Submission by the Australian Nursing and Midwifery Federation

Strengthened Aged Care Quality Standards Guidance Consultation

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Australian Nursing & Midwifery Federation

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INTRODUCTION

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of more than 326,000 nurses, midwives, and care workers across the country.
2. Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best-practice care in every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.
3. Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.
4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving the health of our national and global communities.
5. The ANMF welcomes the opportunity to provide feedback on the Strengthened Quality Standards guidance consultation.

BACKGROUND

6. On behalf of its members, the ANMF has provided extensive feedback to the Department of Health and Aged Care throughout the development of the new strengthened Quality Standards (the standards),[1,2] which to date has not been strongly considered and or resulted in policy change. The ANMF is concerned that the revised strengthened Quality Standards have not addressed calls for more detailed, measurable standards including embedding workforce requirements throughout and greater alignment with the comprehensive Hospital and Health Service Standards from the Australian Commission on Safety and Quality in Health Care (ACSQHC).

GUIDANCE DOCUMENTS FOR EACH STRENGTHENED QUALITY STANDARD: STANDARD 1-7

7. The ANMF notes the draft guidance documents for each of the strengthened Quality Standards from 1-7. The response to this section of the consultation focuses on a number of elements of the standards that are missing, are of concern or require enhancement.

The importance of workers in the strengthened quality standards

8. Underpinning all commentary and recommendations in this submission is the ANMF position that the new strengthened quality standards must support the aged care system to have enough workers with the right skills, training, and qualifications to provide consistently safe, high-quality care to meet the independently assessed needs of our ageing population. This is particularly critical in the current context of increasing workforce pressures across Australia's health and care systems.

9. To deliver high-quality, safe care to older people, workers must also have their rights protected through legislation that is reflected in the standards. The intersection between workers and those in their care, and care delivery, cannot be viewed as separate and the standards and guidance documents must reflect this important connection.

10. The ANMF is concerned that the standards or the draft guidance documents do not recognise the invaluable first-hand experiences and knowledge of direct care workers. The standards also fail to make explicit provision for the setting of a workforce Quality Standard outlining the basic conditions that should be provided to enable workers to deliver high-quality care.

Worker voice

11. The standards do not contain sufficient provisions to ensure workers are empowered to proactively contribute to continuously improving workplaces and care. It is critical that regulatory settings enable the voice of the worker/worker representative (worker voice) to be heard. Workers need to be empowered to advocate for the interests of direct care workers in planning, monitoring and delivering quality care, including through a recognised role which affords workers a role or committee and associated protections to voice concerns directly to the regulator where non-compliance with care minutes and Registered Nurse (RN) 24/7 obligations are observed.

12. Embedding a worker voice mechanism in the regulatory and compliance system for aged care will complement the external regulatory functions of the Aged Care Quality and Safety Commission (the Commission) and the Department of Health and Aged Care and enhance the safety of older Australians.
13. The standards and the regulatory functions must include a mechanism, which requires providers to actively consult with workers in an open and transparent manner and enable workers to raise any concerns when required without fear of retribution. Workers must also be assured that when they speak up, there will be clear pathways for resolving issues including the Commission responding with timely, visible and meaningful compliance and enforcement action.
14. The ANMF proposes modelling the Worker Voice mechanism on the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015. This established Act contains compliance and reporting powers and enforcement by way of dispute resolution.

