

# Aged Care Worker Regulation Scheme Consultation Paper

Report prepared for the Department of Health  
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mpconsulting ™

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### Making a submission

This paper has been prepared for the Department of Health (the department) as a basis for stakeholder consultation on an aged care worker screening or registration scheme.

The department is keen to consult widely and engage with as many individuals and organisations with an interest in aged care and the aged care workforce as possible. This includes engagement with:

- consumers, their families and carers
- aged care providers
- key sector consumer and advocacy groups
- staff of aged care organisations, health and disability services providers
- State, Territory and other Commonwealth government stakeholders.

The department seeks to ensure that the broadest possible range of individuals and organisations, including from urban, regional, rural and remote areas, can have their say about any new worker registration scheme.

The department invites your comments on this Consultation Paper. Comments may be submitted via the [department's consultation hub](#). With your consent, your comments will be made publicly available.

Comments must be received no later than **29 June 2020**.

Comments will be closely considered and used to inform the further development of options for consideration by government.

Thank you for your interest and we look forward to receiving your comments.

## Purpose of this paper

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Over the last five years, various inquiries and reports have recommended implementation of a worker screening or registration scheme in aged care. Most recently, the Royal Commission into Aged Care Quality and Safety (the Royal Commission) has been exploring this issue, with a focus on a registration scheme specific to personal care workers (PCWs).

Stakeholders have differing views about the problems that an aged care worker screening or registration scheme might address, the objectives of any such scheme, what the scheme would include and how such a scheme could be implemented.

The purpose of this Consultation Paper is to:

- outline the objectives of any new worker screening or registration scheme
- describe the existing regulation of aged care workers
- identify the key issues that any worker screening or registration scheme could potentially address
- describe models used in related sectors, such as health and disability
- propose various features and options for a worker screening or registration scheme
- seek feedback on the options and issues.

This paper has been developed for the purpose of consultation. It focuses on high level conceptual approaches to understand stakeholder preferences and concerns with any features of a potential model. It therefore does not include detailed implementation questions that would necessarily need to be considered before any scheme was introduced.

## Context

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### Who are aged care workers?

In 2016, it was estimated that there was over 366,000 people working in aged care with a wide range of roles, skills and qualifications. Aged care workers represent approximately 3 per cent of Australia's total workforce.<sup>1</sup>

This includes:

- personal care workers (PCWs)
  - PCWs, also referred to as 'personal care attendants' (PCAs), provide personal care to residents as a core part of their jobs (usually under the direction of nursing staff)<sup>2</sup>
  - PCWs can include Assistants in Nursing (AINs), care support workers, health care assistants, personal care assistants, community support workers and community care workers
  - PCWs provide direct personal care for activities of daily living such as feeding, showering and emotional support to aged care consumers and are by far the largest occupational group of all direct aged care workers. In residential care, they make up 70 per cent of the direct care workforce, and in-home care and home support, they make up 84 per cent<sup>3</sup> (which equates to 108,126<sup>4</sup> PCWs)
- health practitioners registered under the National Registration and Accreditation Scheme (National Scheme), such as:
  - enrolled nurses and registered nurses, including nurse practitioners (who represent approximately 24 per cent of the workforce in residential care and 10 per cent in home care settings<sup>5</sup>), medical practitioners and certain allied health practitioners (e.g. podiatrists, dentists and physiotherapists) who are required to be registered under the National Scheme.
- non-registered health professionals such as speech pathologists and dietitians
- kitchen and catering staff
- cleaners and drivers
- laundry and maintenance staff
- lifestyle coordinators
- administrative and other support staff
- service managers.

For the purposes of this Consultation Paper, volunteers and students are not included under the term aged care worker and are proposed to be exempt from complying with any new aged care worker regulation scheme, as described in this Paper.

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<sup>1</sup> National Institute of Labour Studies, *2016 National aged care workforce census and survey—the aged care workforce*, 2017, pp. 158-9; Aged Care Workforce Strategy Taskforce, *A matter of care: Australia's aged care workforce strategy*, 2018, p. 1.

<sup>2</sup> Department of Health, March 2017, [Additional information about the 2016 National Aged Care Workforce Census](#), p. 195.

<sup>3</sup> National Institute of Labour Studies, *op. cit.*, p. xvi.

<sup>4</sup> *Ibid.*, p. 18.

<sup>5</sup> *Ibid.*, p. 13, Table 3.2 (Direct care employees in the residential care)(14.6% RN; 10.2% EN) and p. 70, Table 5.2 (Direct care employees in the home care and home support)(8.1% RN; 2.2% EN).

## How are aged care workers regulated?

Currently the aged care legislation does not place any direct requirements on aged care workers. However, the aged care legislation does place certain responsibilities on providers in respect of all aged care workers. For example, the aged care legislation requires that all providers of residential care, home care and flexible care must ensure that:

- certain standards relating to workers are met. The [Aged Care Quality Standards](#) require that:
  - an organisation has a workforce that is sufficient, and is skilled and qualified to provide safe, respectful and quality care and services<sup>6</sup>
  - members of the workforce are competent and have the qualifications and knowledge to effectively perform their roles.<sup>7</sup>
- persons with certain criminal convictions do not provide aged care
  - Providers have a responsibility to ensure that people with certain criminal convictions (such as murder, sexual assault or assault for which the person was imprisoned) do not become or do not continue to be a staff member.
  - All aged care staff members have a **police certificate** (and/or have made a statutory declaration) which is current within the last three years, stating that the person has not been convicted of certain offences.<sup>8</sup>
- consumers 'live without abuse and neglect' and receive 'safe and high-quality care' in accordance with the [Charter of Aged Care Rights](#) (the Charter). The Charter operates as a right-based contract with the aged care provider and its workers to inform how services are delivered to the consumer. Aged care providers are responsible for ensuring their workforce uphold these rights in service delivery.

Residential care providers are also required to report certain **allegations or suspicions of assault**<sup>9</sup>. Under the legislation, providers are required to report incidents of alleged, suspected or actual reportable assaults, including unreasonable use of force or unlawful sexual contact with an aged care consumer. The report must be made to the police and the Aged Care Quality and Safety Commission (the ACQS Commission) within 24 hours of receiving an allegation or forming a reasonable suspicion that a reportable assault has occurred. Under the current arrangements<sup>10</sup> there are limited circumstances in which approved providers are not required to report certain alleged, suspected or actual assaults (specifically, where the incident has already been reported, or where the alleged assault was by a consumer with a previously diagnosed cognitive or mental impairment and the provider has taken the required steps to manage the behaviour).

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<sup>6</sup> Standard 7, organisation statement (7(2)), Aged Care Quality Standards.

<sup>7</sup> Requirement 7(3)(c), Aged Care Quality Standards.

<sup>8</sup> Sections 48 and 49 of the *Accountability Principles 2014*.

<sup>9</sup> *Ibid.*, Part 6.

<sup>10</sup> Note that the current arrangements for mandatory reporting are under review and are expected to be replaced by the Serious Incident Reporting Scheme (SIRS).

In addition, the legislation places specific requirements on aged care providers in relation to the suitability of **key personnel** (essentially someone who is a director or member of the service's governing body or otherwise has authority or significant influence over the activities of the service):

- all key personnel must undergo police certificate checks, a bankruptcy search and previous employment and referee checks<sup>11</sup>
- there are certain circumstances in which key personnel are not permitted to be employed or continue to be retained in that role (i.e. convicted of indictable offences, insolvent, mental incapacity).<sup>12</sup>

Similar requirements exist in relation to care delivered under the Commonwealth Home Support Programme (CHSP) and National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) where providers are also required to comply with the Aged Care Quality Standards.

The relevant program manuals also require that all new staff members and executive decision makers have obtained a police certificate before they start work.<sup>13</sup> Due to the nature of these programs, there are exceptional circumstances where new staff members and executive decision makers can commence work prior to receipt of a police certificate.

### What are the limitations of the existing approach?

Despite these controls, various concerns have been described by stakeholders:

- **Concern that abuse and neglect continue to exist in aged care**
  - All Australians have the right to live free from abuse and neglect as a matter of human rights, laws and a reasonable community expectation. Consumers receiving Commonwealth funded aged care services also have rights and expectations that they will be provided with safe and quality care.
  - Despite these measures, abuse and neglect of older people continues to occur and there is community expectation that more be done to address this issue.
  - While no single measure will address this complex issue (and different people play different roles in eliminating abuse – from families, to carers, to medical professionals, providers and government), stakeholders have highlighted the potential value of a worker screening or registration scheme to provide further assurance that people working in aged care are suitable to do so.
- **Concern that unsuitable workers can move between providers and care settings, posing risk to aged care consumers**
  - Stakeholders have expressed concern about the potential for unsuitable workers to move between aged care providers and aged care settings, avoiding employment termination or reporting of behaviours of concern.

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<sup>11</sup> Section 53B of the *Accountability Principles 2014*.

<sup>12</sup> Section 8A of the *Aged Care Quality and Safety Commission Act 2018*.

<sup>13</sup> Commonwealth Home Support Programme Manual (2018-2020); National Aboriginal and Torres Strait Islander Flexible Aged Care Program Manual (2019).

- **Concern that some critical workers (such as PCWs) may not have adequate qualifications or skills, English proficiency and/or access to continuous professional development (CPD) to support the delivery of safe and high-quality consumer-centred care**
  - As noted above, PCWs comprise approximately 70 per cent of the aged care workforce<sup>14</sup>. Over the coming years, there will be an increasing demand for PCWs with industry estimates suggesting that an additional 980,000 workers will need to be recruited to perform roles such as those of PCWs.<sup>15</sup>
  - While it is critical that unnecessary barriers to employment are not introduced, stakeholders have highlighted the potential value of a registration scheme for PCWs incorporating features such as minimum qualifications, English proficiency or continuing professional development.
  - Potential benefits of this include highlighting the value of the workforce and also driving a culture of continuous professional development and training.

Stakeholders have also suggested there may be value in:

- A centralised register where providers could verify whether a potential worker has clearance to be employed by virtue of not only criminal history screening but compliance with minimum registration standards relating to their qualification, currency of practice and continuing professional development.
- A single scheme that operates across disability and aged care such that a worker who is screened in one sector would be eligible to be employed or recognised by the other.

### What has been recommended by recent inquiries?

An aged care worker regulation scheme has been discussed in various forums over the past four years:

- In 2016, a Senate Committee recommended that the government examine the implementation of workforce regulation across all carer service sectors, and that it include: a national employment screening or worker registration scheme; the full implementation of the National Code of Conduct for Health Care Workers; nationally consistent accreditation standards; continuing professional development requirements; an excluded worker scheme, and workplace regulation of minimum duration for new worker training.<sup>16</sup>
- In the 2017 report, *Elder Abuse – A National Response*, the Australian Law Reform Commission recommended the implementation of a national employment screening process for potential workers and volunteers in Commonwealth-regulated aged care.<sup>17</sup>

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<sup>14</sup> National Institute of Labour Studies, *op. cit.*, p. xvi.

<sup>15</sup> Productivity Commission, *Caring for older Australians*, Report No 53, 2011, Vol 2, p. 354; Royal Commission into Aged Care Quality and Safety, Background Paper 1, *Navigating the Maze: An overview of Australia's current aged care system*, February 2019, p. 27.

<sup>16</sup> Senate Committee, Community Affairs Reference Committee, *Future of Australia's aged care sector workforce* (2016), p. xv.

<sup>17</sup> Australian Law Reform Commission, *Elder Abuse – A National Legal Response: Final Report* (ALRC Report 131), 2017, recommendation 4-9.



- Numerous stakeholders have commented on the desirability of national regulation for aged care workers (particularly PCWs) before the Royal Commission and past Senate Committee. For example, organisations such as ACSA,<sup>18</sup> United Voice<sup>19</sup> and the Aged Care Guild<sup>20</sup>.
- Aged Care Workforce Taskforce proposed in the report *A Matter of Care* that the Aged Services Industry Council consider existing accreditation frameworks and codes of conduct and consider ‘centralising registration for all care staff and volunteers to ensure that all workers have completed mandatory police checks (as already required) and are trained and accredited to work with aged care consumers’.<sup>21</sup>
- Counsel Assisting the Royal Commission has suggested that the Commissioners make final recommendations regarding unregulated care workers (specifically PCWs) to be subject to a registration process with a minimum mandatory qualification as an entry requirement.<sup>22</sup>

### Worker screening versus registration?

‘Worker screening’ or ‘worker registration’ are terms that are often used interchangeably to describe different types of schemes that prescribe certain minimum requirements that a worker (or employer) must comply with.

Despite being used interchangeably there are important differences between screening and registration schemes. While worker screening focuses on screening for criminal convictions and may also require the consideration of certain behaviours of concern (e.g. complaints, disciplinary findings), a registration scheme generally includes broader requirements such as minimum qualifications and ongoing CPD and is assessed across broader terms.

Both approaches can also incorporate the use of a register (or a database) to record the outcome of worker screening or registration, whether as a positive (cleared/registered) or negative (not cleared/prohibited) list of workers or as a register that reflects both positive and negative screening worker outcomes.

