The National Nursing and Nursing Education Taskforce

N^{3}ET

Implementing minimum qualifications and suitability checks for the direct care workforce

August 2006

Progress on Recommendations 7 and 35 of the National Review of Nursing Education (2002)
Our Duty of Care report

Australian Health Ministers' Advisory Council

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Executive summary

There is currently a shortage of health care professionals in Australia, which is further exacerbated by increased demand and an ageing population. As the population ages, it will become increasingly difficult to find the number and quality of staff required to provide high quality care (Richardson 2004). In order to meet demand, governments are examining how to increase productivity through better utilisation of skills, opportunities to improve skill sets and ways to broaden the scope of services to be more effective and efficient (Australian Government Productivity Commission 2005). This means that a wider range of health care providers will increasingly perform work traditionally restricted to certain professions.

In Australia, unregulated care workers form part of the *care workforce* providing services across health and community settings. Care workers have many and varied roles within these services, some of which involve providing *direct or hands-on care* to clients, patients and residents. The unregulated care workforce has grown considerably in size, and in the face of growing workforce shortages, there is great awareness of the valuable contribution these workers make in providing direct or hands-on care and in assisting nurses and other allied health care workers so that their time can be more-effectively utilised. On the other hand, there is also concern regarding the protections afforded to care recipients, when services are provided to frail, vulnerable and dependent people by workers who are not regulated in the same way as health professionals.

In 2003, the Australian Health and Education Ministers supported Recommendations 7 and 35 from the National Review of Nursing Education (2002) *Our Duty of Care report* for a national nomenclature, minimum Certificate III qualifications from the health or community services training package and suitability checks for unregulated Direct Care Workers (DCWs) by 2008. Commonwealth, State and Territory Ministers for Health supported these recommendations as a means to ensure quality care and public safety, a national standard for DCWs education and enhanced employment opportunities.

The ability of jurisdictions to collect the information requested was severely hampered by a lack of available, current and robust data about the direct care workforce. Most of the jurisdictions do not track the number of DCWs and none collect data on the qualifications of their direct care employees. While most jurisdictions identified understanding of DCWs and better data as important for the future, the costs associated with collecting this data prove to be a significant disincentive to undertaking such an activity.

In part, data difficulties stem from the lack of uniform nomenclature used to classify and identify DCWs in health and community settings. Rather than impose an additional nomenclature system to what is already a confusing and fragmented plethora of titles, the Taskforce resolved to check the congruence between the main titles used for DCWs in both settings and the Australian Bureau of Statistics Australian Standard Classification of Occupations (ASCO) and the Australian and New Zealand Standard Classification of Occupations (ANZ-SCO), which was in draft stage at the time.

The information supplied to the Taskforce indicates that the ASCO is not commonly used to identify DCW in either setting, and there is a lack of congruence between existing titles and the titles in both the ASCO at this point in time. A more-inclusive and detailed survey of DCWs in both public and private sectors may yield results that might be closer aligned to the ANZSCO, as this classification has only recently been introduced and is the product of extensive consultation with a range of stakeholders including governments and employer groups. However, the jurisdictions have identified that gathering more definitive data would at this point be difficult, if not impossible, without adequate resources to support and coordinate data collection at a national level.

The limited data supplied to the Taskforce confirms that DCWs do not have national education benchmarks or minimum standards for employment and practice. As such, the qualifications and skills sets for DCWs vary from no qualifications (formal or informal upon commencement of employment) right through to higher-education qualifications in aged care or other relevant training. With the exception of WA and QLD where limited programs are in place, it is evident that the target of minimum qualifications for DCW by 2008 has not received high-level policy support in the jurisdictions and in the context of the broader workforce, achieving this target appears to be a low priority. Where there are no minimum requirements for qualifications, there are also no mechanisms in place in most jurisdictions to collect this information on an ongoing basis to inform workforce planning.

The situation with respect to suitability is somewhat more promising. Suitability checks for employees are considered a normal and expected part of the recruitment process across a range of industries including health. Where this is the case, industry standards exert considerable pressure on employers to manage the risks associated with care provided by unregulated workers. It is also clear that where state or commonwealth policy is tied to funding and where there are statutory measures in place, there is a greater compliance and up-take of suitability checks.

The information provided by the jurisdictions on progress towards these recommendations indicates that the targets agreed by the Health Ministers for suitability checks and minimum qualifications are unlikely to be achieved without further policy direction and support at the jurisdictional level and some national coordination of data collection to ensure a viable national data set. The data provided to the Taskforce also reinforces that there is insufficient robust information about the characteristics of the direct care workforce to enable the development of informed policy and planning strategies for DCWs.

Section 1: Background and overview

In Australia, unregulated care workers form part of the *care workforce* providing services across health and community settings, including the full spectrum of acute, subacute and community health services, residential and aged care, disability and mental health services. Care workers have many and varied roles within these services, some of which involve providing *direct or hands-on care* to clients, patients and residents. In some settings such as health services, direct care workers (DCWs) operate under the direction and supervision of nurses and assist in providing nursing services. They may also provide assistance to a range of allied health professionals.

In other settings using a social rather than a health/medical model the same activity may be categorised as providing *assistance with daily living*, *social support* or *personal care (Nurses Board South Australia 2003).* In settings such as residential or community services the direct care workforce may include unregulated workers such as aged care workers, disability workers and Aboriginal Health Workers[1] and the assistants working alongside them and under their direction.

Australia is currently experiencing shortages of all health care professionals including shortages in the nursing workforce, and further shortages are predicted as increasing demands are placed on care services by an ageing population. There is concern that as the population ages, it will become increasingly difficult to find the number and quality of staff required to provide high-quality care (Richardson 2004). The Australian Health Ministers' Conference (AHMC) Australian Health Workforce Strategic Framework (2004) highlights this issue and identifies the need to create a "flexible and integrated health workforce". The framework promotes the "complementary realignment" of health workforce roles and the creation of new roles as necessary.