Worker Standard

15. The proposed standards and guidance documents focus on aged care recipients receiving safe and quality care and services. They outline governing body, provider organisation and worker obligations. The ANMF is opposed to the imposition of worker obligations where there is no provision for the setting of conditions of employment that enable workers to fulfil these obligations safely.
16. Further, there is no specific provision within the standards for workers to raise pre-emptive issues of concern about staffing and quality of care which feeds into the Aged Care Quality and Safety Commission compliance risk algorithm. A Workforce Standard would operationalise this concept in a way that protects workers, and ensures risk is not only determined by serious incident and complaints reporting, but in a way which enables identification of risk before it results in adverse consequences for older people receiving care and workers.
17. The ANMF strongly advocates for the introduction of an Aged Care Quality Standard that is specific to and addresses the systemic issues in relation to the aged care workforce. A draft of the Standard has been included as Appendix A and is intended to describe the responsibilities and obligations of providers in ensuring the direct and indirect workforce has the capability and capacity to deliver safe and high-quality care that meets the individual needs of older people. The introduction of this standard would be a positive step in addressing the significant and systemic workforce issues identified by the Royal Commission into Aged Care Quality and Safety (Royal Commission)[3] and provide a clear signal to both providers and the Commission on the minimum workforce expectations.
18. Care delivered in aged care settings, including nursing homes, is a context of health care. The health care delivered in these settings should not, and cannot, be considered separate from other health care contexts, such as acute health, mental health, primary care, community care and in-patient rehabilitation services.

19. As identified by the Royal Commission, the linkages and intersections between the aged and health sectors must be improved and acknowledged. Nursing care delivered by RNs and enrolled nurses (ENs) in aged care settings must be considered in the same way it is in any other health care setting. This must be recognised in the Standards through the inclusion of a workforce standard that enables nurses and care workers to practice safely, in the same way workforce standards are provided to support workers in other health care contexts. The workforce standard will provide a baseline to exceed rather than a ceiling of compliance. It will enable the Commission to transparently consider a provider's workforce practices.

Care minutes

20. As has been well-documented, staffing levels and skill mixes have been inadequate in providing the level of care, including health care, required for the reablement of older people. This issue has been particularly prevalent within residential aged care, where the bulk of care has historically been provided by care workers (CW). Results of the National Aged Care Staffing and Skills Mix Project Report 2016, identified aged care staffing and skill mix as deficient and not fit for purpose, resulting in high rates of missed care.[4,5] Based on empirical evidence the report makes a recommendation on the level of care required in residential aged care facilities, expressed as the duration of direct care per resident per day[6]:
    - An average hours of care per resident per day of 4.3 hours or 258 minutes.
    - A staffing mix of 30% RNs, 20% ENs and 50% CWs.

    Using these findings, the apportionment of care minutes should be:
    - RNs = 77.4 care minutes per resident per day
    - ENs = 51.6 care minutes per resident per day
    - CWs = 129 care minutes per resident per day.
21. While the mandated care minutes introduced in October 2023 of 40 RN care minutes within a total of 200 direct care minutes per resident per day is supported by the ANMF, this is notably lower than the best practice recommendations outlined above.[7] The current mandated care minutes should be considered as an important starting point and the minimum required for safe care delivery. ANMF members understand the importance of these minutes being increased in October 2024 to 215 minutes per resident per day, but advise that the current minimum care minutes requirements remain inadequate. The ANMF strongly advocates for the continued increase of care minute requirements as the needs of older people and rates of chronic conditions, acuity, frailty, and comorbidities continue to increase.
22. Despite ever-increasing acuity and frailty of older Australians across the aged care sector, the majority of direct care (approximately 70% of all care delivered) continues to be provided by CWs. While care workers provide essential personal care and are a critical part of the aged care workforce, they have a limited skill set, which does not include delivery of complex health care.[8] Staffing and skills mix across aged care must be sufficient to meet residents' needs and to be able address increasing co-morbidities, polypharmacy, and care complexity among older people.

23. Research commissioned by the Royal Commission, undertaken by the University of Wollongong, indicated that residential aged care continues to be understaffed compared to international and national benchmarks.[9,6] The report reveals that, based on 2016-17 star rating dates, over half of all Australian aged care residents are in homes with only 1 or 2-star-rated staffing levels and that only 2% of Australian aged care residents are in homes that provide 22 minutes of allied health services per day recommended in the British Columbia system.[10] While the ANMF recognises that the essential reforms in recent years, such as mandatory care minutes and 24/7 RN have increased adherence, these reforms do not include allied health, which continues to be underdelivered to aged care residents.