Features of a potential aged care worker regulation scheme described in this paper could be implemented as stand-alone measures or built upon to form a broader scheme. For example:

- existing worker screening requirements (i.e. police clearances) could be expanded
- worker screening outcomes could be recorded on a national register
- worker screening requirements could be combined with minimum qualification requirements, the outcomes of which are all recorded on a national register.

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<sup>18</sup> Royal Commission into Aged Care Quality and Safety, Melbourne Hearing 3, 16 October 2019, P-6010.

<sup>19</sup> Royal Commission into Aged Care Quality and Safety, Melbourne Hearing 3, 14 October 2019, P-5758.

<sup>20</sup> Mr Cameron O’Reilly, Aged Care Guild, Committee Hansard, 3 November 2016, p. 5 cited in the Senate Committee, Community Affairs Reference Committee, *Future of Australia’s aged care sector workforce* (2016), p. 67.

<sup>21</sup> Aged Care Workforce Strategy Taskforce, *op. cit.*, p. 42.

<sup>22</sup> Royal Commission into Aged Care Quality and Safety, 21 February 2020, Transcript, P-7859.

## What can we draw from other worker screening or registration schemes?

Three existing Australian schemes are described below that are instructive in the context of considering the most appropriate approach in aged care.

### Case Study 1 – NDIS Worker Screening Check and Database (commences 1 July 2020)

Key features of this scheme:

- Applies to workers in risk-assessed roles (i.e. key personnel, those workers whose normal duties include either direct delivery of specified supports and services or are likely to require more than incidental contact with people with disability).
- It is a condition of registration that registered NDIS providers ensure workers in risk-assessed roles have a NDIS Worker Screening Check.
- Screening is undertaken across three tiers: convictions that result in automatic exclusion (Tier 1); convictions and circumstances presumed to disqualify a person (Tier 2); and convictions and conduct that require a risk assessment (Tier 3).
- Worker screening is undertaken by State/Territory worker screening units (WSUs), which consider a person's circumstances and any risk to determine whether convictions and/or circumstances warrant an exclusion decision.
- Clearances remain current (and are valid nationally) for five years.
- Workers can seek internal review by the WSU for certain decisions including decisions to issue an exclusion and revocations or suspensions of an NDIS Worker Screening Check (except exclusion decisions from Tier 1 offences). If the individual is not satisfied after the internal review, they may seek an external review by a tribunal or authority within that jurisdiction.
- From 1 July 2020, the NDIS Quality and Safeguards Commission (NDIS Commission) will maintain a national database known as the NDIS Worker Screening Database which contains details about the worker's clearance including whether there is an exclusion decision or clearance decision and the status of the clearance.
- Certain persons and bodies, including the WSUs, will have access to the database and the NDIS Commission will monitor access on the basis that information provided is only done so to the extent that is proportionate and necessary.
- Employers will be able to enter a potential or existing employee's name and application number (held by the worker) for confirmation of whether the person is cleared, or if the person is excluded.
- The NDIS Code of Conduct applies to all workers (including registered health professionals). Complaints regarding the Code are managed by the NDIS Commission, and findings may be referred to the WSUs for consideration in the context of a worker's ongoing clearance.
- The NDIS model does not address minimum qualifications or CPD. This is a policy decision based on a focus on participant choice and control and a desire to see workers with the right capabilities and experience (matched to the participant's need and preferences) rather than only formal qualifications. The intent is to build a workforce that represents the different needs and interests of participants including age, gender, language and culture.

**Case Study 2 – National Registration and Accreditation Scheme for health practitioners**

Key features of this scheme:

- The National Registration and Accreditation Scheme (or ‘the National Scheme’) regulates 16 health professions.
- Registration standards are set by each of the 15 National Boards that collectively regulate 16 health professions. Registration standards cover matters such as a person’s criminal history (with relevant offences varying between jurisdictions), English language skills, continuing professional development requirements for ongoing education, professional indemnity insurance arrangements and requirements for recency of practice.
- The ‘National Law’ is the legislative foundation of the National Scheme. Under the National Law, there is a set of protected titles that apply to registered practitioners. Penalties apply to people who use these protected titles when they are not entitled to.
- Under the National Law, registration must be renewed annually.
- Ahpra maintains a public register of health practitioners, which can be searched by family name or registration number. Information on the register includes the information about a practitioner’s registration and registration expiry date, endorsements, conditions on registration, disciplinary matters, etc. There is also a register for cancelled and/or prohibited health practitioners.
- Both Ahpra and the National Boards can be notified of certain conduct through its notifications process, which may be investigated by a National Board in most States and Territories (alternative processes exist in Queensland and New South Wales).
- In response to a notification about a registered practitioner, a National Board can take a range of actions, for example, cautioning the practitioner, imposing conditions on registration or referring the practitioner to a professional standards panel.
- A health practitioner can appeal certain regulatory decisions (e.g. to suspend or impose a condition on registration) and decisions made as a result of the notifications process.
- There are Codes of Conduct and Codes of Ethics relevant to the various registered professions, which go to professional conduct of the practitioner. Alleged breaches are reviewed by the relevant National Board.

**Case Study 3 – Child educator model (National Law)**

Key features of this scheme:

- The National Law applies to workers who provide early education and care services (including child educators, early childhood teachers, family day care).
- Early child educators are required to be screened and apply for a Working with Children or Vulnerable Person Check in their relevant State/Territory conducted by the relevant WSU in their jurisdiction.
- The approved provider of the service is responsible for ensuring that all staff, including family day care co-ordinators and family day care educator assistants engaged or employed by the service, hold a current Working with Children Check or teacher registration.
- An approved provider must notify the relevant State/Territory regulatory authority in writing of the suspension or cancellation of a Working with Children Check held by a nominated

supervisor or certified supervisor. Failure to comply with this requirement is an offence under the National Law.

- As part of its National Quality Standards, approved providers of child services and their staff must comply with professional standards and ethical principles, for example, the Early Childhood Australia Code of Ethics (this is not enforceable by the regulators but will impact the assessment of the service against the National Quality Standards).
- National registers contain public information about approved education and care services and providers. These registers are updated daily from data held in the National Quality Agenda IT System but do not disclose any information about workers. Approved providers are however required to maintain internal records of the Working with Children checks and relevant qualifications.
- The National Quality Framework (NQF) sets out minimum qualification requirements for educators working in children's education and care services and these are determined in relation to the ratios (child-to-educator) that are required under the National Law.

Various State and Territories also have schemes that regulate people working with certain demographics. Examples include various State/Territory Working with Children Checks, the ACT Working with Vulnerable People Scheme and the Victorian Disability Worker Exclusion Scheme (which will be expanded by the upcoming Disability Worker Registration Scheme).

In other countries, there are also different schemes that regulate different categories of workers in the social services sector. For example, Wales (Social Care Wales), Scotland (Social Services Council) and Northern Ireland (Northern Ireland Social Care Council) have implemented workforce regulation schemes for social carers and related professions (such as, care at home workers and adult care home workers).

While each of the schemes differ in the type of worker they regulate, the scope of conduct that is captured in terms of clearances, whether registration is mandatory for all workers covered by the scheme, and how long registration is valid for, there are some common features, including:

- the availability of a public register
- the regulators have powers to set worker registration standards and to either approve or advise on training programs
- powers to receive and investigate complaints.

## Potential features of an aged care worker screening or registration scheme

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### Objectives of an aged care worker screening or registration scheme

Drawing on submissions made by stakeholders to various reviews to date and on the findings of those reviews, it is suggested that the following broad objectives should underpin consideration of any new scheme:

- **Improve the quality and safety of aged care and enhance protections for consumers**
  - First and foremost, any changes to the regulatory framework should be aimed at continuing to improve the quality and safety of aged care.
  - This can potentially be achieved in a range of ways: by improving the delivery of care; by boosting the skills of the workforce; by better recognising aged care workers; and by strengthening mechanisms to reduce the risk of unsuitable people providing aged care.
  - Consumers of aged care services are deserving of protection from staff who are not fit and proper for the role and who represent a risk of harm to them.
- **Avoid unnecessary barriers to workforce entry and facilitate the attraction and retention of aged care workers**
  - The Productivity Commission predicted that the aged care workforce will need to have at least doubled by 2050 in order to meet the projected target of 980,000 workers needed to support the 3.5 million Australians who will be accessing aged care services every year.<sup>23</sup>
  - A new worker registration scheme should be cognisant of this significant workforce need and the importance of reducing unnecessary barriers to entry, as well as facilitating the attraction and retention of aged care workers.
- **Promote consumer-directed care**
  - It is important that any new scheme does not undermine the philosophy of consumer-directed care, which is critical to the expectations of how an aged care provider delivers care and services.
  - Consistent with the direction of the NDIS, the development of a new scheme should acknowledge that part of offering genuine choice and control is building a workforce that represents the different needs and interests of consumers. In this context, the need for formal qualifications must be balanced with the need for workers to also have other competencies and qualities that are important to consumers.
- **Avoid duplicative regulatory requirements for providers and workers operating across sectors**
  - Taking into account similarities in the workforce across aged care, health care and disability services, it is important for worker regulation schemes operating across these sectors to logically intersect and to support the transportability of checks/clearances.
  - Opportunities to mutually recognise clearances/registration should be considered, including to avoid the potential for duplication.
  - Opportunities to support information sharing between relevant government and regulatory bodies with similar worker screening/registration objectives should also be considered,

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<sup>23</sup> Productivity Commission, *op. cit.*, p. 354.

including to reduce the regulatory impact of various schemes on workers, providers and government.

- **Protect the rights of workers**
  - The consequences of not being ‘registered’ or being prohibited from the aged care workforce are significant and the potential impacts on individual workers must be considered in the development of any scheme.
  - For example, the scheme must adhere to the principles of natural justice to ensure that individuals have a right of reply in the context of any adverse findings. It must also ensure that any information included in a register is subject to appropriate privacy protections.
- **Minimise the cost to workers, providers, consumers and governments**
  - It is important to recognise the potential cost impost of a worker screening or registration scheme, including who will bear the costs of the scheme.
  - The costs of implementing the scheme should be minimised (e.g. opportunities for mutual recognition of like schemes could reduce the operational costs for government as well as minimising costs for individual working across multiple sectors).
  - The scheme should be fit-for-purpose for both large and small provider businesses and also metropolitan, rural and remote providers.

## Scope of an aged care worker screening or registration scheme

There are seven key considerations in the development of an aged care worker screening or registration scheme:

1. Who should the scheme apply to?
2. What should be the key features of the scheme?
3. Should worker screening be a positive register of cleared workers and/or a list of excluded workers, and who should have access to the list?
4. What protections should be built into the scheme, particularly for aged care workers?
5. How should the scheme be managed?
6. How should the scheme intersect with other like schemes?
7. Implementation and transition issues

### 1. Who should the scheme apply to?

#### Aged care providers

There are currently over 3,200 aged care providers, delivering a wide range of service types.<sup>24</sup>

The Commonwealth government funds:

- Residential care – At 30 June 2019, there were 873 approved residential care providers operating 2,717 residential aged care services<sup>25</sup>

<sup>24</sup> Aged Care Workforce Strategy Taskforce, *op. cit.*, p. 1.

<sup>25</sup> Department of Health, *2018-2019 Report on the Operation of the Aged Care Act 1997*, June 2019, p. 44.

- Home care – At 30 June 2019, there were 928 operational home care providers<sup>26</sup>
- Flexible care – At 30 June 2019, there were 119 flexible care providers<sup>27</sup>
- CHSP – At 30 June 2019, there were 1,458 funded CHSP organisations<sup>28</sup>
- NATSIFACP – In 2018-19, 35 aged care services were funded to deliver NATSIFACP.<sup>29</sup>

While some stakeholders have suggested that a worker screening or registration scheme apply only to workers in residential care, it is proposed that any scheme apply in respect of all Commonwealth funded aged care services, as described above.

This is because:

- existing requirements relating to matters such as police checks apply to all aged care providers, in respect of all aged care workers across all aged care settings, so it is logical that any expansion of existing requirement also apply in the same settings
- consumers receiving care at home may be just as vulnerable as those in residential care settings (and in some cases may be more so, given their potential social isolation and the fact that care is often provided one-on-one and unsupervised in the home)
- both aged care workers and consumers move between different aged care settings.

## Workers

Two key questions for consideration by stakeholders are:

- how to define the aged care workers to whom any worker screening or registration scheme should apply
- whether different elements of a worker screening or registration scheme should apply to different kinds of aged care workers based on the nature of aged care work they undertake and how directly they engage with consumers.

As a starting point we can look to current definitions and requirements in the aged care legislation (and relevant funding agreements (e.g. for CHSP)). The aged care legislation currently defines ‘staff member’ for the purposes of police certificate requirements as someone who:

- is at least 16 years old
- is employed, hired, retained or contracted by the approved provider (whether directly or through an employment or recruiting agency) to provide care or other services
- has, or is reasonably likely to have, access to consumers.<sup>30</sup>

For the purposes of this Consultation Paper, it is assumed that the subset of aged care workers subject to a worker regulation scheme would include those who were ‘employed, hired, retained or contracted by an approved provider’. This would mean workers contracted through an agency or labour hire agreement would come within the scope of the scheme, provided they deliver the type of care the scheme is designed to cover (e.g. personal care).