More recently, the Australian Government Productivity Commission (2005) "Australia's Health Workforce" report, examined the factors affecting "...the future supply of and demand for health workers, the efficiency with which the available health workforce is deployed; and what health workforce measures might be taken to ensure the continue delivery of quality health care..." (p.xviii). The Council of Australian Governments (COAG[2]) in its July 14 2006 communiqué responding to the Productivity Commission report, noted "...the importance of ensuring health education and training are better aligned with workforce needs..." and committed to implementing structures to support health workforce reform and measures to strengthen effective use of the health workforce.

To address these workforce issues, Commonwealth, State and Territory Governments have undertaken a number of reviews to identify local and national strategies to address shortages in health professions including nursing (Department of Health Government of Western Australia 2001; Department of Human Services Victoria 2001; Senate Community Affairs Committee 2002) with some effect. Employers and service provides have similarly focused on recruitment and retention strategies (Australian Institute of Health and Welfare 2004; Australian Institute of Health and Welfare 2006). The Australian Government has also responded by providing additional funding for increased undergraduate places for health professions including nursing in an effort to increase the numbers of graduates entering the workforce in the future.

It is evident that governments and service providers are actively exploring how to better utilise the skills of the health workforce, whether there are opportunities to broaden the skills set of different workforce groups and whether new health workforce roles will add to effective and efficient delivery of services (Australian Government Productivity Commission 2005). For example, the *"Better skills, Best Care"* project in Victoria encourages health services to explore new and redesigned work roles and provides support to pilot and roll out initiatives. The emphasis is on developing roles that will provide better outcomes for patients, promote greater work satisfaction for staff and contribute to more efficient and sustainable health services[3].

This work is not occurring in isolation as the review of the Community Services and Health Industry Training Package (CS&HTP) is developing and reviewing competencies and qualifications for a range of health and community workers and includes qualifications for care workers such as medical assistants and allied health assistants.

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[1] *It is noted that in NT, Aboriginal Health Workers are a registered profession*
[2] *COAG http://www.coag.gov.au/meetings/140706/index.htm*
[3] *Better Skills, Best Care http://www.health.vic.gov.au/workforce/skills.htm*

These high-level policy directions and trends in workforce development indicated that in the future, a wider range of health care workers will increasingly take on work traditionally undertaken by certain professions. This includes unregulated DCWs who will increasingly, and indeed already are taking on care activities that have been considered part of nurses' roles. For example, unregulated care workers *assist* residents in residential aged care services (RACS) and home care services (eg. home ventilation programs) with administration of their medications and learn to perform such activities as wound management and nutrition administration by devices such as jejunostomy tubes.

The National Review of Nursing Education (2002) *Our Duty of Care Report* highlighted concern by those consulted regarding the protections afforded to care recipients, when services are provided to frail, vulnerable and dependent people by DCWs who are not regulated in the same way as health professionals, especially in the context of rising numbers of DCWs with broadening roles and responsibilities. In Australia, there are nine health professions regulated in all States and Territories, as well as a number of health professional groups that are partially regulated (regulated in one or more jurisdictions, but not all). Regulation of the health professions protects public interest and safety through the statutory registration (or licensing) of suitable, qualified and competent people. As well as maintaining the register of professionals, the legislated powers and functions of health practitioner regulatory authorities include the approval or accreditation of courses (and course providers) for registration purposes, setting professional standards for conduct and practice and managing complaints about professional conduct. In most cases, health professionals have a statutory obligation to notify their regulatory authority (RA) of legal offences and the RA is empowered to take action with respect to their suitability for registration. Similarly, RAs consider the ongoing competence of individuals for periodic renewal of registration.

In contrast, there is no statutory requirement for DCWs to be licensed or registered and there are no minimum mandatory requirements for training or qualifications. With this said, it is noted that while DCWs are not subject to statutory licensing arrangements, they do work in a regulated environment. For example, in some jurisdictions there are other statutory requirements to ensure the suitability of people working with vulnerable populations, which is essentially a reflection of community expectations[4]. It could be also be argued that the Community Services and Health Industry Training Package provides de facto industry standards for unregulated health care workers with particular roles or functions. Similarly, accreditation processes, such as the Aged Care Accreditation Standards linked to funding, provide a framework for quality, safety and risk management. In addition, industry and professional standards impact (albeit less directly) on employment and training practices.

For the most part, where there are no regulatory requirements, the responsibility rests with employers and service providers to manage the risks associated with providing care by ensuring the suitability of their employees and by ensuring they have the knowledge, skills and competence to do the job. For example, it is common for employers to conduct pre-employment suitability checks and to provide on-the-job training for DCWs. This type of arrangement provides employers with the flexibility to develop the workforce to meet service needs. On the other hand, it is argued that without minimum requirements, variable standards will be applied to both training and suitability checks and there is no mandatory process to ensure ongoing suitability.

In the face of growing workforce shortages, there is great awareness of the valuable contribution DCWs make in providing direct or hands-on care to clients and in assisting nurses and other allied health care workers so that their time can be more-effectively utilised. On the other hand, there is a need to manage the risks associated with unregulated DCWs providing care for frail, vulnerable and dependent individuals.

In recognition of these concerns, The National Review of Nursing Education *Our Duty of Care report* (National Review of Nursing Education 2002) recommended that DCWs should have minimum qualifications and suitability checks to ensure the quality of care and public safety[5]:

> ### Rec 7 – Care workers not covered by regulation
> *To ensure quality and safety in the health, aged and community care sectors, all workers*
> *without relevant recognised training who are employed to provide direct care should have:*
> *a) a common national nomenclature*

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[4] *It is noted that the Commonwealth Government plans to introduce mandatory suitability checks for the aged care sector.*
[5] *This concern was echoed in the Senate Community Affairs Committee Inquiry "The Patient Profession" (2002).*

b) a minimum competency level of Certificate III from the appropriate Community Services or Health Training Package
c) an appropriate suitability check.

Rec 35 – Training places for Certificate III

To ensure that those workers involved in direct care work in the health, aged and community care sectors achieve a level of at least Certificate III in the appropriate Community Services or Health Training Package by 2008, a strategy should be developed to expand workplace assessment and the number of training places for Certificate III in the appropriate training packages.