24. Further, staffing and skill mix in nursing homes continues to be insufficient to meet the complex care needs of residents, resulting in a systemic failure to provide quality care.[11] A 2021 review of the quality of care delivered in Australian residential aged care facilities based on adherence to best practice guidelines found that, across six conditions (skin integrity, end-of-life care, infection, sleep, medication, and depression), adherence to practice guidelines was less than 50%.[12] These findings suggested that vulnerable older people are frequently not receiving adequate levels of evidence-based care, with this dearth in care being attributable to several factors including the lack of staff capacity to meet the clinical care needs of the residents; reduction in the number of nurses and their replacement by less skilled care workers; poor staff renumeration leading to low rates of attraction and retention; and lack of access to medical and allied health skills in nursing homes.[13]

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

26. ENs are essential members of the aged care nursing team whose work contributes immensely to the care of many older people around Australia. However, this valuable resource is not only insufficiently recognised but is being actively eroded to the detriment of quality care. This situation must not continue.

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

28. Staffing and skill mix levels directly influence quality of care and care outcomes in residential aged care.[17,18,19] Unless there is clear expectation about workforce composition as determined by a Workforce Standard, this dysfunctional reshaping of the aged care workforce by eroding EN positions, which is clearly against the intention of the aged care reform, will continue.

STANDARD5- CLINICAL CARE

GUIDANCE OUTCOMES 5.3: SAFE AND QUALITY USE OF MEDICINES

29. Over the past 10 years, reports from the Commission have consistently shown medication safety as a top area of non-compliance, which, concerningly, continues to be the number one complaints issue.[20] Despite this trend, subsequent versions of revised standards occurring over this period have systematically watered-down measures relative to safe use of medicines. These Standards have continued this pattern and pose a significant concern for RNs, ENs and CWs engaged in activities related to medicines. The ANMF suggests that the increasing use of CWs to administer, rather than assist with medicines is a factor driving this complaint area.

30. The ANMF believes the Commission has abrogated its responsibility to safely monitor and set standards for aged care providers relative to expectations around administration of medicines, including the most appropriately qualified worker (RNs and ENs) to perform this high risk role. The high risk nature of medicines management (including administration) is articulated in the Medication Safety Standard within the National Safety and Quality Health Service (NSQHS) standards.[21] Clearer expectations, as determined through these standards and guidance is essential to remove any uncertainty for providers, regulators, and workers.

31. Medication administration clearly falls within the scope of practice of both RNs and ENs, however there is an increasing trend of aged care providers to require CWs to undertake medication administration. The increase in RN numbers due to the RN 24/7 and care minute requirements, suggests little justification to use care workers in medicine administration roles.

32. There is confusion between what constitutes assistance with self-administration and administration of medicines, confusion which has been utilised by aged care providers to attach administration of medicines, under the guise of assistance via dose administration aids, as a duty assigned to the lowest paid worker. It is the ANMF's view, personal CWs can only assist in medication administration under the supervision of the RN if the resident/client's clinical record or care plan records an assessment by a medical practitioner, RN or pharmacist that states the resident/client has the capacity to self-administer their medications; and the resident/client is mentally competent and personally requests that assistance.

33. Another key safety issue is the overuse of high-risk drugs in the aged care setting.[22] Due to the high risks of such medications if used in error, the administration and management of these medications require appropriate knowledge and skill by the administering clinician to ensure that this process is undertaken safely and to a high standard. RN and ENs are ideally placed to undertake this role to ensure that medicines are managed appropriately and safely prior to, during and following administration. This should be reflected in the standards and guidance documents.

THE DRAFT AUDIT METHODOLOGY

Provider categories

34. The ANMF provided a submission to the Department of Health and Aged Care Consultation Paper No. 2: A new model for regulating Aged Care[23,24] and notes the change in categories for nursing and case management from 4 to 5. The ANMF is supportive of the change as it reflects the clinical governance and expertise required to deliver this care. As such requires comprehensive auditing and the application of standards 1-5. However, the ANMF remains of the view that personal care (currently placed in category 4) is a domain of nursing care and requires appropriate clinical governance and oversight, therefore, requiring the application of standards 1-5. The ANMF also believes that medical practitioners should be included in the service types identified for Category 5 providers. Medical practitioners are important contributors to health care services provided to older Australians and their care should be identified in these categories.