<sup>26</sup> *Ibid.*, pp. 30-31.

<sup>27</sup> Department of Health, *2018-2019 Report on the Operation of the Aged Care Act 1997*, *op. cit.*, p. 54.

<sup>28</sup> *Ibid.*, p. 22.

<sup>29</sup> *Ibid.*, p. 61.

<sup>30</sup> Section 63-1AA of the *Aged Care Act 1997*; section 4 of the *Accountability Principles 2014*.

The legislation provides examples of the types of worker captured by this definition of 'staff member':

- key personnel of the aged care provider
- employees and contractors of the approved provider who provide care to consumers
- allied health professionals contracted by the aged care provider to provide care
- kitchen, laundry, garden and office personnel employed by the aged care provider
- consultants, trainers and advisors for accreditation support or systems improvement who are under the control of the aged care provider.<sup>31</sup>

This definition is broadly cast and includes those who have contact with consumers even if they do not directly provide personal care (such as kitchen, laundry, garden and office personnel).

In considering possible elements of a worker screening or registration scheme it is important to consider which elements are appropriate for all workers engaging with consumers and which elements might be more appropriate for a subset of workers, for example, those with direct consumer contact who are providing personal and/or clinical care.

For example, while worker screening (based on police checks and ongoing compliance with a Code of Conduct) may be appropriate for all aged care workers, minimum qualification requirements might be appropriate only for workers such as PCWs (i.e. those providing direct personal care).

This issue is further discussed below in relation to each of the possible features of any worker screening or registration scheme.

## 2. What should be the key features of the scheme?

Most of the existing worker screening or registration schemes include one or more of the following five features:

- assessments of criminal history
- assessments of disciplinary information or other misconduct
- proficiency in English
- minimum qualifications
- ongoing professional development.

Each of these features is discussed below.

Please note that while it is valuable to consider all features of any future scheme in their entirety, it would also be possible to phase implementation of different aspects of the scheme. This could be further explored once stakeholder views have been sought regarding the conceptual features.

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<sup>31</sup> Section 4 of the *Accountability Principles 2014*.



## Assessments of criminal history

For the purposes of this Consultation Paper, two options have been described in relation to assessments of criminal history. The options include providers continuing to assess worker criminal history and also the most viable alternative option, whereby assessment of worker criminal history would be centralised. These options are based on consideration of other schemes, the literature and stakeholder preferences as described in submissions to various inquiries.

While views on these specific options are sought, stakeholders are welcome to propose other options (or other relevant considerations) through the public survey and submission processes.

### **Option A1 – Providers continue to assess worker criminal history in line with aged care legislation and guidance**

Under current arrangements, aged care providers must:

- ensure that each staff member has been issued with a police check and, if necessary, has made a statutory declaration stating that the person has not been convicted of certain offences
- not engage individuals with certain criminal convictions to provide aged care and take reasonable measures to require each worker to notify them if they are convicted of specified criminal offences.

Where the police certificate records an offence that is not a precluding offence, providers are expected to assess the suitability of the person to work with older people.

The department publishes guidance for providers (the *Police Certificate Guidelines, July 2019*) about how to apply the requirements and also about assessing worker suitability to be a staff member. These guidelines suggest, for example, that:

- a provider's decision regarding the employment of a person with any recorded convictions must be rigorous, defensible and transparent
- the provider should consider matters such as the degree of access the worker will have to consumers, the relevance of their convictions, when the conviction occurred, their employment history since the conviction and the probability of an incident occurring should the person be employed (or continue to be employed).

The key advantages of the current approach are:

- it is relatively low cost and simple to administer
- it precludes workers with the most significant criminal offences from working in aged care but it leaves decision making with employers (providers of aged care) regarding the relevance of any other non-precluding offences taking into account matters such as the circumstances of the offence, the time since the offending and the experience and work history of the person since the offending.

This second point is also seen by some stakeholders as one of the most significant limitations of the current scheme. These stakeholders have expressed concern that decision making regarding the

relevance of offending resides with over 3,200 providers rather than with State/Territory authorities (or a centralised body) applying consistent risk assessment criteria. Concerns have also been expressed that workers may not always be treated with procedural fairness or may be unnecessarily denied work opportunities on the basis of their criminal history, with providers variously ‘weighting’ different types of offending (and circumstances).

In addition, the approach does not readily support a centralised register of ‘cleared’ workers because there are not currently ways to ensure consistency of decision making across providers. Further, workers (and the public more broadly) are unlikely to have confidence in a national register that draws on decisions made by individual providers (particularly where the aged care law does not currently include mechanisms that afford workers procedural fairness or review rights in the case of an adverse decision). While provider assessments of criminal history currently impact an individual’s employment prospects with that provider, using the same assessments to populate a national register would impact the individual’s employment prospects much more broadly.

### **Option A2 – Centralised assessment of criminal history for aged care workers**

An alternative approach is to centralise the assessment of worker criminal histories, either at the State and Territory level or nationally. This is consistent with the approach for health practitioners under the National Scheme (where assessments are undertaken by National Boards (or State-based bodies)) and by the NDIS Commission (where assessments are undertaken by State/Territory WSUs).

Under the NDIS model there are different tiers of offences, with some automatically precluding employment (similar to aged care), and others triggering a risk assessment by the State/Territory WSUs<sup>32</sup>. For example:

- Some convictions automatically exclude a person from clearance (Tier 1). Disqualifying offences include murder and attempted murder, serious assault against a child or vulnerable person including incest, child pornography-related offences, abduction or kidnapping offences against a child or vulnerable person involving a sexual or abusive element and bestiality and serious animal cruelty offences.
- Some convictions or pending charges are presumed to exclude a person unless exceptional circumstances apply (Tier 2). Such offences include manslaughter, assault or sexual assault offences not captured in Tier 1, dangerous or negligent acts against a person under care, abduction or kidnapping offences or animal cruelty offences not captured in Tier 1, drug trafficking offences, fraud and deception offences against a child or vulnerable person, national security offences and pending charges for offences set out in Tier 1. In such cases, the WSUs undertake a risk assessment and consider the circumstances in determining whether the worker is cleared or not.
- All other criminal convictions (and certain disciplinary or other misconduct information – as discussed below) trigger a risk assessment in line with defined risk assessment factors (Tier 3).

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<sup>32</sup> Intergovernmental Agreement on Nationally Consistent Worker Screening for the National Disability Insurance Scheme, p. 16.

The risk assessments are designed to identify whether there is an unacceptable future risk to NDIS participants in light of the worker's criminal history and/or other relevant information. The risk assessment takes into account matters such as:

- the nature, gravity and circumstances of the criminal history and/or other relevant information
- how relevant the criminal history or relevant information is to the work they will undertake
- the length of time that has passed since the event occurred
- the vulnerability of the victim at the time of the event
- the worker's relationship to the victim or position of authority over the victim at the time of the event
- whether the information establishes a pattern of concerning behaviour
- the worker's conduct since the event.

Such a model could also potentially be introduced in aged care. If the same criteria applied to automatic exclusions, presumed exclusions and criteria for assessing risk, this would also mean that someone cleared through the NDIS processes could also be considered cleared for the purposes of aged care (and vice versa).

While this approach would be more costly to administer than the current approach, the key advantages of such an approach include:

- it would support workers to move freely between sectors and not duplicate existing requirements for people cleared for the purposes of the NDIS
- it would ensure workers are not unnecessarily precluded from employment because it would enable a proper assessment of all of their circumstances
- there are economies of scale (and capacity to build centralised expertise in risk assessment). Rather than every provider needing to undertake its own risk assessment, this function would be centralised with State/Territory bodies or a national body (refer further discussion later in this Consultation Paper regarding how this could be managed).

Centralising criminal history screening would have implications for existing aged care police certificate requirements (such that new worker screening requirements would supersede the need for aged care providers to separately source and assess police certificates in respect of workers).

#### Consultation questions:

1. What is your preferred approach to aged care worker criminal history assessments?
  - **Option A1** – Providers continue to assess criminal history for workers in line with aged care legislation, funding agreements and guidance
  - **Option A2** – Centralised assessment of criminal history for workers (based on NDIS model)
2. Are there other options that should be considered?

## Assessment of information other than criminal history

If there is to be a centralised assessment of criminal history and an assessment to determine if a worker poses a risk, it is also possible for other matters to be taken into account.

For example, in addition to considering criminal history, WSUs conducting screening for the NDIS may also take into account:

- civil penalties
- child protection orders
- information from State-based reportable or notifiable conduct schemes such as State Ombudsman and Complaints Commissions and professional associations
- employer or other professional records/information including professional references
- court and tribunal records.

While each of these matters may be taken into account by WSUs (in accordance with the Intergovernmental Agreement for Nationally Consistent Worker Screening for the NDIS), consistency across the jurisdictions is yet to be ensured in practice noting that the NDIS Worker Screening Check does not come into full effect until 1 July 2020.

For the purposes of this Consultation Paper, the types of information that could potentially be taken into account as part of any aged care worker screening scheme have been grouped into four options.

### **Option B1 – Information from disciplinary bodies such as information from health complaints bodies, the NDIS Commission and National Boards**

- Each of the above bodies has the power to make adverse findings in relation to individuals who may seek employment in aged care
- Any aged care worker screening scheme could take into account any adverse findings made in relation to an individual, where the finding is relevant to their suitability to provide aged care.

### **Option B2 – Information from relevant government agencies**

- This could, for example, include child protection information and information about suspicions or allegations of reportable assaults (as provided currently to the ACQS Commission)
- It could also include a much wider range of information depending on what is considered most relevant to the suitability of a person to provide aged care.

### **Option B3 – Information from courts and tribunals**

- There are a number of courts and tribunals in Australia, considering a wide range of matters from private disputes to migration matters, fair work and the conduct of employees in various professions
- At the Commonwealth level alone, there are four sitting courts and ten tribunals. Likewise, each State and Territory has a number of courts and tribunals. Each of these courts and tribunals may

potentially make adverse findings (or apply penalties) in respect of individuals applying for aged care worker clearance

- The relevance of the court or tribunal finding may not always be obvious based on either the type of court/tribunal or the broad subject matter of the dispute.

#### **Option B4 – Information from employers**

This could be limited only to where the worker has had their employment terminated (on any grounds or on grounds related to their suitability to provide aged care) or could be broader including, for example, a contract has not been extended, a disciplinary action has been initiated/concluded, or a complaint about the worker has been made.

One of the above options can either form a single source of information to inform the assessment, or two or more options could feed into the assessment.

While an aged care worker screening scheme which includes all four options as part of an assessment of risk will inform the most comprehensive assessment of a worker, the broader the assessment:

- the longer it is likely to take (delaying entry into the workforce for people who are much needed to deliver care)
- the greater:
  - the risk that it will act as a disincentive to people seeking to undertake aged care work
  - the likelihood that decisions will be challenged by workers (because there is a wider range of both objective and subjective information being considered by WSUs)
  - the privacy implications
  - the infrastructure/platform required to manage this information
    - For example, if a clearance requires information from the workers' employers, there needs to be a platform through which employers can confidentially submit this information to WSUs. Non-aged care employers could not be compelled to provide such information and so there may be different outcomes for workers depending on whether or not employers choose to provide information to the relevant WSU.
  - the information sharing required between relevant bodies (with implications for what, how and when information is shared)
    - For example, if civil penalties imposed on a worker are to be considered as part of an assessment it would be necessary to determine which civil penalties are relevant and to enable information sharing between the relevant regulatory bodies (where a significant number of bodies have this function).
  - the costs to workers, employers and government. This is particularly relevant to aged care where there is a large and often low paid workforce.
- the more challenging it is to determine (and agree) relevance of the information to aged care
  - For example, provision of false information to the Australian Taxation Office (with subsequent application of a penalty) may be considered by some to be irrelevant to the ability of a worker to provide personal care to an older person. Others may consider that a fine relating to dishonesty heightens the risk to an older person.

- the more challenging it is to develop guidelines to inform consistent decision making nationally (whether by WSUs or a national body)
- the more responsibility (and activity) shifts away from employers to government WSUs
- the harder it is to ensure assessments are current at all times
  - For example, the broader the assessment, the more reliant the scheme will be on declarations from workers that they have not been subject to an adverse finding nor are they aware of any other information relevant to their suitability to work in aged care unless there are real-time inputs from the relevant bodies providing information to WSUs or the national body.

The right balance must therefore be struck to ensure:

- assessment of the most relevant, objective and readily accessible information
- that the scheme is reasonably able to be implemented
- that associated costs are reasonable
- the assessment is proportionate to the risk and the role performed by aged care workers
- continued open disclosure of poor performance or inappropriate conduct (to enable this to be dealt with directly and quickly between the employer and worker). It would, for example, be undesirable if a scheme acted as a disincentive to employers taking disciplinary action (due to concerns of having to report such action) or for employees to raise concerns about fellow workers (for fear that the consequences for that person may be too significant if they are no longer cleared to work)
- that workers, employers and consumers have confidence in the assessment.