In November 2003, Health and Education Ministers supported these recommendations stating that as a matter of urgency, the Commonwealth, States and Territories should establish or utilise an appropriate system to ensure that compliance in relation to the minimum qualification and suitability checks for care workers is achieved by 2008. The Ministers did not, and continue not to support any form of statutory regulation of these care workers, preferring instead to explore other options that may be less costly and burdensome and more flexible to ensure safe and quality outcomes for the community.

The National Nursing and Nursing Education Taskforce (N[3]ET/the Taskforce) was established in 2004 to implement and monitor a number of recommendations from the National Review of Nursing Education (2002) *Our Duty of Care report*. Recommendations 7 and 35 (above) were assigned to the Taskforce to report on the progress made by the jurisdictions in implementation. Due to the nature of these recommendations, the Taskforce resolved to progress the two recommendations as one project.

What is known about the direct care workforce

The existing level of knowledge about unregulated care workers in health and community services is limited. The Australian Institute of Health and Welfare (AIHW) (2001) reports that the unregulated care workforce has grown considerably in size with a reasonable estimate of 117,655[6] in Australia, and is predicted to grow and diversify further, although this estimate does not distinguish between the direct care workforce and those providing other types of support roles or those with different levels of qualification.

Within each State and Territory, the titles used to identify and describe care workers vary across workplace setting, sector of employment, industrial agreements and titles used by the employer. For example, titles may draw on the Australian occupational classification system used by the Australian Bureau of Statistics (ABS), occupational titles from the Community Services and Health Training Packages (CS&HTP), industrial award classifications, or they may reflect historic roles (eg. wardsman), assigned tasks or duties (eg. patient care assistant). This makes it difficult to clearly identify at a jurisdictional or national level those groups of care workers or positions providing direct care which might be targeted for additional education or suitability checks.

In developing the reporting instrument for this work, dialogue with jurisdictional representatives indicated that while there was interest in data about the unregulated direct care workforce, the jurisdictions did not have a comprehensive data source to build a current picture of the size, distribution, qualifications or employment practices for this group of workers. Some information is available though payroll systems, but not in all jurisdictions. Similarly, at the national level there is no single data source that provides an accurate, up-to-date and detailed appraisal of the direct care workforce across the range of services and sectors in Australia, especially not of the kind that would inform complex workforce planning.

More is known about DCWs in the aged care sector as a result of the report commissioned by the National Institute of Labour Studies (NILS) "***The Care of Older Australians: A picture of the Residential Aged Care Workforce***" *(Richardson 2004)* (NILS report*). The NILS report aimed to rectify the gap in knowledge about the whole of the direct care workforce (including professional and unregulated care workers) in the aged care sector by providing some detail as to how many people care for frail elders in residential aged care facilities, and who these people are. The study sourced information through a survey of *all* residential aged care facilities (public and private) in Australia, together with a survey of 6,199 of the DCWs employed in these services *(Richardson 2004)*.

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[6] *50,655 (AIHW 2001 in health and community) and 67,000 (NILS 2003 in aged care). Will be further adjusted…*

While the study was limited to residential aged care facilities and did not include community care or medical facilities, it is instructive in a number of ways:

- The methodology indicates the level at which the data, in the first instance, needs to be collected and therefore the type of resource commitment (time, human resources and budget) required to collect similar data for the broader direct care workforce across sectors.
- The data provides a snapshot in 2003 of the direct care workforce, including those workers the report called personal carers (PCs) and allied health workers":
  - *67,000 were PCs and 9,000 were allied health workers (mainly diversional and recreational officers);*
  - *Only 8% of the PC workforce is full time, the lowest rate of all the groups in the breakdown;*
  - *PCs leave their aged care jobs for a variety of reasons. A sizeable proportion take PC jobs elsewhere, while a smaller group leave to undertake nursing training. This latter group may be important in replacing older registered nurses;*
  - *About 10% of residential aged care facilities indicate that they aim to cater for a specific ethnic or cultural group, and about the same proportion say that a large proportion of their PCs come from a particular ethnic group. About half of this ethnic concentration of PCs seems to be associated with the ethnic specialisation of facilities, and about half is due to other factors;*
  - *In sum, the typical residential aged care worker is female, Australian born, aged about 50, married, in good health, has at least 12 years of schooling, some relevant post-school qualifications and works 16-34 hours per week. She is likely to be a personal carer, working a regular day-time shift. The post-school qualification is likely to be a Certificate III in Aged Care.*

  (Richardson 2004, p.3)

- The report identifies data items (and lack of data) that assist with health workforce planning and that are available for larger sections of the health workforce:
  - *The terms of employment of DCWs (such as full and part-time, casual, contract), in total and according to the different occupations;*
  - *The duration of employment, and job changing;*
  - *Multiple job holding;*
  - *Concurrent education and training, including any employer contribution;*
  - *Details of hours worked and hours preferred;*
  - *Qualifications and highest level of schooling;*
  - *Marital status and ethnic background;*
  - *Hourly and total earnings (p. 12).*

Is there value in pursuing this data?

Given the logistic difficulties associated with collecting this type of data, it has not been surprising that the jurisdictions have been reluctant to commit resources to this type of workforce study. However, there are some clear indications that there might be significant benefits from having a better understanding about this part of the health workforce, including where unregulated workers are employed, their levels of qualifications and the employment processes that provide protection and quality to the public:

Firstly, Health Ministers have supported minimum qualifications and suitability checks by 2008. A clear picture of the workforce is required to plan the implementation of these two measures including the policy levers that may be required and measures for compliance monitoring.

Secondly, a better understanding of the characteristics of the unregulated direct care workforce would assist with workforce development and planning. For example, where workers are known to have minimum qualifications, it is easier to plan training for service and role development through customising education pathways.

Project methodology

Scope of DCW review

Whilst both recommendations 7 and 35 were assigned to the jurisdictions for implementation, the Taskforce's role has been to monitor progress by the jurisdictions. The work has involved collecting and collating information from the jurisdictions as to their progress in this matter, by way of a structured survey or reporting tool.

