas. [35] People living in these areas have significantly higher rates of poverty, unemployment, mental health issues and alcohol-related dependence. In addition, many Indigenous populations live in rural and remote areas and they face significantly poorer health outcomes and life-expectancy compared to non-Indigenous populations.

Section 3:

Individual workers vs multidisciplinary teams

Q 1. What is realistic in terms of the expectation of skills, capabilities and responsibilities of a PCW if the current context of the role is that of an entry- level worker paid minimum wage and with at best an entry-level qualification or none at all?

ACN believes the Certificate III Ageing course appropriately describes the expected entry level skills, capabilities and responsibilities of a PCW. Given PCWs provide direct care to vulnerable people, having these minimum educational requirements and a first aid certificate is essential.

Q 2. In what way could an individual have all the knowledge, skills and capabilities to provide the emotional, social and physical care needs of recipients when many PCWs are already concerned about not having enough time to perform even basic care tasks?

[34] https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes

[35] National Digital Health Strategy - A submission to the Australian Digital Health Agency by the Australasian Telehealth Society January 2017. file:///C:/Users/sdimitrelis/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/1ACYIWKG/Australasian%20Telehealth%20Society%20-%20Your%20Health%20Your%20Say%20Submission%202017.pdf

This is all addressed in the Certificate III Ageing Course. PCWs need to first have the minimum education requirements around caring for older people, then practical experience and CPD in the workforce to reinforce their understanding around emotional, social and physical care needs.

Q.3. If it is not an individual PCW meeting all these needs, how should we aggregate and provide all these different support services and care requirements?

There must be a care plan that is available to all those involved in the collaborative care of the older person including the PCW. If the older person has unstable health needs or requires assistance with complex care tasks, the care plan should specifically allocate clinical care tasks to the RN, or EN under the RN's direct supervision. The plan should allocate personal care procedures to the PCW according to competency and training level; as well as other health providers depending on the person's goals and priorities.

Q 4. How would these skills, services and care be provided by individuals or teams in home care, especially in RRRAs?

ACN's answer to this question is much the same as the response provided to question 3. If PCWs are working individually in home care or RRRAs they must only perform duties for which they have the knowledge and training. Should they encounter a deteriorating health care consumer they should report this immediately to their supervisor.

Q 5. How would authority and responsibility be delegated or referred in these flat, matrix-style teams?

In these care teams everyone should know what they are tasked with doing, who they are responsible and accountable for and who they report to. There needs to be a clear structure so that concerns about consumers of health care can be raised and appropriate action taken.

Q 6. What specialist knowledge and expertise would a T-shaped PCW need to bring to a team of mixed skills?

A PCW needs to have obtained the necessary qualifications and operate within their scope of practice. Every individual in a team brings unique strengths but the main point is that the PCW can adequately and safely perform the tasks that are expected and required of them.

Q 7. What broad knowledge of … other disciplines would PCWs need … to be able to:

a. Work with these other skills groups;

Interprofessional learning workshops and CPD could assist with broadening knowledge of other disciplines.

b. Be more aware of identifying needs, issues or problems;

As above – the need for interprofessional learning workshops (i.e. learning with and from each other).

c. Refer their recipients towards to the right professionals; and

As above – the need for interprofessional learning workshops.

d. Make the right decision in the moment?

See response to Section 1 Q3. Educating PCWs on the complexity of client needs, the scope of their role and when/how to engage other health and social care professionals is a good start. Integrating PCWs into a multi-professional team so that all team members can learn about their respective roles and contributions is also useful. An effective way to achieve this is through supporting learner-development cultures in aged care and developing models for complex and holistic care are developed. If PCWs are to become a regulated profession, as has been recommended, the above could be integrated into their theoretical and practical education and training.

Q 8. If we reduce the specialist vertical axis and make the broad knowledge horizontal axis greater, how will this impact on service delivery and care quality in relatively unsupervised setting or contexts like home & community care or RRRAs?

a. ***And how much***
   i. ***specific expertise***
   ii. ***general knowledge and***
   iii. ***overall capacity and autonomy would they need in these settings or contexts?***

As answered in question 2a and 2b, ACN believes that PCWs should be taught a broad range of skills that are increasingly required in aged care such as palliative care and dementia care. PCWs should have a good general knowledge and specific expertise in aged care-related topics. As mentioned in previous responses to questions, ACN argues that PCWs should only work within their scope of practice; they should never replace an RN or EN.

Q 9. If entry-level PCWs have little or no authority or responsibility, and the Taskforce has called for more supervision of them, how can we ensure that supervision is able to be provided, especially in home and community care?

Government and industry support are needed to:

- increase education and employment of health/social care professionals in aged care services; and
- implement learner-development approaches (see response to Section 1 Q3).
- Supported supervision of staff on the job.

Increased employment of health professionals across all disciplines in aged care would:

- support improved outcomes for clients;
- extend supervision opportunities of PCWs and health professional/other students; and
- help develop the learning cultures that enrich aged care services, boost client outcomes; enhance overall aged care workforce recruitment and retention; and improve knowledge in future health and aged care workforce of working with older clients.

Q 10. How much responsibility and autonomy is it reasonable to give to an unregulated, entry level worker, especially as recipients' medical needs and conditions become more acute and complex?

PCWs make an important contribution to health care consumer support as part of a multi-skilled aged care workforce team. Given the increasingly complex clinical and social needs of aged care clients however, an autonomous role for PCWs is not supported - especially while they remain an unregulated entry level workforce with no minimum qualification or ongoing staff development requirements. In such circumstances it is recommended that PCWs continue to work as part of a multi-disciplinary aged care workforce team under the supervision of suitably qualified and experienced health care professionals.