#### Consultation questions

3. If there were to be a centralised assessment of criminal history, should any other matters be routinely taken into account? If so, which of the following options should be considered?
  - **Option B1** – Information from disciplinary bodies such as health complaints bodies, the NDIS Commission and National Boards
  - **Option B2** – Information from relevant government agencies
  - **Option B3** – Information from courts and tribunals
  - **Option B4** – Information from employers
4. Are there any other matters that should/should not be considered as part of any aged care worker screening scheme?

## Code of Conduct

A common mechanism for guiding worker behaviour is the use of a code of conduct that applies to all workers within an industry/profession or who work with certain consumers.

Examples of this mechanism include the National Code of Conduct for Health Care Workers and the NDIS Code of Conduct.

### National Code of Conduct for Health Care Workers (National Code)

- The National Code applies to the provision of health services by health care workers who are not required to be registered under the National Scheme (unregistered health workers) and those who are registered under the National Scheme but are providing health services unrelated to their profession.
- The National Code addresses over 40 matters across 17 topics including requirements in relation to:
  - safe and ethical service provision
  - record keeping and indemnity insurance
  - making claims to cure illnesses
  - action to be taken in relation to adverse events
- Laws in individual States and Territories enable enforcement of the National Code through investigation of breaches and the issue of prohibition orders (prohibition orders are designed to be mutually recognised across States and Territories). Each State and Territory determines the body responsible for applying the National Code within that jurisdiction.
- Code-based regulation occurs across New South Wales, South Australia, Victoria and Queensland, but has not yet been adopted in all State and Territories. There is also some uncertainty regarding the extent to which aged care workers are captured as ‘health care workers’.

### NDIS Code of Conduct

- All workers who provide supports and services to NDIS participants are subject to the NDIS Code of Conduct.
- The NDIS Code of Conduct describes seven high level expectations for safe and ethical services and supports. It requires workers and providers delivering NDIS supports to:
  - respect consumer rights
  - deliver services competently
  - prevent violence, neglect, abuse and exploitation
  - respect privacy
  - act with integrity
  - take action on quality and safety
  - prevent sexual misconduct
- Complaints and concerns about breaches of the NDIS Code of Conduct are investigated by the NDIS Commission.
- The NDIS Commission may publish compliance action including directed actions for providers and workers who have breached the NDIS Code of Conduct on its website.

- The outcomes from investigations may be provided to the relevant State/Territory WSU where the worker is a registered NDIS provider in order to undertake a risk assessment regarding the worker's clearance.
- Not all workers are registered NDIS providers (some may be unregistered or work for a registered NDIS provider) so this information will not always impact a worker's criminal history check to be able to work in the industry.

It is not considered viable to adopt the National Code for Health Care Workers in respect of all aged care workers. This is because the National Code has a strong focus on the provision of health care, with a number of provisions not necessarily applicable to aged care workers (e.g. requirements relating to treatment recommendations, understanding of adverse interactions between therapies and treatments and consents relating to medical treatments). As many aged care workers deliver personal care or other support rather than health services, not all requirements of the National Code are directly relevant.

Further, if an aged care code of conduct is introduced, it is proposed that this should apply equally to all aged care workers as this:

- avoids the need to define different roles in aged care for the purpose of enforcing the code of conduct
- would be consistent with the NDIS, where the NDIS Code of Conduct applies equally to all workers.

On this basis, there are three primary options in relation to a code of conduct for aged care workers:

- Retain existing arrangements requiring providers to ensure the conduct of aged care workers is in line with the Aged Care Quality Standards and Charter of Aged Care Rights (status quo).
- Adopt the NDIS Code of Conduct for aged care workers.
- Develop a new code of conduct specific to aged care workers.

**Option C1 – Retain existing arrangements requiring providers to ensure the conduct of aged care workers is in line with the Aged Care Quality Standards and Charter of Aged Care Rights (status quo)**

The key advantages of this option are:

- there continues to be clear lines of accountability for the provision of care, with approved providers responsible for the delivery of safe and quality care in line with government and community expectations, as reflected in the Aged Care Quality Standards and Charter of Aged Care Rights
- providers can continue to set expectations regarding the conduct of aged care workers as relevant to their organisation and the consumers to whom they provide care. For example, the provider of a large metropolitan residential care service may have different expectations of staff than a small organisation delivering home care in a remote community.



The primary disadvantage under the status quo is that there is no clear statement outlining the expectations of aged care workers as distinct from the responsibilities of aged care providers. Likewise, there is no formal process for an independent body to investigate the conduct of an individual or to make recommendations regarding the ongoing suitability of that person to provide aged care. Noting that currently the police may play a role where misconduct is criminal in nature, National Boards may play a role where a worker is a registered practitioner (such as a registered nurse) and State/Territory health complaints bodies may play a role if a worker is captured by the definition of a health worker used in that jurisdiction.

### **Option C2 – Adopt the NDIS Code of Conduct for aged care workers**

This option would involve applying the NDIS Code of Conduct to aged care workers.

This key advantages of this are:

- the NDIS Code of Conduct could be readily adopted in aged care settings
- the matters detailed in the NDIS Code of Conduct are broadly stated such that they are directly relevant to aged care workers (e.g. to act with integrity, honesty and transparency)
- workers could move between the disability and aged care sectors, with a standard set of expectations governing worker conduct
- it would provide a basis for the investigation of worker misconduct (effectively mandating compliance with the code by relevant workers).
  - The NDIS Commission investigates breaches of the NDIS Code of Conduct by disability workers (with adverse findings taken into account when WSUs determine suitability). A similar body could investigate breaches of the Code of Conduct by aged care workers, with findings used to determine whether the worker is cleared to work in aged care.

The main disadvantage of this approach is that the NDIS Code of Conduct has been developed for disability workers and guidance materials would need to be developed or adjusted to demonstrate how it applies in an aged care setting. However, the NDIS Code of Conduct could potentially be revised with relatively few changes to suit the aged care context.

### **Option C3 – Develop a new code of conduct specific to aged care workers**

This option could involve developing a new aged care code of conduct, specific to aged care workers. This code of conduct could be developed and codesigned with aged care consumers and providers to ensure the code captures matters of importance specific to the sector.

The key advantages of this option are:

- the code could be developed such that it sets clear expectations of the conduct expected of aged care workers and reflects any subtle differences between the provision of care to people with a disability, people receiving health care and older people
- as per Option C2, it would provide a basis for the investigation of worker misconduct (effectively mandating compliance with the code by relevant workers).

The main disadvantages of this option are:

- it requires the development of a new, aged care specific code of conduct. This would entail significant time and expense, including:
  - consideration of how the code should be framed (e.g. in positive or negative terms) and how detailed the code should be (e.g. whether the code would be principles-based or set explicit requirements and thresholds)
  - the development of guidance and communications materials relating to the code
- it is duplicative, where some aged care workers could be subject to multiple different codes of conduct.
  - For example, an enrolled nurse undertaking contract work for an aged care provider that also offers services as a registered NDIS provider, would be subject to professional registration standards, the NDIS Code of Conduct and an aged care code of conduct.

#### Consultation Question

5. What is your preferred approach to a code of conduct? *(select one or more options)*

- **Option C1** – Retain existing arrangements requiring providers to ensure the conduct of aged care workers is in line with the Aged Care Quality Standards and Charter of Aged Care Rights (status quo)
- **Option C2** – Adopt the NDIS Code of Conduct for aged care workers
- **Option C3** – Develop a new code of conduct specific to aged care workers

6. What do you consider are the advantages and disadvantages of introducing a code of conduct for aged care workers?

## Proficiency in English

A significant proportion of the direct aged care workforce is born overseas (32 per cent in residential care and 23 per cent in care at home) where 22 per cent of those born overseas reported speaking a language other than English.<sup>33</sup>

This is a strength of the current workforce because many older people receiving aged care also have a language other than English and they value workers speaking both English and their preferred language. Of the 3.7 million Australians aged 65 and over, one in three were born in a non-English speaking country with a variety of preferred languages.<sup>34</sup> Staff who speak other languages can also support improved cultural understanding, language skills and community engagement in aged care services.<sup>35</sup>

Many stakeholders acknowledge the value of a diverse aged care workforce and appreciate that high levels of English proficiency may not be critical for all aged care workers. However, a number of stakeholders have raised the need for care workers to have a level of understanding of the English language, Australian cultural practices and idioms. This is particularly important for workers providing direct clinical or personal care such as feeding, showering, dressing, mobilising, providing medications and attending to wounds, where there is risk of communication barriers impacting the quality of care received. A number of stakeholders also urge the provision of English language training and/or English proficiency testing for PCWs, particularly those delivering care in a residential setting.<sup>36</sup>

Consumers and representatives have called on the Royal Commission to address English language proficiency as part of its recommendations. Counsel Assisting stated in their submissions that 'a theme in the evidence has been care recipients and family members informing the Royal Commissioners that they found it hard to understand what care workers were saying to them, especially over the telephone'. As such, Counsel Assisting have considered that 'an appropriate level of proficiency in spoken English is fundamental to being able to form the care worker/care recipient relationship... [and] is essential to high quality care' such that minimum levels of English proficiency should be included as part of any registration scheme.<sup>37</sup>

Given stakeholder concern in this area focuses on PCWs, this Consultation Paper proposes two ways that English proficiency requirements could potentially be strengthened for PCWs:

- require providers to be satisfied that PCWs have the necessary English proficiency to effectively perform their role
- establish a requirement for PCWs to demonstrate their proficiency in English as part of a registration process (consistent with the National Scheme).

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<sup>33</sup> National Institute of Labour Studies, *op. cit.*, p. 18.

<sup>34</sup> Australian Institute of Health and Welfare, [Older Australia at a glance](#), 10 September 2018.

<sup>35</sup> Royal Commission into Aged Care Quality and Safety (2019) [Transcript of Proceedings](#) 6.5.19R1 P-1151.

<sup>36</sup> FECCA, March 2018, [Submission into the Aged Care Workforce Strategy](#); AMA, March 2018, [AMA submission to the Royal Commission into Aged Care Quality and Safety](#); Royal Commission into Aged Care Quality and Safety (2019) [Transcript of Proceedings](#) 16.10.19 P- 6007.

<sup>37</sup> Counsel Assisting's Submissions on Workforce, Royal Commission into Aged Care Quality and Safety, para. 518, pp. 120-121.

Each of these options is discussed below.

### **Option D1 – Require providers to be satisfied that PCWs have the necessary English proficiency to effectively perform their role**

Currently under the Aged Care Quality Standards, providers are required to ensure that workers are competent and have the qualifications and knowledge to effectively perform their role.

While this includes consideration of English proficiency, this could be drawn out more strongly in a provider responsibility. That is, the existing Aged Care Quality Standards could be supplemented by a new provider responsibility that expressly requires providers to be satisfied that PCWs have the necessary English proficiency to effectively perform their role. Guidelines could be developed to support providers (and workers) in understanding this requirement. English language learning and testing could continue to occur through existing channels (for example, through registered VET providers<sup>38</sup>).

The advantages of this approach are:

- it does not require a separate government-managed registration process for PCWs in order to confirm their English proficiency
- it is consistent with the existing aged care framework whereby providers are responsible for ensuring staff are fit to perform their role, but it offers greater clarity regarding government expectations with respect to English proficiency of PCWs
- it clarifies adequate thresholds but continues to provide flexibility for providers in terms of how they determine and test English proficiency as appropriate to their service and their consumers.

The disadvantages of this approach are:

- there are challenges in identifying the cohort of workers to whom this requirement would apply given the range of roles/tasks performed by PCWs and the absence of an agreed definition around the role itself, and the persons who perform it
- it places additional responsibilities on providers to understand and meet the government's expectations with respect to English proficiency for PCWs
- when PCWs move between employers, they may need to have their English proficiency re-tested (relative to the employer requirements for demonstrated proficiency)
- there may be costs for PCWs associated with learning English and undertaking proficiency testing.

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<sup>38</sup> The government regulator, the Australian Skills Quality Authority (ASQA) monitors the delivery of VET, as well as the delivery of English language intensive courses. Legislation requires training providers to meet certain standards and requirements in the delivery of training, including ensuring that the competency of all students is assessed before they are provided certification.

## **Option D2 – Establish a requirement for PCWs to demonstrate their proficiency in English as part of a registration process (consistent with the National Scheme)**

Under this option, new requirements would detail the minimum English proficiency required and also how this is to be demonstrated in different circumstances. PCWs who satisfy the requirements would be registered, assuring any employer that they have met the minimum standard.

The National Scheme adopts a similar approach in relation to registered health practitioners by specifying standards in relation to English Language Skills. For example, the Nursing and Midwifery Board requires registered nurses and enrolled nurses to:

- complete at least five years of continuous education (including secondary, vocational and/or tertiary education) from a recognised country (identified and approved by the National Board) that was assessed in English, or
- demonstrate that they meet the standard by sitting one of the four English language tests and receiving a specified test result<sup>39</sup>. The English language test must have been completed in the last two years before application for registration with the Board, and if it has been more than two years, then they will need to evidence continuous employment or enrolment in approved study programs for currency.