Preliminary dialogue with the jurisdictions highlighted two key concerns; firstly a lack of reliable and consistent data and data sources generally, regarding the unregulated direct care workforce and secondly, the scope of the survey with the inclusion of DCWs in the community sector. There

was a view that the *Our Duty of Care report*, with its focus on nursing, intended these recommendations to apply to DCWs providing assistance to nurses across a range of settings, rather than DCWs in general across these settings. However, the Taskforce determined that, given the confusing plethora of job titles and classifications, it would be impractical to distinguish between DCWs based on this criteria, and that in principle, unregulated care workers, regardless of their role, title and work setting, if providing direct care to patients, clients or residents should be subject to the same standards and quality and safety requirements.

The jurisdictions reported that they have no authority or mechanism by which to collect information from the private sector and could only gather limited data where available from agencies or facilities, which received funding from State or Territory Governments.

In consideration of the rather significant resource and time commitment required to develop an agreed methodology and to collect and collate information on qualifications and suitability checks for DCWs in the range of settings and services indicated in Recommendations 7 and 35 from both public and private sectors, the Taskforce determined for the purpose of this report to limit the scope of information to DCWs in the **public sector**.

Through the inclusion and exclusion criteria, the survey was further limited to information related to DCWs employed to provide direct care to patients/clients/residents, and who were not regulated professionals.

> **Direct care** was defined as providing "*hands on*" care, support or assistance to patients/clients/residents. "Hands on" care may include assistance with Activities of Daily Living (ADLs), such as eating, showering or dressing, mobilising, assisting with self-medication, and support activities, such as diversional therapy (see Appendix 3).

The survey excluded professional health workers (health workers with a tertiary qualification and/or professional registration), enrolled nurses, workers that are not employed (volunteers and students in clinical placements), and health workers whose primary role is to provide services indirectly to clients/patients/residents (administration clerks, environmental service/support and food service workers).

Two-phase approach

A two-phase approach was developed to collect data relating to the direct care workforce was developed:

- Phase 1: <u>A common national nomenclature</u>
- Phase 2: <u>Qualifications, suitability check, Implementation Strategy survey</u>

<u>Phase 1 – A common national nomenclature</u> (Appendix 3)

The purpose of the Phase 1 survey was to:
- Identify and rank (1-20) the most common job titles for DCWs in each jurisdiction in health and community sectors;
- Map the most common job titles against the Australian Standard Classification of Occupations (ASCO) and he Australian and New Zealand Standard Classification of Occupations (ANZSCO) for health and community sectors to determine if a national nomenclature for DCWs was already in use and consistent across the jurisdictions;
- Identify the sectors in which DCWs were employed.

Recommendation 7 proposed that a common national nomenclature be developed for DCWs. This would assist in identifying the section of the workforce requiring targeted suitability checks and further training. It would also be useful to have an agreed national system of classifications to bring consistency to data collections used to inform a wider national strategy for minimum qualifications and workforce planning.

It is evident that there is already a confusing plethora of job titles for DCWs drawn from various sources. ASCO is the most commonly used system of classification and is used by the Australian Bureau of Statistics (ABS) in collecting census data. Titles for DCWs may also be drawn from a number of other sources including industrial agreements or job descriptions. ASCO is a skills-based classification, which encompasses all occupations in the Australian workforce. An 'occupation' is a set of jobs with similar sets of tasks. An occupation in ASCO is a collection of jobs, which are

sufficiently similar in their main tasks to be grouped together for the purposes of the classification (ABS. 1997).

Rather than add an additional layer of complexity by creating new definitions to classify DCWs, the Taskforce instead undertook to check the congruence between common job titles and the **Australian Standard Classification of Occupations (ASCO)** and the **draft Australia and New Zealand Standard Classification of Occupations (ANZSCO)**, which has since replaced ASCO in 2006, to determine if this nationally-accepted (and widely used) classification might provide the foundation for greater standardisation in data collection.

The survey tool provided a list of ASCO occupational titles and also included a number of common job titles as identified by the NILS report, the CS&HTP and through advertised job vacancies across Australia. There was also provision for jurisdictions to add more job titles if common titles were not included on the list.

To identify the *sectors* in which the DCWs were employed, the survey used definitions from the ABS 1292.0 - Australian and New Zealand Standard Industrial Classification (1993), which was current at the time[7], to describe the health, aged and community care sectors:

– *The health industry is divided into three sectors: hospitals; medical and dental services; and other health services. For example, mental health services might be provided by hospitals, clinics in the community and through mobile community intervention services such as Crisis Assessment and Treatment services.*

– *Community services consist of two broad sectors: children's services and community care. Community care includes aged care, and residential and non-residential care.*

Drawing on this nationally-accepted classification, aged care was incorporated into community care for the purpose of the surveys. However, in recognition of regional variations in the way services are categorised, the survey requested identification of the types of services which were included in both health and community for that jurisdiction. It was anticipated that there would be overlap between health and community services, as distinctions between the two are not always clearly drawn. Further detail is available in Appendix 4.

Phase 1 surveys were distributed to each State and Territory for completion. Collated information was then reflected back to the jurisdictions in the Phase 2 survey.

Phase 2 – Qualifications, suitability check, Implementation Strategy survey (Appendix 4)

The Phase 2 survey collected information on:
- qualifications of DCWs;
- requirements for suitability checks; and
- strategies (in place or planned) to meet the recommended deadline (2008) for minimal qualifications of Certificate III in a relevant recognised training program.

For the purposes of the survey, a suitability check was described as:

A suitability check may be done as an employment or pre-employment process to determine if a candidate has the appropriate skills, qualifications, experience or qualities (such as "good character") for the position. For the purpose of this report, suitability check relates specifically to checks done to verify the bona fides of a potential employee and/or processes to determine whether a prospective employee poses a risk to the safety or welfare of vulnerable groups of clients/patients/residents. Suitability checks of this type may include:
- Conducting referee checks;
- Requiring self declaration of convictions, employment details;
- "Police checks" (or criminal record checks).

Specifically, Phase 2 requested information on the number of DCWs in each State and Territory, the level of qualifications held (less than, equal to or greater than a Certificate III), the types of suitability checks in place for DCWs and the strategy or plan in place to work towards the 2008 targets.

