AUSTRALIAN DENTAL ASSOCIATION

14-16 Chandos Street St Leonards NSW 2065 Australia
PO Box 520 St Leonards NSW 1590
Tel 02 8815 3333 | ada.org.au

29 June 2020

Ms Amy Laffan
Acting First Assistant Secretary
Aged Care Reform Compliance Division
Department of Health
GPO Box 9848
Canberra ACT 2601

Submitted online: https://consultations.health.gov.au/aged-care-reform-compliance-division/aged-care-worker-regulation-scheme-consultation/

Dear Ms Laffan,

Re: Aged Care Worker Regulation Scheme Consultation

Thank you for providing the Australian Dental Association (ADA) with the opportunity to provide feedback on matters relevant to the design of a new aged care worker regulation scheme, as set out in the *Aged Care Worker Regulation Scheme Consultation Paper*.[1]

The ADA's interest in such a scheme stems from the role that personal care workers (PCWs) and home aged care workers (HCWs) ideally play in assisting older people who need daily help to clean their teeth or dentures and maintain oral hygiene, and in screening for and reporting any apparent or suspected oral health problems that may require a dental practitioner's professional assessment and care.

Of all the staff working in residential aged care facilities, or in home aged care services, it is PCWs/HCWs who spend the most time with their aged care clients, and provide the most day-to-day care—including the most intimate forms of personal care, such as teeth-brushing, denture care, and other personal hygiene requirements. Through their frequent interactions and relationships with these clients, and the quality and safety of the regular care they deliver, PCWs/HCWs have a major impact on the physical, mental and oral health and wellbeing of older people. Yet there is currently no Commonwealth agency responsible for registering or regulating this category of workers.

The ADA supports Counsel Assisting's Submissions to the Royal Commission into Aged Care Quality and Safety (the Royal Commission) on the need for a *national registration scheme* specific to PCWs, including:

- mandatory minimum qualifications,
- continuing training and professional development requirements,
- minimum levels of English proficiency,
- criminal screening requirements,
- a Code of Conduct, and
- power for the registering body to investigate complaints into breaches of that Code of Conduct.[2]

[1] https://consultations.health.gov.au/++preview++/aged-care-reform-compliance-division/aged-care-worker-regulation-scheme-consultation/supporting_documents/Consultation%20Paper%20%20Aged%20Care%20Worker%20Regulation%20Scheme.docx
[2] Royal Commission into Aged Care Quality and Safety, *Counsel Assisting's Submissions on Workforce*, 21 February 2020, RCD.0012.0061.0001.

Next month, the ADA will be lodging a second submission to the Royal Commission providing comment on this, and a range of other issues that must be addressed to improve the accessibility and quality of oral care for people in receipt of aged care services.

The ADA's response to the present consultation is limited to questions on which the ADA has a particular view – other questions are marked as N/A.

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)

For a variety of reasons, the ADA prefers Option A2 (centralised assessment of criminal history for workers based on the NDIS model) to Option A1 (the current model whereby providers assess criminal history as revealed in police checks, agree not to employ those with certain types of criminal convictions and decide whether or not to employ other workers guided by aged care legislation, funding agreements and the *Police Certificate Guidelines* issued by the Department).

The Consultation Paper acknowledges that "abuse and neglect of older people continues to occur" in aged care, and that "there is a community expectation that more needs to be done about this issue."[3] Given the numerous case examples cited in recent reviews and inquiries into aged care, and in evidence to the current Royal Commission, it is also clear that the current model (Option A1) is inadequate to protect older people from aged care workers who assault, abuse and/or neglect older people in their care, sometimes on a serial basis.

There are many deficiencies in the current screening model, including the fact that the kinds of checks that aged care providers are required to make before hiring[4], and the kinds of convictions that must be recorded on police certificates[5] are too narrow to ensure that potential employers will be alerted to attitudes or behaviours on the part of potential employees that may indicate unsuitability for caring work within the aged care system.

Secondly, even the limited character check implicit in the requirements of Option A1 relies on an assumption that police will lay charges where there is evidence of a worker physically or sexually assaulting an older person they are caring for, such that a court has the opportunity to further examine the evidence and make a finding. Yet the Royal Commission has found that police have often failed to lay charges where there is clear evidence of assaults by an aged care worker against an aged care client, meaning that such workers are never brought before the courts, nor convicted, and continue to "fly under the radar" during police check and hiring processes.

Thirdly, under the current scheme, the cost of police checks, which is borne by PCWs/HCWs, is particularly onerous given the nature of employment and low wages paid in the industry. Each aged care provider that a PCW/HCW wishes to work for will require a police check (or certified copy of a police check) which costs the worker around $50 per check/copy. As the sector tends to offer PCWs part-time or casual work rather than full-time employment, most PCWs work part-time for multiple employers, and on very low wages, so the cost of police-checks is quite a burden.