Exemptions to these requirements also apply where a registered nurse or enrolled nurse applies for limited registration and perform a demonstration of their clinical techniques, undertake research that involves limited patient contact or undertake postgraduate or supervised training while working in a supported environment.<sup>40</sup>

The key advantages of this approach are:

- it would provide confidence to consumers and others that people working as PCWs have a certain level of English proficiency
- there is an existing model that could be drawn upon to develop an approach specific to PCWs (i.e. the National Scheme)
- once a PCW has satisfied the requirement, this would attach to their registration such that when they move between employers (or sectors) their English proficiency would not require re-testing.

The key disadvantages of this approach are:

- as outlined in the disadvantages for Option D1, there are challenges in defining the cohort of workers to whom this requirement would apply
- this approach would not be consistent with that adopted for PCWs working with people with a disability and providing services and supports through the NDIS
- formal requirements for PCWs to demonstrate English proficiency could act as a barrier to entry to the aged care workforce

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<sup>39</sup> International English Language Testing System (minimum overall score of 7 and a minimum score of 7 in each of the four components (listening, reading, writing and speaking)); Occupational English Test (minimum score of B in each of the four components); Pearson Test of English Academic (minimum overall score of 65 and a minimum score of 65 in each of the four components); Test of English as a Foreign Language internet-based test (minimum total score of 94 and minimum scores for each component).

<sup>40</sup> Nursing and Midwifery Board of Australia, *Registration Standard: English Language Skills* (1 March 2019).

- there would be costs for PCWs associated with improving and/or demonstrating their English proficiency
- there would be costs to government (with flow through costs to providers, workers and consumers) of establishing and maintaining the scheme. This is because a national body would be required to set the standards and administer tests or consider test results. While the National Scheme could be drawn from, it is unlikely that existing National Boards would take on the role of PCW registration (see discussion below in relation to who would manage an aged care worker regulation scheme). This would mean establishing a new body (or expanding the role of an existing aged care body) to perform the role of registering PCWs.

**Consultation questions:**

7. What is your preferred approach to strengthening English proficiency in aged care?
  - **Option D1** – Require providers to be satisfied that PCWs have the necessary English proficiency to effectively perform their role (extension of the status quo with improved guidance as to the expected thresholds for proficiency)
  - **Option D2** – Establish a requirement for PCWs to demonstrate their proficiency in English as part of a registration process (consistent with the National Scheme)
8. What are the other options for strengthening English proficiency in aged care (particularly for those providing personal and clinical care)?

**Minimum qualifications**

Over the past few years various reviews have suggested that workforce competencies could be boosted. For example, the 2017 *Legislated Review of Aged Care* (the Tune Review), recommended the development of a workforce strategy with the aim of increasing entry-level training and qualifications. Likewise, the Aged Care Workforce Taskforce report also identified that workforce competencies required enhancement in specific areas.

Many of these reviews have highlighted the role of industry in facilitating and enhancing the qualifications and training of aged care staff, calling for the sector itself (rather than government) to take the lead in considering how to build and extend the skills sets, competencies and knowledge needed in the aged care workforce<sup>41</sup>.

One area in which some stakeholders have suggested an enhanced role for government is in relation to setting minimum qualifications for PCWs. Specifically, it has been suggested that a Certificate III in Individual Support should be a minimum requirement for all PCWs.

Consistent with the options proposed in relation to English proficiency (and for the purposes of this Consultation Paper), three options have been proposed in relation to minimum qualifications.

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<sup>41</sup> Australian Government Department of Health, *Legislated Review of Aged Care 2017*, Commonwealth of Australia, 2017, p. 184.

- retain the status quo (providers must ensure that all workers, including PCWs, are competent and have the qualifications and knowledge to effectively perform their role)
- require providers to be satisfied that PCWs have certain minimum qualifications or competencies
- establish a requirement for PCWs to meet certain minimum qualifications or competencies as part of a registration process (consistent with the National Scheme).

**Option E1 – Providers must ensure that PCWs are competent and have the qualifications and knowledge to effectively perform their role (status quo)**

Currently under the Aged Care Quality Standards, providers are required to ensure that workers are competent and have the qualifications and knowledge to effectively perform their role. The Standards also require regular assessment, monitoring and review of the performance of each member of the workforce. The ACQS Commission assesses provider performance against these requirements, taking into account:

- consumer feedback about whether they consider that staff are sufficiently skilled and capable to meet their care needs
- the documented competencies and capabilities for different roles
- the organisation's staff performance framework
- feedback from managers and staff about their performance appraisals and the changes made following performance appraisals.

Retaining this approach:

- enables providers to determine the necessary combination of skills, qualification and knowledge relevant to the particular role being performed, the nature of the service and the profile of consumers
  - For example, a worker may not have formal qualifications but may have worked in aged care for over 20 years and have the necessary skills and knowledge to perform the role (supported by CPD opportunities), despite not having formal qualifications. The worker may however receive recognition of prior learning.
- provides flexibility where providers may not have access to PCWs with minimum qualifications (for example, in some rural or remote areas)
- enables providers to work with each individual to determine their specific training needs, rather than requiring uniform minimum qualifications for all
- enables workers to test their suitability for the aged care sector through on the job exposure prior to embarking on training.

The main disadvantages of this approach are:

- it does not address the concerns of some stakeholders that all PCWs hold certain minimum qualifications to ensure competency
- it does not encourage the upskilling of PCWs as a cohort, nor does it promote the role of a PCW (including public confidence in PCWs), in a way that could potentially be achieved through a registration scheme
- it relies on the ACQS Commission's assessment against the Aged Care Quality Standards to identify where qualifications may be required.

## Option E2 – Require providers to be satisfied that PCWs have certain minimum qualifications or competencies

As for English proficiency, under this option the existing requirement on providers (that all workers are competent and have the qualifications and knowledge to effectively perform their role) would be supplemented by a new provider responsibility that expressly requires providers to be satisfied that PCWs have minimum qualifications, specifically a Certificate III in Individual Support (or equivalent), or minimum competencies (for example, in infection control, managing challenging behaviours, manual handling, etc.).

The advantages of this approach are:

- it would provide assurance to consumers and others that all PCWs hold a core qualification or meet minimum competencies
- it does not require a separate government-managed registration process for PCWs (where the purpose of registration is to confirm minimum qualifications or competencies) and as such would be a lower cost approach
- it is consistent with the existing aged care framework whereby providers are responsible for ensuring staff are fit to perform their role, but it offers greater clarity regarding government expectations and requirements with respect to minimum qualifications or competencies for PCWs.

The main disadvantages of this approach are:

- it would potentially place more administrative burden on both providers and workers, in that providers would not be able to check a centralised register to confirm that applicants for a PCW role have the required qualifications or competencies, instead needing to satisfy themselves that this is the case
- additional costs would be imposed on PCWs to obtain minimum qualifications or competencies.
  - For example, in the case of minimum qualifications, the cost of a Certificate III in Individual Support (based on the average cost across 99 training providers listed on Myskills) is \$3,015<sup>42</sup>.
  - In 2016, two-thirds of services reported that more than 75 per cent of their PCWs held a Certificate III in Aged Care<sup>43</sup> (the predecessor to a Certificate III in Individual Support).
  - Based on these statistics, at least 25 per cent of PCWs would require further training in order to meet the new minimum qualification requirements.
  - The cost of gaining a qualification needs to be considered in the context of a worker with an average annual wage that equates to \$35,828.00<sup>44</sup>.
  - These costs may be reduced if compliance with minimum competencies was adopted, such that workers could complete units of competency rather than Certificates. This could enable micro-credentialing of workers rather than workers needing to gain a full qualification.

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<sup>42</sup> MySkills website, Certificate III in Individual Support, <https://www.myskills.gov.au/courses/details?Code=chc33015>.

<sup>43</sup> National Institute of Labour Studies, *op. cit.*, p. 10.

<sup>44</sup> *Ibid.*, pp. 27-28 based on a residential PCAs working 16-34 hours per week receiving a median weekly wage of \$689.



### **Option E3 – Establish a requirement for PCWs to demonstrate their qualifications as part of a registration process (consistent with the National Scheme)**

Noting stakeholder comments across various inquiries and reviews for national minimum qualifications to form the basis for any registration scheme, a third option would be to draw on the registration model of minimum qualifications applied under the National Scheme.

The National Scheme requires health practitioners applying for registration to evidence that they have an approved qualification to practice in the relevant health profession, or a qualification that the relevant National Board considers to be substantially equivalent or based on similar competencies to an approved qualification. National Boards identify approved study programs including approved education providers, approved campuses and course type and length for Australian-based study and bridging for any internationally qualified health practitioners.

Under this option, the relevant managing body for aged care worker registration would set minimum qualifications (e.g. a Certificate III in Individual Support) for PCWs, which individuals would have to complete in order to gain registration to work as a PCW. Transition arrangements would be required in respect of the existing PCW workforce.

The advantages of this approach are:

- it would provide assurance to consumers and others that all PCWs hold a core qualification
- it would provide a simple mechanism for providers to check whether PCWs hold the required qualifications
- specifying minimum qualifications may lift the status of PCWs, thereby enhancing the appeal of the profession and the potential recruitment of workers to the profession.

The key disadvantages of this option are:

- there are challenges in defining the cohort of worker to whom this requirement would apply (i.e. how a PCW is defined)
- this approach would not be consistent with that adopted for PCWs working with people with a disability and providing services for the NDIS (creating a situation where registration is required to be a PCW in an aged care service but not when providing care to a person with a disability)
- this could act as a barrier to entry into the aged care workforce. It may also mean some PCWs leave the workforce if they do not wish to (or cannot afford to) undertake the minimum qualifications. This situation may be particularly pronounced for older workers, who may consider exiting the workforce prematurely rather than achieving additional qualifications
  - Implementation options that do not disadvantage current PCWs would need to be considered, for example, phased introduction, setting a timeframe in which minimum qualifications must be undertaken (or enrolled in) and/or recognition of experience as part of meeting any minimum qualification requirements.
- there would be costs to government (with flow through costs to providers, workers and consumers) of establishing and maintaining the registration scheme (including setting minimum qualifications).

**Consultation questions:**

9. What is your preferred approach to minimum qualifications?

- **Option E1** – Providers must ensure that PCWs are competent and have the qualifications and knowledge to effectively perform their role (status quo)
- **Option E2** – Require providers to be satisfied that PCWs have certain minimum qualifications or competencies
- **Option E3** – Establish a requirement for PCWs to demonstrate their qualifications as part of a registration process (consistent with the National Scheme)

10. What are the other options for strengthening the skills and knowledge of PCWs in delivering aged care?

**Continuing professional development**

Based on the 2016 National Aged Care Workforce Census and Survey, continuing professional development (CPD) is reported to occur within the industry for the direct care workforce (58 per cent in residential care and 48 per cent of the home care and home support).<sup>45</sup>

As for minimum qualifications, various reviews have suggested setting minimum CPD requirements as a mechanism for strengthening the skills of aged care staff, particularly PCWs. For example:

- In 2016, the Community Affairs Reference Senate Committee, recommended that the government examine the implementation of consistent workforce regulation across all carer service sectors, including CPD.<sup>46</sup>
- In 2017, the Tune Review recommended that the aged care sector, in collaboration with the VET and tertiary education sectors, should act to ensure education and training is responsive to the sector's needs, including CPD and specialised training.<sup>47</sup>

The National Scheme provides an example of where CPD has been incorporated as part of ongoing registration requirements for certain registered health practitioners, including enrolled and registered nurses.

**Case Study – CPD Registration Standard under the National Scheme**

As part of the registration model under the National Scheme, the Nursing and Midwifery Board requires nurses and midwives to complete a minimum 20 hours of CPD on topics directly relevant to the context of their practice within a registration period. RNs who have an endorsement as a nurse practitioner or who hold an endorsement for scheduled medicines must complete an additional 10 hours of CPD.

<sup>45</sup> *Ibid.*, p. xvi.

<sup>46</sup> Senate Committee, Community Affairs Reference Committee, *Inquiry into the future of Australia's aged care sector*, 2016, p. xv.

<sup>47</sup> Australian Government Department of Health, *op. cit.*, p. 17.

Registered health practitioners must declare that they have complied with the CPD registration standard to renew their registration and compliance may be audited by the National Board.

A failure to meet the standard may result in conditions being imposed on registered health practitioner's registration, action being taken by the National Board (e.g. health, conduct or performance action) or disciplinary proceeding.<sup>48</sup>

Consistent with the options proposed in relation to minimum qualifications (and for the purposes of this Consultation Paper), three options have been proposed in relation to CPD.

1. Retain existing arrangements whereby providers must ensure that PCWs are recruited, trained, equipped and supported to deliver the outcomes required by the Aged Care Quality Standards (status quo).
2. Require providers to be satisfied that PCWs meet specified minimum CPD requirements.
3. Establish a requirement for PCWs to demonstrate they have met specified minimum CPD requirements as part of a registration process (consistent with the National Scheme).

**Option F1 – Retain existing arrangements whereby providers must ensure that PCWs are recruited, trained, equipped and supported to deliver the outcomes required by the Aged Care Quality Standards (status quo)**

Under the Aged Care Quality Standards, providers are required to ensure that PCWs are recruited, trained, equipped and supported to deliver the outcomes required by the standards. It is expected that aged care providers review the training, learning and development needs of the workforce regularly and when practices change and the providers support workers to take up training, learning and development opportunities so they can meet the needs of their role. The ACQS Commission assesses provider performance against these requirements.