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[7] *It is noted that the 1993 version has been recently superseded by **1292.0 - Australian and New Zealand Standard Industrial Classification (ANZSIC), 2006.***

Working protocol
The Taskforce working protocol for both phases was to liaise with Chief Nursing Officers (CNOs) as the nominated jurisdictional representative for N^{3}ET work. It was anticipated that the CNOs would liaise further with key people and other departments in the jurisdiction to complete the surveys. The surveys were available online as e-forms and print-friendly versions of the surveys were also available. The project officer was available to provide guidance and support in collating and submitting relevant data. Upon submission, email notification of receipt was sent. The Taskforce individually followed up on responses where further clarification or detail was required. Further detail is available in Appendix 4.

The data gathered from the jurisdictions has informed this summary of progress.

Limitations to the survey
Discussions with the States and Territories identified a number of barriers to progressing implementation of the recommendations. These barriers included the complex reporting relationships between departments of health, human services and aged care across and within State and Territory governments, reporting relationships of various sectors, gaps between the public and private sector, differing state and territory legislation, lack of a common nomenclature to identify the workers to be reported on, access to data and the quality of the data where available.

At the same time, the Taskforce is acutely aware that due to the complexity of arrangements, the Health Ministers' ***support*** for these recommendations has not, on all occasions translated to whole of government support, policy and action at the jurisdictional level. In this context, the Taskforce anticipated challenges in collecting the data about sections of the workforce that might lie outside the health portfolio. It was evident that the information reported to the Taskforce would likely be limited to the areas where the data was already being collected by the jurisdictions.

These issues have most certainly impacted on the quality of the information reported to the Taskforce on this matter and is evident in the substantial data gaps.

SECTION 2: Summary of progress

All States and Territories completed both Phase 1 and Phase 2 of the surveys.

Phase 1: National nomenclature

In Phase 1 (Appendix 3), the jurisdictions were asked to identify and rank (1-20) the most commonly-used job titles (in that jurisdiction) for DCWs (as defined in the survey) in health and community. A list of common titles was provided with provision to add further titles to the list if the most common titles were not included. Tables 1 and 2 summarise the five most common job titles used in health and community service areas in each jurisdiction.

Table 1: Most common job titles in health

ACT	NSW	NT	QLD	SA	TAS	Vic	WA
Wardsperson	Wardsperson	Patient services Assistant	Carer	Patient services assistant	Hospital aide	Personal Care Assistnat/Worker	Personal Care Assistant/Worker
Ward Assistant	Ward Assistant	Support Worker	Wardsperson	Assistant in nursing	Orderly/Medical assistant	Patient Services Assistant/Carer	Personal Care Giver
Aged Care Worker	Patient Services Assistant	Wardsperson	Assistant in Nursing	Therapy Aide (Therapist Assistant)	disabilitiy worker/officer	Care Assistant	Patient Services Assistant
Specimen Collector	Porter	Hospital Assistant	Orthopedic technician	Orderly/Medical Orderly	Health Care Assistant	Personal Care Giver	Support Worker
Therapy Aide (therapist assitant)	Orderly/Medical orderly	Therapy Aide (Therapist Assitant)	Plaster technician	Porter	Personal Care Assistant/Worker	Nursing Assistant	Orderly/Medical Orderly

Table 2: Most common job titles in health

ACT	NSW	NT	QLD	SA	TAS	Vic	WA
Therapy Aide (therapist assitant)	Assistant in Nursing	Community Support Worker	Assistant in Nursing	Residential Aged Care Worker	Personal Care Assistant/Worker	Personal Care Assistant/Worker	Carer
Allied Health Assistant	Personal Care Assistant	Support Worker	Allied Health Assistant	Disability Servies Officer	Extended Care Assistant	Residential Aged Care Worker	Care Assistant
	Aboriginal health Worker	Therapy Aide (therapist assitant)	Carer/ Personal Care Assistant/Worker	Carer	Disability Services Officer	Care Assistant	Residential Aged Care Worker
	Personal Care Assistant	Commonity Care Worker	Support Worker	Care Assistant	Therapy Aide (therapist assitant)	Therapy Aide (therapist assitant)	Personal Care Giver
	Therapy Aide (therapist assitant)	Care Assistant	Therapy Aide (therapist assitant)	Personal Care Giver	Carer	Developmental &Disability worker	Personal Care Assistant

The common job titles identified in Phase 1 were mapped against the ASCO to determine if the commonly-used terms were reflected in the ASCO national classification.

Table 3: Most common job titles (for both sectors) mapped to the ASCO

ASCO	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Therapy Aide (Therapists' Assistant)	✓	✓	✓	✓	✓	✓	✓	✓
Personal Care Assistant	✗	✓	✓	✗	✓	✓	✓	✓
Nursing Assistant (Nurses' Aide)	✗	✓	✓	✗	✗	✓	✓	✓
Aged or Disabled Person Carer	✗	✗	✓	✗	✓	✓	✓	✓
Residential Care Officer	✗	✗	✗	✗	✗	✗	✗	✗

This exercise shows that, with the exception of *therapy aide* or *therapists' assistant* there is currently limited congruence between the job titles most commonly used for DCWs and the ASCO classification.

The results were also mapped against the draft of the ANZSCO, which although not finalised at the time, has since replaced ASCO in 2006.

Table 4: Most common job titles (for both sectors) mapped to the ANZSCO (2006)

ANZSCO	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Therapy Aide (Therapists' Assistant)	✓	✓	✓	✓	✓	✓	✓	✓
Hospital Orderly (Patient Services Assistant, Wardsperson)	✓	✓	✓	✓	✓	✓	✓	✓
Nursing Support Worker (Assistant in Nursing, Nurses Aide (NZ))	✗	✓	✓	✓	✓	✓	✓	✓
Personal Care Assistant	✗	✓	✗	✓	✓	✓	✓	✓
Aged or Disabled Person Carer (Home Support Worker, Personal Care Worker, Personal Carer)	✓	✗	✗	✗	✓	✓	✓	✓
Residential Care Officer	✗	✗	✗	✗	✗	✗	✗	✗

The ANZSCO terms are similar to those used in the ASCO (1993), however there is greater congruence between contemporary job titles and the titles in the classification, and a greater emphasis on title stems such as "assistant". In this case, **therapy aide** (**therapists' assistant**) and **hospital orderly** (**patient services assistant/wardsperson**) were identified as being used in some form in each State and Territory.