Introduction of the audit methodology

35. The ANMF is concerned by the language used in the introduction to describe the regulation of aged care outlining it as "relational regulation". This language could suggest a bias in the application of regulation, outlining the priority of the aged care regulator in prioritising the relationship with providers instead of prioritising public safety and quality care that is person-centred meeting the needs of older people. This language should be adjusted. The ANMF strongly recommends that the primary legislated role of the ACQSC must be to protect the public who use aged care services so that the consumer/client is at the heart of the ACQSC's regulatory stance and not lost in any "relational" regulatory regime which risks capture by the very entities that the Commission is meant to regulate.

Audit methodology

36. The ANMF is generally supportive of the proposed audit methodology, it is consistent with other regulatory processes including the Australian Council on Healthcare Standards. The introduction of stage 1 -audit preparation and desktop audit are an important addition to the audit methodology. However, all sources of evidence including provider self-reporting is only one way in which compliance can be assessed and requires validation. Self-reporting needs to be validated using available triangulated evidence including data, direct observation, and feedback from workers and older people themselves. Therefore, the ANMF recommends that there is 'on the ground' presence through auditing all providers regularly, even if stage 1 of the auditing methodology meets expectations.

37. The ANMF is unclear on the minimum qualification and experience requirements of auditors. Auditors must be appropriately qualified, skilled and have the experience to effectively assess compliance against the quality standards. Experienced RNs should make up a significant part of the audit team along with other multidisciplinary team members to ensure quality care is being provided to older people. This role should be appropriately remunerated.

38. The ANMF reiterates that the worker voice is critical in the audit methodology and all regulatory processes. Workers need to be empowered to advocate for the interests of direct care workers in planning, monitoring and delivering quality care, including through a recognised role that affords workers the ability, and associated protections, to voice concerns directly to the regulator where non-compliance with care minutes and RN 24/7 obligations is observed.

39. Further, the audit methodology outlines that *worker feedback will be gathered to test how well workers know the older people*. Although this is not unreasonable it is limited in its approach. Worker feedback should be gathered on significantly broader matters than only the older person. Like the requirements for consumers, worker feedback including confidential surveys should be gathered identifying the workers' application and understanding of the provider/services systems and processes, including staffing and skills mix per shift.

40. The audit methodology also outlines that there will be a closing meeting with the provider. In line with previous comments regarding the importance of empowering workers with transparency of information in aged care, the ANMF recommends that all workers be invited to the closing meeting. This is also consistent with the final summation meetings held with the Australian Council on Healthcare Standards in health service accreditation processes.

41. The ANMF notes that unannounced and random compliance visits do not seem to be addressed in the audit methodology and recommends that these visits be outlined in detail within this document.

AN EVIDENCE MAPPING FRAMEWORK

42. The evidence mapping framework (the framework) is generally supported by the ANMF. However, its effectiveness may be severely negated if the current system for proportionate regulation continues to focus site visits on compliance against some, rather than all, Aged Care Standards. Whilst we acknowledge the role of targeted site audits, compliance activity must always examine high-risk areas such as staffing, clinical care (including medicines management) and safeguarding against abuse and neglect.

43. The peripatetic nature of site audits relies on continuous data input to determine risk and inform the frequency of visits. As outlined previously the ANMF considers ongoing intelligence from workers, as the primary care deliverers, as non-negotiable. Their voice must be deemed part of the information used to feed into the regulator's risk algorithm.

44. As previously discussed, there must be scope to triangulate all sources of evidence, provider self-reporting is only one way in which compliance can be determined and needs to be validated by workers, older people, and observation. Case tracking methodology should be utilised by assessors undertaking on-site audits using random selection as well as a pre-determined sample. This will require experienced RNs as part of the audit team to interpret clinical information and how that relates to the delivery of safe care.