Retaining this approach:

- enables providers to work with individual PCWs to determine their specific training needs and identify appropriate CPD to address these needs, rather than requiring a defined scope of CPD
- provides flexibility where formal CPD opportunities may not be readily available to PCWs, particularly in some rural or remote areas.

The main disadvantages of this approach are that it:

- does not provide for an environment whereby aged care consumers can expect that all PCWs providing personal care have undergone a consistent, minimum level of CPD
- does not address the expectations of some stakeholders that all PCWs undergo a set standard of CPD.

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<sup>48</sup> Nursing and Midwifery Board of Australia, *Registration Standard: Continuing Professional Development*, 1 June 2016.

### **Option F2 – Require providers to be satisfied that PCWs meet specified, minimum CPD requirements**

Under this option, existing requirements would be supplemented by a new responsibility that expressly requires providers to be satisfied that all PCWs have undertaken specified, minimum CPD.

The advantages of this approach are that it:

- would provide a level of assurance to consumers and others that all PCWs have undertaken a certain minimum standard and amount of CPD
- is not tied to a separate registration process for PCWs and as such, is lower cost
- is consistent with the existing aged care framework whereby providers are responsible for ensuring staff are fit to perform their role, but it offers greater clarity regarding government expectations and requirements with respect to CPD for PCWs
- may enhance the culture of ongoing learning and professional development within the industry.

The main disadvantages of this approach include:

- additional costs would be imposed on PCWs (and/or providers) to meet CPD requirements
- it requires providers to monitor the CPD undertaken by PCWs, including whether this occurs in the workplace or outside the workplace
- it would place administrative burden on PCWs to track and keep records of the CPD completed each year in order to demonstrate they have met the minimum requirements
- relative to Option F2, it has increased costs for government to determine minimum CPD requirements and evidence requirements and regulate against these requirements.

### **Option F3 – Establish a requirement for PCWs to demonstrate they have met specified, minimum CPD requirements as part of a registration process (consistent with the National Scheme)**

This option effectively puts the onus on the PCW to identify and undertake relevant CPD in line with specified, minimum CPD requirements. To implement this option, a separate registration process would need to be established with an independent body responsible for registering workers and assessing worker compliance with CPD requirements.

The advantages of this approach are that it:

- provides assurance to consumers and others that all PCWs have undertaken a certain minimum standard and amount of CPD (noting that this does not necessarily equate to an improved quality of care)
- may elevate the status of PCWs as a registered profession, enhancing the appeal of the profession and the potential recruitment of workers to the profession
- may enhance the culture of ongoing learning and professional development within the industry.

The key disadvantages of this option include:

- challenges in defining the cohort of worker to whom this requirement would apply (i.e. how a PCW is defined)

- this approach would not be consistent with that adopted for PCWs working with people with a disability and providing services for the NDIS (creating a situation where registration is required to be a PCW providing care to older consumers by not when providing care to people with a disability)
- it could act as a barrier to the retention of PCWs in the aged care workforce (particularly if the costs of CPD were borne by PCWs themselves)
- there would be costs to government (with flow through costs to providers, workers and consumers) associated with establishing and maintaining the registration scheme (including setting minimum CPD requirements).

**Consultation questions:****11. What is your preferred approach to continuing professional development?**

- **Option F1** – Retain existing arrangements whereby providers must ensure that PCWs are recruited, trained, equipped and supported to deliver the outcomes required by the Aged Care Quality Standards (status quo)
- **Option F2** – Require providers to be satisfied that PCWs meet specified minimum CPD requirements
- **Option F3** – Establish a requirement for PCWs to demonstrate they have met specified minimum CPD requirements as part of a registration process (consistent with the National Scheme)

**12. What are the other options for strengthening the CPD of PCWs and others delivering aged care?****3. Should worker screening be a positive register of cleared workers and/or a list of excluded workers, and who should have access to the list?**

The previous parts detailed three potential elements of a worker screening scheme, including assessment of:

- criminal history
- information regarding disciplinary action or other misconduct
- conduct in line with a code of conduct.

Regardless of the scope of worker screening, a separate question exists as to whether the results of any screening/assessment should generate a positive register of cleared workers and/or a list of excluded workers.

For the purposes of this Consultation Paper, it is assumed that the register (list) would be accessible to employers (i.e. aged care providers), with protections in place for the privacy of workers. This can be achieved, for example, through prospective workers providing consent to aged care providers to access the register (for example, by searching for a number provided by the worker).

**Positive register and/or list of excluded workers****Option G1 – A list of workers who have been cleared to work in aged care (positive list)**

This option would involve presenting a list of those workers who had been screened and cleared to work in aged care.

The main advantage of a positive register of ‘cleared’ workers is that it:

- provides an easy reference point for employers to identify cleared workers
- it presents only those workers who have been positively cleared without, reflecting negatively on those who have not been cleared (including to better protect the privacy of people who have not been cleared).

The main disadvantage of this approach is that it does not clearly identify those workers who have been determined to be unsuitable to work in aged care. This is because if the list is a positive one only, a person may not be on the list either because they have not applied for clearance or because they have actively been denied clearance which are two very different scenarios.

**Option G2 – A list of workers who have been excluded from working in aged care (negative list)**

This option would involve presenting a list of workers who have been found on initial screening not to be suitable to work in the aged care sector, or workers who although initially screened as suitable are later determined to be unsuitable to continue working in the sector. Both scenarios would result in the worker being included on the excluded list.

The advantages of this approach are that:

- it would not require the full list of all workers screened to be uploaded, which would ensure that the list was not burdensome to administer
- it would be less costly to administer and require less infrastructure to monitor the addition and removal of names from the list
- a list that only records the name of excluded workers does not also reveal the names of cleared workers, thereby reducing the amount of personal information that is maintained in a register.

The main disadvantage is that, without coupling the negative list with a positive list, there would be limited information available to employers regarding cleared workers. However, a negative list of excluded workers presents more significant privacy issues than the presentation of a positive list of cleared workers.

A negative list of excluded workers also removes the potential benefit of maintaining a positive list of cleared workers, which could enhance the public perception of aged care (both as an industry and the workforce specifically) and give workers something to aspire to.

### **Option G3 – A list of workers who have been cleared to work in aged care and a list of workers who are excluded from working in aged care**

This option would involve a list of workers who had been cleared as well as those who present as an unsuitable risk to aged care consumers and have therefore not been cleared (either for a specified period of time, or forever).

This is consistent with most of the existing schemes that include both a positive register and an exclusion list. For example:

- under the NDIS model, from 1 July 2020 there will be a database of both cleared and excluded workers
- Ahpra maintains a list of registered health practitioners and provides details about whether an individual practitioner's scope of practice is limited by the type of registration they have and any conditions that are applicable to the health practitioner. It also maintains a register of those health practitioners who have had their registration cancelled or prohibited.

#### **Consultation questions:**

#### **13. How should the register of cleared workers be presented?**

- **Option G1** – A list of workers who have been cleared to work in aged care (positive list)
- **Option G2** – A list of workers who have been excluded from working in aged care (negative list)
- **Option G3** – A list of workers who have been cleared to work in aged care and a list of workers who are excluded from working in aged care

## **4. What protections should be built into the scheme, particularly for aged care workers?**

A determination about an aged care worker's suitability (however described through the registration scheme) has very significant implications. Failure to be cleared or registered will mean that the person cannot work in aged care for a certain period or ever again. It may also have implications for them working in other related fields, including in disability care and childcare.

Given the significance of these consequences, a scheme that enables a decision not to clear or register a person to work in aged care, or to cancel a worker's registration, must have safeguards built in it to ensure there is procedural fairness for aged care workers.

For example:

- Under the NDIS, if a person is excluded on the basis of a criminal history check they have a right to appeal the decision unless the decision was automatic (on the basis that the offence fell into the relevant category of exclusion offences). Likewise, if a complaint is made about a person in terms of their adherence to the NDIS Code of Conduct, that person has the right to respond to any concerns of the NDIS Commission and also has a right to seek internal review of certain decisions made by the NDIS Commission. Following internal review, an affected person can seek

to have the Administrative Appeals Tribunal review the decision if they remain unhappy with the outcome.

- Similarly, under the National Scheme, a health practitioner can appeal certain decisions made by a National Board in relation to decisions around registration and decisions made as a result of the notifications process. For example, decisions by a National Board to impose or change a condition on a practitioner's registration; refuse to change or remove a condition imposed or an undertaking given by the practitioner, or a decision to suspend the registration. A health practitioner can also appeal certain decisions made by a panel.

It is proposed that any screening and/or registration scheme include similar protections for aged care workers.

## 5. How should the scheme be managed?

### Identifying the appropriate regulatory body

Any screening and/or registration scheme will require management by a government agency or third party (such as an industry body). An aged care worker regulatory scheme could potentially be managed by:

- an existing body that already performs a registration function such as Ahpra or the NDIS Commission
- the ACQS Commission
- a new government body established specifically for this purpose, or
- a non-government body.

There are advantages and disadvantages to each of these options.

For example:

- **Ahpra** – While Ahpra currently administers the registration of 744,437 health practitioners, it does so on the basis of distinct and identifiable professions which each have defined scopes of practice and attract the use of a protected title.
  - There are strict guidelines in relation to the creation of new regulated professions under the Intergovernmental Agreement relating to health practitioners.<sup>49</sup> If Ahpra were to expand its current registration function it would require agreement of all States and Territories, changes to National Law and the creation of a new National Board, etc.
  - While the function of registering PCWs may broadly align with Ahpra's registration functions in relation to enrolled and registered nurses, it would mean extending the existing registration framework to over 108,000 PCWs and distinguishing the role of PCWs from that of enrolled nurses, registered nurses and other aged care workers
  - While the registration model used under the National Scheme could theoretically apply to PCWs, the proposals relating to worker screening more broadly (as discussed in this Consultation Paper) would not be consistent with Ahpra's existing role.

<sup>49</sup> Intergovernmental Agreement for National Registration and Accreditation Scheme for the Health Professions.



- **State/Territory WSUs and the NDIS Commission** – The NDIS Worker Screening scheme involves only worker screening and not also worker registration. While the NDIS Commission will (from 1 July 2020) maintain the Worker Screening Database, the scheme is operationalised by WSUs in each State and Territory (that undertake the assessments of worker suitability and feed information into the database about whether a worker has or has not been cleared).
  - One option would be for the WSUs in each State and Territory to also screen aged care workers and for the NDIS Worker Screening Database to be expanded to include both disability and aged care workers.
  - As for the discussion regarding Ahpra, this would expand the remit of WSUs and the NDIS Commission considerably and would not be consistent with existing NDIS legislation, funding and policy.
  - Any such changes would require the agreement of States and Territories (noting that the NDIS worker screening scheme has been established via an Intergovernmental Agreement) in addition to changes to NDIS legislation.
  - Further, if the aged care worker regulatory scheme extended beyond screening (for example, to include PCW registration) this would go further than the current NDIS worker screening scheme where an active decision has been taken not to include such registration requirements for PCWs.
- **The ACQS Commission** – The ACQS Commission currently regulates aged care providers, not aged care workers. From 1 January 2020 the Commission’s operations include managing approved provider approvals, and responding to mandatory reports from approved providers regarding incidents of assault and unexplained absences. The ACQS Commission currently uses a range of regulatory tools to respond to provider risk, based on intelligence and risk assessment.
- If the ACSQ Commission were to be responsible for screening of all workers (and/or registration of PCWs) this:
  - would significantly expand the role of the ACQS Commission to undertake or at least be the repository for worker screening outcomes and registration
  - would require changes to functions of ACQS Commission and legislation
  - would mean that one body would be largely regulating and managing aged care matters, and worker screening/registration would be complementary to the Commission’s existing functions in relation to both complaints about aged care workers and aged care providers such that issues could be examined and understood holistically
  - would intersect with functions in relation to compulsory reporting of allegations or suspicions of assault.
- **A new government body** – A new government body could be established specifically for the purpose of screening aged care workers and/or registering PCWs.
  - The key advantage of this is that there would be a dedicated body for this purpose (making independent decisions, with clarity of purpose given its dedicated focus).
  - The main disadvantages are:
    - There are high overheads associated with establishing a small body with a limited range of functions. However, consistent with suggestions of the Counsel Assisting the Royal Commission, a new body could also have overall responsibility for aged care workforce

planning.<sup>50</sup> Any new body established for the purposes of the worker registration scheme could also have a broader role to address the workforce planning functions foreshadowed by these recommendations.

- When complaints are first made by consumers it is not always clear whether the root of the problem rests with the aged care provider and/or one or more workers. Separate investigation of each party by two separate bodies (i.e. ACQS Commission and a new government body established for the purpose of worker screening/registration) is unlikely to be as efficient as a single investigation by the one body examining the conduct of both the aged care provider and the worker.
- **A non-government (i.e. industry) body** – The functions of screening and registration could be outsourced to an industry body.
  - The key disadvantages of this option are that it would not be consistent with other like schemes, would be unlikely to provide the expected level of independence and could therefore lack the required public confidence, and may present privacy concerns about an industry body holding personal and sensitive information relevant to worker screening.