Summary

While this exercise was completed by all jurisdictions, the results of this survey are an indication only of the common job titles for DCWs across a range of services in the public sector. Most jurisdictions indicated that they do not commonly use titles from the ASCO or ANZSCO to identify workers, at either the employment or the government level for either health or community services. Therefore, beyond their function as identifiers in this survey, the ANZSCO job titles are of limited value unless governments choose to adopt them and incorporate them as identifiers in data collection mechanisms.

A more-inclusive and detailed survey of DCWs in both public and private sectors may yield results that might be closer aligned to the ANZSCO, as this classification has only recently been introduced and is the product of extensive consultation with a range of stakeholders including governments and employer groups. However, the jurisdictions have identified that gathering more definitive data would at this point be difficult, if not impossible, without adequate resources to support and coordinate data collection at a national level.

Phase 2: Qualifications, suitability check, implementation strategy

The Phase 2 survey collected data on the qualifications of DCWs, requirements for suitability checks and strategies in place to meet the 2008 targets for minimum Certificate III qualifications and compliance with suitability checks. The most commonly identified job titles for each jurisdiction were reflected back to the jurisdictions in the Phase 2 survey to assist with completion of the tool.

Specifically, Phase 2 requested information on the number of DCWs in each State and Territory, the level of qualifications held (less than, equal to, or greater than a Certificate III in a relevant training package), the type, if any, of suitability check in place for DCWs and the type of strategy or planning that each jurisdiction has in place to fulfil the recommendations.

Size of the direct care workforce

Based on the information provided by the jurisdictions, accurate quantification or even estimation of the size of the DCW workforce (as defined in the survey) by either actual employee numbers (or equivalent full-time) is not possible. Indeed, CNOs reported that determining the total number of DCWs in the health and community care sectors was very problematic.

In the public sector, there are also few if any mechanisms to collect reliable and consistent data on the number of DCWs employed in health and community services. This is largely a result of decentralised human resource management systems. Some jurisdictions provided an *estimate* of the total number of DCWs employed in health and/or community care. However, the criteria or

sources used to support such estimates were not verifiable, thus the quality and accuracy of the data limits the ability to provide an accurate picture or to draw conclusions or comparisons.

The main mechanism in place, where it did exist, for jurisdictions to estimate the number of DCWs was through various human resources information systems (HRIS) that distinguish between employment types. Barriers to better data include lack of HRIS or other mechanisms in place to track the workforce and that some mechanisms only report on the FTE when the majority of DCWs are part time or casual *(Richardson 2004; Australian Institute of Health and Welfare 2001).*

The data provided to the Taskforce on the size of the direct care workforce is incomplete and fragmented and does not provide a clear picture of either the total number of DCWs by jurisdiction or by sector in the jurisdictions. Without more consistent and uniform jurisdictional data, a national picture cannot be formed. It is clear that reporting accurately on the size of the direct care workforce is not possible without better mechanisms to identify DCWs and a more-comprehensive baseline data collection that is common in all sectors and across jurisdictions to track this segment of the health workforce over time. At the time of this report, no such mechanism existed.

Qualifications of the direct care workforce

From the data provided to the Taskforce, as it is not possible to quantify the direct care workforce across Australia, it is also not possible to accurately determine the number of DCWs holding relevant recognised qualifications from the Health and Community Services Training Package (or relevant qualifications from the tertiary sector), although it is understood from the NILS report (2004) that a high proportion of those DCWs working in residential aged care are likely to have a minimum Certificate III from the CS&HTP.

In public sector health and community care, only the NT, Qld and NSW could provide an estimate on the number of people holding any type of qualifications. However, the estimates were not based on sufficient evidence to be representative of the direct care workforce in those jurisdictions, and as such, cannot be used as indicative of the qualifications in those jurisdictions. There was no mechanism to distinguish between the various kinds of qualifications gained through VET or to identify what might be considered relevant recognised training as identified in Recommendation 7.

Suitability checks

The Health Ministers supported the recommendation from the National Review of Nursing Education that all people working in direct care with patients, clients and residents should have an appropriate suitability check (glossary) and proposed this be implemented by 2008. At the time of this report, there were no national standards regarding police checks and clearances for the health or community sectors. As the States and Territories (and individual employers) have their own policies and procedures, people seeking employment have to fulfil the requirements in each State or Territory (and employer) in which the person is working[8].

Phase 2 involved surveying the use of suitability checks for people employed in health and community care. Table 5 shows that all States and Territories (except SA) reported having some form of mandatory suitability check in place for all DCWs in publicly-provided health and community care.

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[8] *http://www.aifs.gov.au/nch/policechecks.html#nat Australian Government's national clearinghouse of police checks and clearances.*

Table 5: Suitability checks for DCWs

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Suitability check?	✓	✓	✓	✓	✗	✓	✓	✓
Includes police check?	✓	✓	✗	✓	✗	✓	✓	✓
Includes working with children check?	✗	✓	✗	✓	✗	✗	✗	✓
Legislated checks (applies to private sector)?	✗	✓	✗	✓	✗	✗	✗	✗

The suitability checks in place and reported to the Taskforce ranged from referee checks, to providing proof of identity and national criminal history record checks. It is evident that suitability checks are seen by as important not only to protect vulnerable client groups, but as a way to ensure that only appropriate individuals are providing care. Increasingly, suitability checks are considered a normal part of the recruitment process (although not mandatory) conducted before a person can be considered for a particular employment opportunity.

In most States and Territories (except SA and NT), suitability checks routinely include a criminal records check. In most cases, suitability checks are mandatory for employment in the public sector (Vic, Act, NSW, Qld, WA). To comply with the privacy provisions, however, applicants are required to give approval prior to obtaining a check (Tasmania requires the approval of the Commissioner for each check) and in most cases, individuals must take responsibility for initiating the check and bear the associated costs.