45. In addition, our members continue to report open advertisement of forthcoming site audits which allow providers scope to present an artificial representation of their day-to-day operation. An efficient risk algorithm should be sufficiently robust to negate the need for announced visits and unannounced, including out of hours visits, should become the norm as part of usual compliance and where risk is monitored and identified.

46. As noted above, the ANMF objects in principle to workers having expectations placed upon them through the framework when the proposed aged care quality standards and this framework do not provide for measures that protect workers themselves.

47. Workers can only deliver safe, quality care if they are provided with optimal working conditions, including protected rights to voice concerns about staffing and other matters such as organisational barriers which hinder delivery of safe, quality care. This can only be achieved by the implementation of better systems to engage workers throughout the regulatory cycle, embedded in the risk algorithm used by the regulator and a workforce quality standard (suggested standard 8) with associated framework measures to determine compliance.

48. Questions which probe workers about their feelings, for example on p.7 *'Do you recall a time where you felt uncomfortable with the way an older person from a different background was treated or noticed them unhappy with the way they were treated? What happened?'*. And p.11 *'Have you heard or seen another worker mistreat, disrespect, abuse or be violent/racist against an older person or their family, carer?'* could cause distress to workers. Whilst it is important to understand worker knowledge, questions such as this are subjective and triggering and are not supported.

49. Observations on p.12 require assessors to observe if worker interactions with older people include use of an aggressive or calm voice. Again, there is an element of subjectivity to this, and potential for accent discrimination to impact the assessment, particularly given the high level of culturally and linguistically diverse aged care workers and a lack of clarity about required skill sets required to complete audits in busy aged care work environments.

50. P.33 provides for workers to feedback whether they feel safe and supported to raise concerns and disclose issues or incidents or suggest improvements. However, without formalised systems for workers to raise concerns with associated protections, it is unlikely they would feel empowered, or safe to do so. This highlights the importance of having a workforce standard (Standard 8) which makes provision for this. It would also ensure matters were dealt with in real-time rather than identified retrospectively at a periodic audit.

51. The ANMF supports the suggestions on p.55 outlining questions to ask workers about staffing numbers and shortfalls. However, there is currently no system for workers to raise issues in real-time. Embedding a system whereby workers can raise staffing shortfalls and concerns in real-time, provided through a workforce standard (Standard 8) would be a far safer system.

52. The ANMF would support a system to measure compliance under 'care outcomes' including a workforce committee for workers to voice concerns. Such a committee could be subject to quarterly reporting in a similar way to Serious Incident Reporting/National Quality Indicator Program, or embedded within either and would offer a more timely approach to risk management. However, any system for quarterly reporting would need to be transparent and the system to submit reports (such as through the Provider Portal) not restricted to a selected number of operational managers or providers.
53. On p.85 there is a non-exhaustive list of clinical care needs outlined. Whilst this contains important areas, it fails to identify one of the most common areas of complaint and/or non-compliance, that of medication management. Given the prevalence of chronic co-morbidities and polypharmacy within a typical resident cohort, the omission of medication safety is significant and concerning.
54. As previously outlined the ANMF position is that administration of medicines (and medicines management) is the role of RNs and ENs. Medication safety is embedded throughout the three-year graduate program of study for RNs and two-year diploma level education for ENs. This includes pharmacokinetics and pharmacodynamics. This cannot be replicated by a short course in medication safety for CWs, nor would it be appropriate to do so. This would not be the expectation in a public hospital or in primary care and older people must not be subjected to a lesser expectation relative to clinical risk.
55. Framing medication safety as a clinical risk would draw providers' attention to the need for better due diligence in the overall management of medication safety. The ANMF has multiple examples where cost-cutting measures implemented by providers have led to reduced safety for older people receiving care. There is an increase in the number of CWs required to administer medication and a general lack of understanding at provider level regarding the implications of poor administration practices.
56. The Infection Prevention and Control (IPC) section commencing p.104 should include a question for providers and workers around the fit testing as well as supply of personal protective equipment. Additionally, the IPC lead should be given the opportunity to advise whether they have sufficient time to undertake the additional responsibilities. ANMF members often report insufficient time and lack of recognition as barriers to effective operation of the IPC lead role.
57. Medication management commencing p.111 does not mention the need to assess, document and review the person's ability to self-administer their medicines which is a key component of the Guiding principles for medication management in residential aged care facilities: Principles for Medication Management.[25] Additionally, it does not provide a definition of administration, assistance and prompting. ANMF members frequently report confusion regarding what constitutes assisting with self-administration versus administration of medicines. Whilst clear in the Guiding principles for medication management in residential aged care facilities it is unclear in the framework.