Regardless of which body undertakes the tasks, there are a wide range of implementation issues that would require consideration including:

- the functions of any body
- the powers of any body
- worker protections
- how information could be shared between regulators
- how existing infrastructure and platforms could be utilised to minimise cost and achieve streamlined processes for workers and employers.

**Consultation questions:**

**14.** What are the advantages and disadvantages of different bodies managing screening of all aged care workers and/or registration of PCWs?

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<sup>50</sup> Counsel Assisting Submission, Royal Commission into Aged Care Quality and Safety, 21 February 2020, recommendation 10, p. 150.

## 6. How should the scheme intersect with other like schemes?

There will be aged care workers who have transitioned from related sectors (such as disability and health) or who work in both aged care and disability at the same time.

Consistent with the objectives described at the commencement of this Consultation Paper, care must be taken to avoid duplicative requirements and to minimise the impost (including cost) on both workers and providers.

To this end it is proposed that if worker screening is adopted in aged care, the aged care scheme could recognise NDIS worker screening clearances such that if a person has been cleared by the NDIS they would be automatically cleared for aged care. Likewise, if a person is excluded from providing services to people with a disability (because they are unsuitable to do so) they should also be excluded as an aged care worker.

Further consideration would need to be given to how to achieve this in practice, including required information sharing and procedural fairness for workers.

A more complex issue is whether anyone who is registered as a health practitioner (such as an enrolled nurse) would automatically be registered as a PCW if they wish to perform that role in aged care.

### Consultation questions:

15. In principle, should a person cleared to work with people with a disability be automatically cleared to work in aged care?
16. Are there any other clearances that should support automatic clearance in aged care?
17. What are the relevant considerations regarding the interplay between Ahpra (and any other professional registrations) and PCW registration for aged care?

## 7. Implementation and transition issues

Subject to stakeholder views on the preferred options, considerable further work would need to be undertaken to determine the overall worker regulation model and the mechanisms to implement any such model.

For example, further consideration would need to be given to:

- the sequencing of implementation, and the possibility of ‘phasing in’ the various features of any new scheme, including to account for the transition of the existing workforce to whom the regulation will apply, including any mechanisms needed to assist aged care providers and the current aged care workforce to transition to any new scheme
- the costs associated with establishing any new regulatory body or expanding the capacity of a current regulator to accommodate the worker screening and/or registration scheme

- the legislative basis for any such scheme
  - Should the worker screening and/or PCW registration scheme impose direct obligations on workers (rather than on providers as the aged care legislation currently does) consideration will need to be given to the constitutional basis on which this may be done and the implications for any Commonwealth legislation
- any opportunity to leverage existing arrangements, particularly the State and Territory WSUs (utilised for the purposes of NDIS worker screening)
- the supporting infrastructure needed to support the implementation of a national scheme across a sizable workforce such as the required IT platform necessary to manage a register of screened workers and/or registered PCWs
- the way that the aged care worker screening and/or PCW registration scheme might intersect with existing schemes (e.g. NDIS worker screening, National Scheme, health complaints)
- the mechanisms for requiring compliance with any new scheme.

## Attachment A – Further detail regarding existing schemes

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### NDIS Worker Screening Check and Database

The NDIS Quality and Safeguards Commission (NDIS Commission) is an independent agency established under the NDIS Quality and Safeguards Framework to:

- regulate NDIS providers
- provide national consistency
- promote safety and quality services
- resolve NDIS service and supports quality and safety issues
- identify areas for improvement.

All NDIS providers are regulated by the NDIS Commission and must comply with the NDIS Code of Conduct. Entities delivering NDIS supports and services include not-for-profit organisations, sole traders, private businesses, and in some States and Territories, government agencies. Providers of specified supports and services must register with the NDIS Commission and comply with the NDIS Practice Standards. This compliance assures NDIS participants of the quality of service delivery expected from registered providers. Self-managing participants may choose to engage providers not registered with the NDIS Commission with the exception of certain higher risk supports and services. These providers are still required to comply with the NDIS Code of Conduct and to manage participant complaints.

#### Worker screening

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As a condition of NDIS registration, registered NDIS providers are required to ensure workers in risk-assessed roles have an appropriate clearance to work with NDIS participants.

It may also be an offence under State and Territory legislation for workers to work without a check if their role requires one - for example, for some States, it is not permitted to start working where an application has been made but a clearance has not been given.

A person will be characterised as holding a 'risk-assessed role' if:

- they are key personnel as defined under the *NDIS Act 2013*
- their normal duties include the direct delivery of specified supports or specified services to a person with disability, or
- their normal duties require more than incidental contact with a person with disability.

While other roles are not required to undergo a NDIS Worker Screening Check, a registered NDIS provider is still able to request those workers to undertake a check.

Worker screening of risk-assessed roles is undertaken by State/Territory WSUs. A worker can apply in one State/Territory and complete the relevant screening requirements in that jurisdiction and thereafter receive clearance to work across all States/Territories for a period of up to five years (subject to ongoing monitoring).

The types of convictions and conduct that determine a worker's clearance is outlined in the Intergovernmental Agreement between Commonwealth, State and Territory governments.

The risk assessment completed by WSUs is undertaken against a range of considerations. Criminal codes across all States and Territories have undergone an equivalence process, allocating them into three tiers.

There are three tiers that are assessed across all WSUs:

- convictions that lead to an automatic exclusion from the disability sector (where clearance will not be given) (Tier 1)
- convictions and circumstances that are presumed to disqualify a person from being provided with clearance unless there are exceptional circumstances (Tier 2)
- convictions and conduct that require a risk assessment by the WSU to determine if there is a risk of harm to a NDIS participant (Tier 3).

Criminal convictions allocated to Tier 2 and Tier 3 progress to a WSU risk assessment. The Intergovernmental Agreement lists what information is considered by WSUs in their assessment of a worker. It includes national criminal history information, disciplinary and misconduct information provided by the NDIS Commission, adverse actions taken by the NDIS Commission, additional circumstances information held by law enforcement agencies where available, and a range of self-disclosure matters including civil penalties, international criminal history, etc. The Intergovernmental Agreement also provides that 'all other relevant criminal, disciplinary, or misconduct information, or any other information considered relevant by the WSU, should trigger an assessment of a person's eligibility...'

As clearance and risk assessments are conducted at a State/Territory level, workers are provided with protections in relation to the decisions made by the State/Territory WSUs. Workers can seek internal review by a WSU for certain decisions including decisions to revoke or suspend a NDIS Worker Screening Check. If the individual is not satisfied after the internal review, they may seek an external review by a tribunal or authority within that jurisdiction. There is no right of appeal for a decision that a worker is excluded on the basis of a Tier 1 criminal conviction.

WSUs' IT systems interface with the NDIS Worker Screening Database uploading the clearance or exclusion status of an applicant for viewing by their NDIS employer. The database holds clearance decisions only – no criminal conviction information is held on the database. The database will commence the display of Check outcomes from 1 July 2020.

Note that the NDIS model does not address minimum qualifications or CPD as part of the risk assessments or clearance decisions. This was a policy decision based on a focus on participant choice and control and a desire to see workers with the right capabilities and experience (matched to the participant's need and preferences) rather than only formal qualifications. The intent is to build a workforce that represents the different needs and interests of participants including age, gender, language and culture.

## NDIS Code of Conduct

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Separate to receiving a clearance to work, all NDIS providers and workers (including, for example, Ahpra registered health practitioners) who deliver specified services and supports to NDIS participants are required to comply with the NDIS Code of Conduct (NDIS Code).

Compliance with the NDIS Code is regulated by the NDIS Commission. The NDIS Commission is responsible for receiving complaints about NDIS supports and services and in particular, non-compliance with NDIS Practice Standards, the NDIS Code and other quality and safeguarding requirements.

The NDIS Commission determines from the complaints and other referral information it receives whether there has been a breach of the NDIS Code. It also has powers to commence an own motion investigation.

If there is sufficient evidence of a breach of the *NDIS Act 2013* or NDIS Code, the NDIS Commission may take the following action:

- seek civil penalties against a registered NDIS provider or a worker
- require a registered NDIS provider or worker to undertake further training
- impose conditions on a registered NDIS provider
- vary, suspend or revoke the registration of a registered NDIS provider
- issue a banning order on a registered NDIS provider or a worker.

In most cases, a banning order may only be made where the person has been given an opportunity to make submissions to the NDIS Commission on the matter.

Compliance and enforcement action taken by the NDIS Commission is published on the NDIS Commission's website for public viewing.

If the investigation involves the conduct of a worker, relevant information may be shared with the relevant WSU in accordance with information disclosure provisions in the *NDIS Act 2013*. This information can then be utilised to re-assess the NDIS worker's suitability to continue to provide supports and services to NDIS participants.

## Database

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The database has been established to provide registered NDIS providers a tool to meet the NDIS Practice Standards. It provides a single source of clearance information for employees of registered NDIS providers. The database also supports self-managing participants to seek clearance of unregistered providers employed to deliver service and supports included in the NDIS participant's plan..

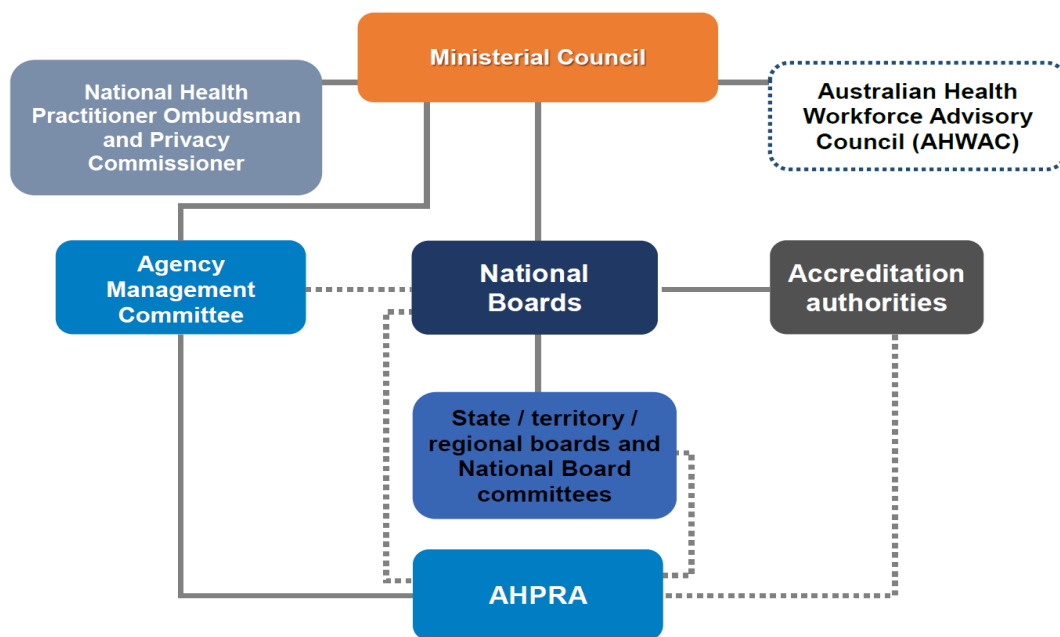
The database will keep a record of decisions made in relation to anyone who has applied for an NDIS Worker Screening Check and the register will list the cleared and excluded workers from all States and Territories to enable national application of clearances. It will not contain information about a person's criminal history, including convictions and charges and any other information relied on to support a decision that is made under NDIS worker screening law.

The NDIS Commission is responsible for administering the database and providing access to certain persons and bodies including the States and Territories and a subset of employers and self-managing participants. Personal information available to employers accessing the database is limited to a worker’s Worker Screening ID, their Stat/Territory application number, their full name, their date of birth, clearance or exclusion status, expiry date, and whether the clearance permits the worker to work. Employers will not have access to the details of a worker’s other employers, or sensitive information.

**The health practitioner national registration and accreditation scheme**

Under the National Registration and Accreditation Scheme (National Scheme), a health practitioner can apply for registration with a National Board. They must provide evidence that they are eligible to hold registration. This means that they must hold recognised qualifications suitable for registration in the profession and demonstrate that they meet the registration standards of the National Board.

The National Scheme is delivered by Ahpra in partnership with National Boards, with the Ministerial Council providing high-level oversight and Accreditation Authorities exercising accreditation functions for programs of study and health practitioners who were qualified overseas. Ombudsman, privacy and freedom of information oversight is provided the National Health Practitioner Ombudsman and Privacy Commissioner. The figure below shows the inter-relationships between the entities within the National Scheme.



**Registration with a National Board**

In order for a person to use one of the health practitioner ‘protected titles’ (e.g. medical practitioner, registered nurse, chiropractor, etc.) the practitioner must be assessed in line with the registration standards set by the relevant National Board.



The registration standards that are mandatory for each profession cover matters such as a person's criminal history, English language skills, continuing professional development requirements for ongoing education, professional indemnity insurance arrangements and requirements about the recency of their practice.

When a health practitioner first applies for registration, the relevant National Board requires the applicant to declare their criminal history in all countries, including Australia.