While the private sector may also conduct a range of suitability checks for their employees, only NSW and Qld report that mandatory checks are required for potential employees in both private and public sectors.

Only NSW, QLD and WA reported that suitability checks included mandatory Working with Children Checks (as required). Victoria noted that the *Working with Children Act 2005* is not yet active, but in 2006 before any person can work with children (provide direct and supervised care in both public and private settings) they must apply for a Working With Children Check from the Department of Justice and receive an Assessment Notice. Victoria reports that police checks are currently undertaken via the Victoria Police, although the department will be moving to an electronic system of submission and receipt of police checks. This will be undertaken through CrimTrac, a national agency, which matches names against the police records of all Australian police jurisdictions. Police records will be released depending on where the offence may have been committed and will be consistent with that jurisdiction's limitations on disclosure. Victoria Police have an *Information Release Policy*, which governs what information is released for offences committed in Victoria. This will have implications for the recruitment of DCWs in a range of settings.

Further information from the National Institute of Family Studies clearinghouse on Working with Children Checks is included in Appendix 5, and shows that a number of jurisdictions have introduced specific legislation for the protection of children and others are considering suitable options.

It is also noted that the Australian Government has recently announced its intention to mandate police background checks for all aged care workers, in an effort to help prevent abuse and mistreatment of elders and aged care residents. As a result, people with previous convictions for sexual or indecent assault or serious assault against a vulnerable person will be precluded from employment or volunteering in aged care homes. People with convictions for other offences (eg. theft) may also be excluded from working with older people[9].

The jurisdictions reported variations in current approaches to monitoring compliance with mandatory suitability checks. For the most part, checks are built into the routine recruitment process and supported through department guidelines and policy, ie. an offer of employment is conditional upon an approved suitability check (Vic, NT, WA, NSW). Department policy may also stipulate, as part of the funding agreement between the government department and the agency

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[9] *10 April 2006 Media Release http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2006-ss-san034.htm?OpenDocument&yr=2006&mth=4.*

(eg. Vic), that suitability checks be conducted, although there were no systems or data related to monitoring compliance reported.

Minimum Certificate III from the Community Service and Health Industry Training Package

In Australia, only QLD and WA identified that a strategy or plan was in place to work towards a minimum qualification of Certificate III from the CS&HTP by 2008. Queensland has provided targeted training programs for assistants in nursing and advanced assistants in nursing, while WA is working towards providing care workers with VET, including Certificate III. It is unclear from the information provided whether the same policy direction will apply to DCWs who do not work alongside nurses (eg. allied health assistants), or whether the training initiatives will extend to community settings.

Some jurisdictions identified that, at this point, they were *not considering* implementing minimum Certificate III requirements for unregulated DCWs. In the NT, for example, all DCWs employed in public services receive on-the-job training for their roles. As such, it is believed that those DCWs are adequately trained to provide care services and further formalised training is not a priority.

Several jurisdictions identified that within the broader context of health workforce planning and development, the State/Territory had identified and allocated funding to support a range of other pressing workforce priorities.

It was also acknowledged that DCWs may have qualifications, skills or competence levels through on-the-job training or short courses equivalent to those acquired through the CS&HTP. However, no State or Territory has in place a system of formalised workplace assessments of current competencies or strategies for recognition of prior learning as a pathway to attain Certificate III qualifications. Individual employers may provide support for VET to skill up the local workforce.

A number of issues were identified by jurisdictions as barriers to achieving the target set for minimum qualifications:
- lack of identified funding;
- a range of other pressing workforce training priorities (eg. medication competencies for enrolled nurses);
- the need for a national approach and leadership;
- limited availability of VET places;
- return on investment with respect to turnover in the DCW workforce (ie. movement to the private sector);
- industrial issues (not required to be Certificate III).

It was particularly noted that with the lack of robust and current data about the direct care workforce, the level of investment required to either provide appropriate training or to undertake a systematic program of recognising current competence to meet the minimum qualifications level for all DCWs, cannot be readily or accurately determined.

Summary

The ability of jurisdictions to complete the Phase 1 and Phase 2 surveys, even if only for the public sector, was severely hampered by a lack of available, current and robust data about the direct care workforce. Most of the jurisdictions do not track the numbers of DCWs and none collect data on the qualifications of their DCWs. While most jurisdictions identified understanding of DCWs and better data as important for the future, the costs associated with collecting this data are a significant disincentive to undertaking such an activity.

The limited data supplied to the Taskforce confirms that DCWs do not have national education benchmarks or minimum standards for employment and practice. This is despite industry-agreed qualifications being available through the CS&HTP. As such, the qualifications and skills sets for DCWs vary from no qualifications (formal or informal upon commencement of employment) right through to higher-education qualifications in aged care, or other relevant training. With the exception of WA and QLD where limited programs are in place, it is evident that the target of minimum qualifications for DCWs by 2008 has not received high-level policy support in the jurisdictions and in the context of the broader workforce, achieving this target appears to be a low priority. Where there are no minimum requirements for qualifications, there are also no mechanisms in place in most jurisdictions to collect this information on an ongoing basis to inform workforce planning.

The situation with respect to suitability is somewhat more promising. Suitability checks for employees are considered a normal and expected part of the recruitment process across a range of industries including health. Where this is the case, industry standards exert considerable pressure on employers to manage the risks associated with care provided by unregulated workers. It is also clear that where State or Commonwealth policy is tied to funding, and where there are statutory measures in place, there is a greater compliance and up-take of suitability checks.

SECTION 3: The way forward

In 2003, the Australian Health and Education Ministers supported Recommendations 7 & 35 from the National Review of Nursing Education (2002) *Our Duty of Care report* for a national nomenclature, minimum Certificate III qualifications from the health or community services training packages and suitability checks for unregulated DCWs by 2008. Through these measures, employers and the public can be assured that DCWs have the training and skills and are suitable to work with frail, vulnerable and dependent people in the health and community sectors.