58. The framework asks management about how they train workers to ensure they are competent to administer medication (p114). The ANMF believes this point perpetuates the idea that CWs can be trained to safely administer medications. RNs and ENs are the most appropriate workers to administer medicines and would not require training since medication administration is a fundamental part of their assessed knowledge and competency to gain registration to practice governed by the Nursing and Midwifery Board of Australia (NMBA). CWs require a level of education, but only to support assistance with self-administration. We are strongly opposed to the use of this highly misleading question.

59. Additionally, the questions on p.116 for workers also continue to enforce the idea that CWs are engaged in activities related to medication administration and management. Since a RN is now legislated for in every residential aged care facility, the framework must support the administration of medications by the most suitably skilled and educated workers (RNs and ENs). Omission of a question regarding the scheduling and availability of the appropriate skill mix of workers to support safe administration of medicines is an oversight and must be rectified.

60. Considering this, the ANMF believes the section of the framework which examines medication management to be ambiguous and misleading and not promoting best practice. It must be reviewed to ensure safe medication practices are embedded and effectively regulated.

GUIDANCE FOR AGED CARE WORKERS

Importance of workers

61. The ANMF is supportive of an established worker guidance document. Workers must have access to detailed information that is easy to understand and clear about the employer's responsibilities in supporting them to provide quality care. They also require resources that they can easily access, relevant to their role in understanding the quality standards.

62. Education and training for nursing and personal care workers must be provided by employers/ organisations to assist them to fully understand and implement the strengthened Aged Care Quality Standards. For example, the expectation of workers to understand and be responsible to provide trauma informed care and supported decision making may be new and complex concepts for workers in the context of aged care provision, especially by those without formal education.

63. To deliver high-quality, safe care to older people, workers must have their rights protected through legislation that is reflected in the standards and guidance. The intersection between workers and those in their care, and care delivery, cannot be viewed as separate. The worker's guidance must reflect this important connection.

Worker Voice

64. Workers in aged care play a critical role in advocating for those who are vulnerable and unable to represent themselves. Many older people living in residential aged care facilities suffer from degenerative neurological conditions that result in a declining cognitive capacity. This can make it difficult for them to know when they or their care is at risk. These situations demand strong advocacy, and the worker plays a crucial role in raising concerns that occur in the day-to-day delivery of care. As identified earlier the ANMF is concerned that the standards and therefore the guidance documents including the draft worker guidance does not provide provisions to empower workers to proactively contribute to continuously improving workplaces and care. It is critical that the standards and guidance documents enable the voice of the worker to be heard and acknowledged.

65. Workers must be empowered to advocate for the interests of direct care workers in planning, monitoring, and delivering quality care, including through a recognised role, either individually, or through a workforce committee within internal governance systems which affords workers the ability and associated protections to voice concerns directly to the regulator where non-compliance with care minutes and RN 24/7 obligations is observed. This needs to be detailed in the standards and guidance documents.

66. The standards and the guidance documents must detail a mechanism that requires providers to actively consult with workers openly and transparently and enable workers to raise any concerns when required without fear of retribution.