All registered health practitioners must inform their National Board if they have been:

- charged with an offence punishable by 12 months' imprisonment or more, or
- convicted or found guilty of an offence punishable by imprisonment in Australia and/or overseas.

While the requirements of the registration standard are the same or similar across National Boards, the offences listed in the criminal history check varies between the States/Territories.

Registration with the relevant National Board is required to be renewed annually and requires a registered health practitioner to disclose any changes to their criminal history, declare that they continue to meet the relevant National Board's recency of practice and CPD requirements, and to advise of any complaints that Ahpra has not been made aware of.

There are different types of registration which identify the scope of practice applicable to the health practitioner (e.g. general, specialist, limited, provisional).

## **Register**

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Ahpra maintains a register of practitioners which enables the public to search for a health practitioner via their family name or registration number.

The search results include the registration details (including the status, type of registration and expiration date), any endorsements or current conditions that are applicable to the health practitioner.

There is also a register for cancelled and/or prohibited health practitioners. This register contains the names of:

- practitioners who have had their registration cancelled or prohibited since the National Law came into force
- practitioners who were not registered at the time of the relevant tribunal decision, but have been subject to a determination that the tribunal would have cancelled the person's registration had the person been registered
- former registered health practitioners who have been prohibited from providing health services or using a title.

## Notification

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The National Scheme also has a notification scheme whereby Ahpra and the National Boards can be notified of certain conduct in order to investigate whether:

- a health practitioner's behaviour is placing the public at risk
- a health practitioner is complying with conditions imposed on their registration or an undertaking given by the health practitioner
- a health practitioner is practising their profession in an unsafe way, or
- a health practitioner's ability to make safe judgements about their patients might be impaired because of their health.

While registered health professionals, employers and education providers have mandatory reporting obligations imposed by the National Law, the majority of reports made to AHPRA are voluntary (i.e. from patients and community members).

Ahpra can receive notifications directly in all jurisdictions except New South Wales and Queensland. In New South Wales, notifications are managed by 15 professional councils (supported by the Health Professional Councils Authority (HPCA)) and the Health Care Complaints Commission (HCCC). Ahpra plays no role in notifications. While Ahpra and the National Boards manage registration of NSW health professionals, complaints and notifications are managed jointly by the HPCA and the HCCC under the National Law (NSW) legislation. Similarly, in Queensland, the Office of the Health Ombudsman (OHO) receives all complaints about health professionals and determines which of those complaints are referred to a National Board and Ahpra to manage.

Where a notification is reviewed by a National Board, the relevant Board has the power to take a range of actions at any time after receiving a notification or after an investigation. These actions include:

- taking no further action
- referring the matter to another entity such as a health complaints entity
- taking immediate action to limit a health practitioner's registration where it believes there may be a serious risk to persons and that it is necessary to take immediate action to protect public health or safety

If a National Board believes that a health practitioner's conduct or performance was unsatisfactory, or their health was impaired, it can:

- caution the health practitioner
- accept an undertaking from the health practitioner
- impose conditions on registration
- refer the health practitioner to a panel (e.g. professional standards panel), or
- refer the health practitioner to a State/Territory tribunal for the purposes of determining if the practitioner has engaged in serious misconduct and/or whether the registered practitioner's registration should be cancelled.

A health practitioner can appeal certain decisions made as a result of the notifications process. For example, decisions by a National Board to impose or change a condition on a practitioner's

registration; refuse to change or remove a condition imposed or an undertaking given by the practitioner, or a decision to suspend the registration. A health practitioner can also appeal certain decisions made by a panel.

The National Law requires the National Boards and the relevant health complaints entity in each State and Territory to share complaints and notifications (in most States and Territories) and try to agree on how to deal with each complaint or notification.

### **Codes of Conduct and Ethics**

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In addition to the registration standards created by each National Board and the notification scheme, there are Codes of Conduct relevant to each profession. This information is used to outline what would constitute a breach of professional behaviour or a departure from accepted standards of professional conduct. Suspected breaches of the Code are reviewed by the relevant National Boards.

### **Child educator model**

The National Quality Framework (NQF) sets out the minimum qualification and educator to child ratio requirements for children's education and care services. The NQF was introduced in 2010-11 as a key policy measure intended to professionalise and improve the quality of the early childhood sector through increased requirements for the employment of early childhood teachers and educators.

The early childhood sector is regulated by a national scheme which is governed by a nationally consistent law passed by each State and Territory (the National Education and Care Services National Law (National Law)). The National Law outlines the legal obligations of approved providers, nominated supervisors and educators, and explains the powers and functions of the State and Territory Regulatory Authorities as well as the Australian Children's Education and Centre Quality Authority (ACECQA) as the national authority.

The Education and Care Services National Regulations (National Regulations) support the National Law by providing detail on a range of operational requirements for an education and care service including:

- the National Quality Standards
- application processes for provider and service approval
- staffing arrangements (i.e. child-to-educator ratios and qualifications)
- jurisdiction-specific provisions
- conduct of criminal history or other security checks
- performance improvement, professional standards, professional development.

Regulatory Authorities administer the NQF in each State and Territory, usually as part of that State or Territory's education department or agency. They are responsible for, among other things, granting provider approval and service approvals and assessing and rating services against the National Quality Standards which sit under the NQF.

ACECQA is an independent national authority that works with the Commonwealth and State/Territory governments to monitor and promote the consistent application of the National Law, maintains the national registers of approved providers and services and undertakes the assessment and approval of individual and organisation qualifications. ACECQA does not regulate or oversee the State and Territory regulatory authorities or deal with complaints about the operations of services.

The sharing of information about education and care services between the Commonwealth and the State and Territory regulatory authorities administering the National Law is underpinned by the COAG National Partnership Agreement on National Quality Agenda on Early Childhood Education and Care (December 2009) for the purposes of the NQF.

### **Worker screening**

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State and Territory WSUs are responsible for completing and granting the Working with Children and Vulnerable People Checks in the respective jurisdictions.

The child educator model requires approved providers to read or ensure that a nominated supervisor or a person in day-to-day charge of the service has read a person's current Working with Children Check before that person is engaged or employed as a staff member at the service. The approved provider is also responsible for ensuring that all other staff, including family day care coordinators and family day care educator assistants engaged or employed by the service, hold a current Working with Children Check or teacher registration.

An approved provider must notify the regulatory authority in writing of the suspension or cancellation of a Working with Children Check held by a nominated supervisor or certified supervisor. Failure to comply with this requirement is an offence under the National Law.

### **Approval of qualifications**

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The NQF sets out the minimum qualification requirements for educators working in children's education and care services. As the scheme operates on ratios of educators to children, the number of educators within a service who are required to have certain qualifications is linked to the ratio.

For example, generally 50 per cent of educators are required to meet the relevant ratios in a centre-based service working with children preschool age and under, and must have, or be actively working towards, at least an approved diploma level education and care qualification. All other educators required to meet the relevant ratios at the service must have, or be actively working towards, at least an approved certificate III level education and care qualification.

There are also some State and Territory specific qualification requirements for working with school age children (e.g. in outside school hours care services).

Some States and Territories require early childhood teachers (ECTs) to hold teacher registration or accreditation. It is also important to note that individual employers may specify higher qualification requirements (for example, a four-year ECT degree) as part of their employment policy.

There is an NQF approved qualifications list which identifies:

- the qualification levels
- awarding institution
- qualification name
- qualification code
- date awarded
- which jurisdiction the qualification is approved in.

### **Code of conduct and ethics**

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As part of the National Quality Standards, the approved provider and staff are required to use professional standards and ethical principles to guide professional conduct in decision-making and practice. The approved provider must provide clear guidance to all staff about their responsibilities in relation to one another and to the families and children using the service. The approved provider should also ensure that all staff know and understand the requirements of the NQF, as well as the services' philosophy, policies and procedures.

Early Childhood Australia produces a Code of Ethics, but this is not enforceable and is used as a guide for professional behaviour and principles to inform individual and collective decision-making.

### **Registers**

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The national registers contain public information about approved education and care services and providers. These registers are updated daily from data held in the National Quality Agenda IT System but do not disclose any information about workers.

The National Regulations require approved providers of family day care to maintain a register of family day care educators, co-ordinators and educator assistants including evidence of any relevant qualifications held by the educator (or if the educator is actively working towards a qualification) and a record of the Working with Children or a Working with Vulnerable People Check (including the identifying number and expiry date) and details about the date that the check or registration was sighted by the approved provider.

### **Exemptions for pre-scheme commencement**

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As the scheme was implemented in 2010-11, transitional arrangements and exemptions exist for those workers who were in place prior to the commencement of the scheme. Under the National Regulations, there are qualification exemptions for educators specific to remote and very remote areas. It applies an exemption to the ratios in that an educator at a centre-based service can be included to meet a relevant educator to child ratio for the service without having, or actively working towards, a certificate III if:

- the educator has been continuously employed as an educator in an education and care service or a children's service for a period of at least 15 years up to immediately before the scheme commenced
- the educator is employed by the same approved provider as the educator was employed by immediately before the scheme commenced.

## Attachment B – Existing codes of conduct

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### NDIS Code of Conduct

The NDIS Code of Conduct applies to all NDIS providers, registered and unregistered, and all persons employed or otherwise engaged by an NDIS provider.

In providing supports or services to people with disability, a person covered by the Code must:

- act with respect for individual rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions
- respect the privacy of people with disability
- provide supports and services in a safe and competent manner, with care and skill
- act with integrity, honesty and transparency
- promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability
- take all reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of, people with disability
- take all reasonable steps to prevent and respond to sexual misconduct.

Breaches of the NDIS Code are investigated by the NDIS Commission who has a broad range of powers.

The outcome of an investigation may result in information being provided to the relevant State/Territory WSU where the worker is a registered NDIS provider in order to make a risk assessment in relation to the worker's clearance. Note, not all workers are registered NDIS providers (some may be unregistered or work for a registered NDIS provider) so this information will not always impact a worker's criminal history check to be able to work in the industry.

### National Code of Conduct for Health Workers

In 2007, the NSW Parliament enacted legislation to strengthen public protection of health care consumers who use the services of unregistered health practitioners in NSW. The NSW scheme established an enforceable code of conduct for unregistered health workers, with powers for the NSW Health Care Complaints Commission (HCCC) to investigate breaches of the code and issue prohibition orders where there is a risk to public health or safety.

Inspired by the NSW scheme, the outcomes of a 2011 consultation were released in August 2013 under the title *Final Report: Options for regulation of unregistered health practitioners* (Final Report). The Final Report found that the option of a single national Code of Conduct for unregistered health workers with enforcement powers for breach of the Code was likely to deliver the greatest benefit to the community.

All State, Territory and Commonwealth health ministers sitting as the Standing Council on Health agreed in principle to strengthen State and Territory health complaints mechanisms via:

- a single National Code of Conduct for unregistered health workers (National Code), to be made by regulation in each State and Territory, and statutory powers to enforce the National Code by investigating breaches and issuing prohibition orders
- a nationally accessible register of prohibition orders
- mutual recognition of State and Territory issued prohibition orders.

Under the proposed arrangements, each State and Territory would be responsible for:

- enacting new (or amending existing) legislation and regulations to give effect to the national Code of Conduct, the national register of prohibition orders, and mutual recognition of prohibition orders across jurisdictions
- determining a suitable local body to receive and investigate breaches of the Code of Conduct and issue prohibition orders.

*A National Code of Conduct for health care workers* sets out the content of the National Code.

The National Code regulates the provision of health services by health workers who are not required to be registered under the National Scheme, and health professionals who are registered under the National Scheme who provide health services that are unrelated to their registration.

It aims to set national standards against which disciplinary action can be taken and, if necessary, for a prohibition order issued in circumstances where a health care worker's continued practice presents a serious risk to public health and safety.

The Code covers matters such providing health services in a safe and ethical manner, infection control, and prohibitions on practicing with certain physical or mental conditions, under the influence of alcohol or drugs, nor financially exploiting or providing misinformation to clients/patients.

It has been acknowledged that the extent to which the Code of Conduct applies to aged care workers is not clear based on the definition of 'health service', and there may be variations across the jurisdictions depending on how closely the National Code is adopted.

## **NSW Code of Conduct**

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In the NSW context, complaints about unregistered health workers can be made to the HCCC about alleged breaches of the NSW Code. Where it appears that there is a breach of the NSW Code or a risk to public health or safety, the HCCC can investigate.

If an unregistered health worker is found to have breached the NSW Code, the HCCC may make a prohibition order against the unregistered health worker. It is an offence for an unregistered health service provider/worker to continue to provide a health service in breach of a prohibition order. The worker has the right to appeal to the NSW Administrative Decisions Tribunal against the Commission's decision.

The HCCC does have the discretion under certain circumstances to disclose information it receives in line with its functions (e.g. information received through NSW Code breaches) to a suite of persons and bodies listed in the legislation including any person or body regulating health service providers in Australia.

As discussed above, it is unclear whether the NSW Code is designed to cover aged care workers (specifically, personal care workers) given the broad scope of the definition of a ‘health service’ and the use of ‘health practitioners’ in its governing legislation (*Public Health Act 2010*).