[3] p.7.
[4] under the Aged Care Quality Standards, and under the *Accountability Principles* 2014 of s.96-1 of the *Aged Care Act 1997*
[5] being limited to convictions for murder, sexual assault, or other kind of assaults for which a sentence of imprisonment is imposed

One advantage of a centralised screening model or registration scheme (Option A2) over the current model is that prospective employers could check a centralised register so that employees would need only pay once every few years for the checks they have to undergo.

The NDIS worker screening model appears quite appropriate to aged care and could easily be expanded/modified slightly to cover any additional concerns specific to aged care if the sector considered that necessary.

Another important advantage of Option A2 over the current model is that the NDIS screening model includes a more nuanced assessment of a relatively broad range of offences, pending charges, domestic violence and child protection orders, and any relevant workplace misconduct findings. Some categories of offences automatically exclude a person from getting a clearance, other offences and pending charges exclude clearance unless there are exceptional circumstances, and yet other kinds of offences/misconduct will trigger a further risk assessment process against defined criteria.

Finally, and looking to the future, another important benefit of using this model is that demand for workers in both the NDIS and aged care sectors is growing rapidly, particularly in relation to support/care provided at home, with an increasing number of providers operating within both systems. As it is expected that an increasing number of workers will also wish to work in both sectors, it makes sense to use the NDIS screening model as an element of a PCW/HCW registration scheme.

2. Are there other options that should be considered?

N/A.

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

All of the above, where relevant. See also response to Q.1.

4. Are there any other matters that should/should not be considered as part of any aged care worker screening scheme?

N/A.

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

The philosophy underpinning the training of disability support workers and aged care workers, the actual day-to-day work they carry out, and the requirements of Aged Care and NDIS legislation are quite different. For these reasons, the ADA prefers Option C3, and believes that a distinct Code of conduct for aged care workers should be developed in close consultation with the aged care sector.

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

The key advantage of introducing a Code of Conduct is that it would be the first and only document within the Australian aged care system setting out explicit expectations of the conduct of PCWs/HCWs.

Codes of conduct provide important fundamental guidance for any category of worker about the values and ethics they are expected to bring to their work. Having such a document to refer to can only help to engender a greater sense of professional pride and accountability amongst individual workers.

That being said, evidence from the Royal Commission and several other recent inquiries and reviews demonstrates that in many cases, aged care workers struggle to provide safe, high quality care because they don't have the time, colleagues or supervisory support to do so. Many aged care workers operate in contexts characterised by inadequate government funding (or a profit focus that is inconsistent with quality care provision), inadequate staffing numbers, inadequate training, unrealistic expectations on the part of management, and an inadequate staffing mix that does not include sufficient registered nursing staff.

These issues, which are mostly beyond the control of individual PCWs/HCWs, must be taken into account in the development of any Code of Conduct for aged care workers, and its interpretation by the relevant regulatory body in the context of disciplinary matters.

The ADA agrees with a number of other stakeholders that it is insufficient to rely on complaints mechanisms to improve the quality of aged care, and that as a complement to the introduction of a Code of Conduct for PCW's/HCWs, whistle-blower protections under the *Aged Care Act 1997* should also be strengthened, to encourage staff to speak up without fear of repercussions.

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)

The ADA is aware that PCWs/HCWs with fluency in languages other than English are often particularly valuable within the aged care system, as many older people for whom English is a second language and who may have spoken their first language at home all their lives feel most comfortable in an aged care environment where this can continue. The ADA also recognises that some aged care facilities specifically market themselves towards the needs of older people who have a specific first language other than English.

Nevertheless, it remains that all PCWs/HCWs need to be able to understand communications/instructions written in English, to explain them to older people in their care (with whom they may share a first language) and to comprehend, compose and respond effectively to oral and written communications in English between themselves and other residents, nurses, family members, health practitioners and employers.

Option D2 is preferable as it would ensure consistency of standards across providers and across Australia. Nevertheless, the ADA believes that as for other requirements that may be introduced under a potential worker registration scheme, new English proficiency provisions should be introduced in a way that does not preclude registration of existing aged care workers who are valued by their employers and their clients, but who need time to meet particular registration provisions, such as English literacy.

8. What are the other options for strengthening English proficiency in aged care (particularly for those providing personal and clinical care)?

N/A

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)

The ADA favours Option E3, where providing evidence of minimum qualifications would be a pre-requisite to eligibility for registration under a national registration scheme for PCWs/HCWs.

The Certificate III in Individual Support (Ageing) (or Care Support as it is now to be known) should be the minimum qualification for personal care/home care workers. However, to ensure that the 25% or so of workers who do not have this qualification can keep working in the industry, the registration scheme will need to incorporate recognition of prior learning and grandfathering provisions.