Care minutes and RN 24/7

67. The draft guidance does not address minimum care minutes. Mandated minimum levels of care, in the form of care minutes, RN 24/7 and staff-mix, must be a core, and explicit, aspect of the worker guidance. Along with the introduction of a worker standard as outlined throughout this submission, the standards and guidance documents present an opportunity to protect critical, safe staffing standards and, ultimately, quality care delivery.

68. The worker guidance must provide clear details on how workers can support the delivery of minimum direct care minutes and what support employers must provide. It should provide detail empowering workers to advocate for the interests of residents in planning, monitoring, and delivering quality care, outlining how they are uniquely placed to contribute to continuous improvement.

69. The standards and worker guidance should require providers to outline the minimum care minutes for the facility per shift, easily accessible for all staff and consumers to view. The rosters should reflect how care minute requirements are being met and each worker should be provided detail outlining how much of their work is counted towards minimum care minutes. This will enable transparency in how minimum care minutes are being met, enabling workers to contribute to planning and monitoring quality care delivery.

Professional Regulatory Responsibilities

70. The ANMF notes that the guidance material aims to target all workers and volunteers providing care delivery in aged care services. However, the worker guidance does not address the worker's responsibilities of professional regulation. For nurses, the worker guidance must outline and be consistent with their responsibilities under the NMBA. For example, the ANMF notes the brief commentary included on workers practicing within their scope of practice. The information provided has oversimplified the issues relevant to the scope of practice requirements of the NMBA. Nurses are required to understand their own scope of practice, understanding their skills, competence, and education to deliver care along with what the organisation expects them to deliver. Additionally, CWs do not have a defined scope of practice through a regulatory mechanism and expecting them to understand this and work within this framework is unfair and unrealistic. In addition, the guidance material must address the supervision and delegation requirements for nurses and care workers which must be consistent with the NMBA's Decision-making framework for nursing and midwifery.[26]

Evidence-based care delivery

71. The ANMF is concerned by the lack of reference to and importance of evidence-based care in the worker guidance. The Royal Commission into Aged Care outlined at length the poor, neglectful care being provided in aged care and recommended the need to improve not just clinical care but also personal care with a focus on nutrition, dementia care and palliative care.[27] The worker guidance needs to outline how workers require access to best practice guidelines, available evidence and decision support tools relevant to their practice to enable them to provide quality care that is based on evidence.[28]

CONCLUSION

72. The ANMF welcomes the opportunity to provide feedback on the Strengthening Quality Standards-Guidance documents and looks forward to working with the Commission and the Department of Health and Aged Care to expand and improve the regulatory setting for aged care. The voice of workers must be identified as an essential, valued part of the new regulatory setting. Workers need to be empowered to advocate for the interests of direct care workers in planning, monitoring, and delivering quality care, including through a recognised role which affords workers the ability and associated protections to voice concerns directly to the regulator where non-compliance with care minutes and RN 24/7 obligations is observed.

APPENDIX A

Standard 8: The Workforce

Intent of Standard 8

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

Standard 8 expectation statement for older people:

The workforce that provides my care has the appropriate number and skill-mix of staff to meet my planned care needs effectively, safely and to a high standard.

Standard 8 expectation statement for employees:

I am treated as a valued member of the organisation, and this is demonstrated by:

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

Standard 8 expectation statement for the provider:

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

Outcome 8.1: Workforce planning

Outcome statement:

The provider understands and manages its workforce needs and plans for the future.

Actions:

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

a) provides evidence that the strategy and plan is based on a gap analysis of current and anticipated future workforce needs and risks.

b) identifies the number and skill-mix of direct and indirect care workers to manage and deliver safe, quality care and services.

c) specifically identifies the number and skill-mix of health practitioners (nursing and allied-health) required to meet the clinical and health care needs of older people cared for by the nursing home or service and to meet regulatory requirements.

d) Identifies the skills, qualifications and competencies required for each role.

e) Identifies strategies and processes for engaging suitably qualified and competent workers.

f) Is based on a permanent workforce model and identifies strategies to minimise the use of indirect employment workers wherever possible.

g) Identifies strategies to mitigate the risk of workforce shortages, absences or vacancies.

h) Identifies and demonstrates strategies to support the physical, psychological and cultural safety of the workforce including work-life balance.