With respect to the oral health content of the Certificate III, students seeking to graduate with Ageing or Home and Community Support specialisations must complete not only the core units, but the mandatory elective CHCCCS011 *Meet personal support needs.* This unit provides a basic introduction to oral hygiene, and requires that candidates have demonstrated in a relevant workplace that provides personal care that they have been able to support two real individuals with oral hygiene care (and other forms of personal care) according to requirements set out in individualised care plans.

Whilst there are also five other VET units that are specifically about the oral health care of the aged, one of which is offered as an elective for the Certificate IV course, it is not feasible to attempt to include any of them as mandatory units to the Certificate III course, particularly when the pressing need to include more content on dementia in the course is considered.

Nevertheless, responses to the first and second round consultation on the re-packaged Certificate III currently being considered by the Aged Services IRC would suggest that there is scope to amalgamate the content of some of the existing units, which might leave more space for additional content.

In light of this, and to improve the oral health knowledge and skills of Certificate III students before they enter the workforce, the ADA strongly recommends the incorporation of the *Better Oral Health in Residential Aged Care Staff Portfolio*[6] training curriculum and resources into the Certificate III course. It includes three relatively short modules that cover theoretical knowledge, practice in using techniques to overcome common difficulties encountered when providing daily oral hygiene care to aged care residents, and training in how to recognise common oral health problems.

This part of the curriculum should be taught by registered dental practitioners.

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

It is clear from evidence provided to the Royal Commission that the quality of Certificate III in Individual Support courses offered by registered private training organisations (RTOs) varies widely, which means that the skills of graduates of these courses vary widely too.

[6] SA Dental Service. (2008). *Better Oral Health in Residential Aged Care Staff Portfolio Education and Training Program.* https://www.sahealth.sa.gov.au/wps/wcm/connect/09fa99004358886a979df72835153af6/BOHRC_Staff_Portfolio_Full_Version%5B1%5D.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-09fa99004358886a979df72835153af6-n5hOC7k

Evidence presented to the Royal Commission in 2019 by members of the Aged Services Industry References Committee, both of whom are involved in the provision of relevant Certificate III courses, also suggests that one reason for these variations in course quality is that standards around issues like face-to-face teaching hours, teacher credentials, and minimum work placement hours contained in companion volumes to the industry training package are not enforceable standards. This means that the Australian Skills Quality Authority does not have the power to force RTOs to comply.[7]

It has been suggested to the Royal Commission that these difficulties stem from the fact that the recommendations of the 2014 *AQSA Process Review Final Report*,[8] which were designed to address this issue, have not yet been fully implemented.

The ADA believes that the Australian and State governments should take action to ensure that these recommendations *are* fully implemented, so that the sector can employ graduates of these courses confident in the knowledge that their education and training has provided them with the competencies necessary to provide safe, high quality care.

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)

The ADA prefers Option F3, as it affords maximum portability to workers registered under the scheme, meaning that their police clearances, qualifications, and evidence of their CPD activities effectively "travel with them" when they move on to new employment.

12. What are the other options for strengthening the CPD of PCWs and others delivering aged care?

Given the relatively high turnover of staff in aged care settings, and the fact that some staff currently working in the industry do not yet have Certificate III qualifications, the ADA believes that ongoing training in provision of oral health care to aged clients should be mandated.

For staff working in residential aged care, this ongoing training should be provided by dental practitioners, on a face-to-face basis.

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

N/A

[7] Transcript. Robert Bonner, Deputy Chair, Aged Services Industry Reference Committee, Melbourne 3 Hearing, p. 5870, https://agedcare.royalcommission.gov.au/hearings/Documents/transcripts-2019/transcript-14-october-2019.pdf; see also Health Services Union *Submission on the Aged Care Workforce*, 21 October 2019, https://agedcare.royalcommission.gov.au/submissions/Documents/read-workforce-submissions/AWF.650.00053.0002.pdf

[8] Price Waterhouse Coopers, 2014, *ASQA Process Review: Final Report*. Prepared on behalf of State, Territory and Commonwealth Governments, https://www.voced.edu.au/content/ngv%3A63423

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

The ADA shares the view of several organisations representing stakeholders across the sector that AHPRA is not the appropriate body to manage the registration of PCWs/HCWs.

A registration scheme might best be managed by an independent authority reporting to the Aged Care Quality and Safety Commission. Such an authority should be comprised of a board of representatives that is equally weighted with representatives of different stakeholder groups across the sector.

15. In principle, should a person cleared to work with people with a disability be automatically cleared to work in aged care?

N/A

16. Are there any other clearances that should support automatic clearance in aged care?

N/A

17. What are the relevant considerations regarding the interplay between AHPRA (and any other professional registrations) and PCW registration for aged care?

N/A

Should you have any further questions concerning this matter, please do not hesitate to contact Dr Fiona Taylor, Senior Policy Officer, on 02 8815 3334 or at fiona.taylor@ada.org.au.

Yours sincerely,

Dr Carmelo Bonanno
President