Outcome 8.2: Workforce utilisation

Outcome statement:

The provider ensures that the workforce is fit for purpose to meet the individual care and clinical needs of older people receiving care provided by the service.

8.2.1 The provider demonstrates that sufficient numbers and mix of suitably qualified and skilled staff are employed to meet the care needs of older people cared for by the nursing home or service to meet regulatory requirements:

a) Best practice rostering optimises the skills, knowledge and abilities of staff to meet care needs of residents and clients

b) Staff work-life balance requirements are considered in all deployment decisions

c) Business planning is demonstrated to match workforce capability and capacity to service demand.

8.2.2 Direct care workers are provided in sufficient numbers and skills-mix to meet the needs of the resident or client cohort but not less than those numbers required through direct care minutes funding and any other relevant legislation or regulation:

a) Rosters clearly identify average minutes of care per resident and registered nurse minutes of care in the residential setting so that these metrics can be easily accessed by staff.

Outcome 8.3: Workforce development

Outcome statement:

The provider demonstrates that a planned, communicated and continuously evaluated strategy, plan and process is in place to support the role, and professional and personal developmental needs of the workforce.

8.3.1 Staff receive the appropriate support, training, professional development, supervision and personal performance and development relevant to their job description.

8.3.2 Staff are supported, enabled and encouraged to obtain further qualifications relevant to the role they perform within the organisation.

8.3.3 Employees are enabled to undertake training and education needs which:

a) Is consistent with the assessed needs of the resident or client cohort

b) Includes both mandatory and non-mandatory learning opportunities

c) Enable health practitioners to comply with their continuous professional development requirements

d) Enables career progression and meets individual learning needs.

8.3.4 Priority training areas are encouraged and supported within the organisations workforce plan:

a) The health service organisation provides access to supervision and support for the workforce providing:

- end-of-life care, including palliative care
- dementia care
- skin integrity care
- behaviour management
- nutritional support.

Outcome 8.4: Workforce regulatory requirements

Outcome statement:

The provider demonstrates that the organisation enables and supports Health Practitioners registered with the Australian Health Practitioner Regulation Agency (Ahpra), or Self Regulating Allied Health Professions, to meet the standards of practice and code of conduct requirements of the relevant professional regulator.

8.4.1 Care staff including health practitioners and unregulated care workers are enabled to identify situations that compromise their professional standards of practice or codes of practice.
There is a system in place to support staff to report concerns or situations that compromise their capacity to meet their professional standards or codes of practice.

a) Reported concerns or situations are responded to by the provider in a timely manner (where possible within 24 hours).

b) Staff are supported to meet continuing professional development or credentialing requirements for registration or membership of a professional body.

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

a) Contemporary policy and procedures in relation to physical, psychological and cultural safety are in place.

b) Processes are in place to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems.

c) Systems are in place for workers to raise concerns regarding staffing and skill-mix, incidents, complaints and workplace health and safety issues.

d) Whistle-blowing policies and procedures are in place and known to employees and they are enabled and supported to raise concerns in good faith and protected against reprisal.

e) Direct care workers are provided the opportunity to raise issues of concern relative to staffing and skills mix, resident and client safety and quality and workplace safety with the relevant regulatory authority and a workforce representative.

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

a) Orientation and transition to practice programs are individualised to the learning needs of individual practitioners.

b) Health practitioners are supported to connect with external healthcare providers and any other entity deemed appropriate to maintain and update their clinical knowledge and skills.

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

a) Employees are enabled, without disadvantage or adverse consequence relative to their employment, to engage a workplace representative for industrial and or other matters including professional advice, undertaking a union position, or being a union member in the workplace, including Health and Safety Representative roles, and through education, networking and advisory groups.

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

a) role responsibilities and accountabilities

b) scope of practice issues

c) supervision and delegation

d) professional advice, direction and performance.

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