Information provided by the jurisdictions on progress towards these recommendations indicates that the targets agreed by the Health Ministers for suitability checks and minimum qualifications are unlikely to be achieved without further policy direction and support at the jurisdictional level and some national coordination of data collection to ensure a viable national data set.

To date, the logistical challenges associated with data collection on DCWs have been a disincentive to undertaking this activity, even though there is certainly interest in understanding the direct care workforce and in exploring the potential of DCWs in health and community services. It is also clear that in the context of the whole of health workforce, there are other competing workforce training and development needs that currently take priority.

However, workforce projections indicate that professional health workforce shortages will continue to grow and this will generate a growing need for unregulated health workers to take on more of the work currently undertaken by health professionals such as nurses and allied health professionals.

The data provided to the Taskforce reinforces that there is insufficient robust information about the characteristics of the direct care workforce to enable the development of informed policy and planning strategies for DCWs. There is some evidence indicating that a proportion of DCWs already hold relevant qualifications (Richardson 2004; Community Services and Health Industry Skills Council 2005). For example, the NILS report (2004) found that the majority of residential aged care workers hold a Certificate III in Aged Care (79.2%). The evidence also suggests that many more people involved in direct care work are undertaking training in relevant certificate programs or undertaking training towards enrolled nursing (Certificate IV), registered nursing or other allied health roles (Richardson, 2004 #166). In this context, the cost of supporting training to maintain the coverage of Certificate III qualifications for the workforce may be moderate, whereas potential training costs are largely perceived to be substantial and a significant barrier to further action in this matter.

However, the level of information needed to accurately predict training costs is not currently available for DCWs in other services and without ongoing data collection capability, the available data from the aged care sector will likely become outdated. To address this issue, ongoing collection of data for this section of the health workforce merits further exploration.

With only two jurisdictions currently acting to introduce programs to address the training needs of DCWs, there is a long way to go to implement the recommendations from the *Our Duty of Care report*. There are certainly serious concerns about the cost of training such a large cohort of workers and the jurisdictions are reticent to commit to a program of work without a better understanding of the scope and costs that might be involved. This will continue to be difficult without a mechanism for identifying those requiring formalised education and distinguishing those who may already have achieved the required levels of competence through experience and on-the-job training.

There is also valid concern from public sector employers with respect to realising a return on the training investment, especially as DCWs are thought to be transient and mobile, moving from public to private institutions once they have achieved better qualifications. The NILS report (2004) suggests that DCWs with aged care qualifications do tend to stay working in the aged care sector. It is not known if attrition rates are similarly less for DCWs with qualifications working in other settings, but best practice in human resources management supports investment in employees in order to have a more-productive and efficient workforce, increased rates of job satisfaction and decreased attrition and turnover.

The provision of training and recognition of prior learning and current competence through workplace assessment would enhance career opportunities and training pathways for DCWs.

Providing training to the direct care workforce where needed, would also create opportunities to re-align work roles (Community Services and Health Industry Skills Council 2003; Community Services and Health Industry Skills Council 2005). A direct care workforce with known skills and competence levels would add to the general understanding of the health workforce and lay a foundation for the development of national workforce directions, which would lead to full utilisation of skills sets and exploration of potential.

Robust data is needed to inform national health workforce and education policy for the whole of the health workforce. This includes tracking the size and location of the direct care workforce and the characteristics of DCWs, such as current qualifications. While there are pockets of detailed information available through various workforce surveys on the health workforce (NILS, ABS, AIHW), there is no one comprehensive data source across the sectors and jurisdictions that at present provides the data necessary to inform workforce planning for DCWs.

While there has been targeted investment in various sectors (ie. Victoria Disability, Department of Health and Ageing (DOHA) aged care), it remains fragmented and restricted to the local or sector level. Currently, there is no single source that can provide the number of people employed as DCWs, let alone provide details regarding their qualifications.

National nomenclature

There is certainly a confusing plethora of job titles in health and community services. For governments, the role of a national nomenclature for DCWs in health and community service sectors would facilitate data collection through a consistently-identifiable workforce across jurisdictions for strategic workforce planning. The information provided to the Taskforce shows that the ASCO and ANZSCO are currently not widely used to classify DCWs either in health or community services. Indeed, there was a low level of congruence between the reported common job titles and the ASCO and ANZSCO.

The Taskforce is not in favour of adding further confusion with an additional layer of classification. As the ASCO/ANZSCO is widely used by governments, the AIHW and the ABS for other purposes, there would be considerable benefits to be gained from building the ANZSCO into workforce reporting systems (and perhaps integrating the classification into industrial award classifications) in order to better quantify employee types. This would facilitate a nationally-consistent data set and would also allow for cross-referencing between data collections for different purposes. It would similarly enable benchmarking across jurisdictions and would facilitate national workforce strategic planning and action. There is sufficient range within the ANZSCO titles to allow for variations from sector to sector.

Suitability checks

In Australia, the majority of jurisdictions require a suitability check for employees working with vulnerable or 'at risk' communities. However, the type of checks vary from reference checks to police checks. Only NSW and QLD reported that suitability checks are mandatory for all employees in both the public and private sector. At the federal level, the DOHA has committed to ensuring police checks occur for all employees and volunteers of aged care facilities (public and private) in Australia. At the time of the surveys, some States and Territories were also examining their policies regarding mandatory police checks. It would be worthwhile and timely to introduce a nationally-consistent approach or minimum standard for suitability checks for all health workers and volunteers in all sectors, not just in aged care.

It should be noted that the private sector was not surveyed regarding suitability checks for DCWs. It is very likely that within the private industry, employers and service providers use a multitude of checks and policies to ensure the suitability of employees. Legislated measures for the protection of children and elders in residential and aged care services generally apply to both public and private services.

While the direct link between police checks and incidents of criminal behaviour cannot be measured, the same principle to which the police check is applied (to protect a vulnerable population), should apply to all vulnerable populations in Australia, regardless of sector. Even so, suitability checks performed prior to employment provide evidence of the person's suitability at one point in time, whereas the regulatory framework for regulated professions provides ongoing certainty of the person's suitability with periodic check points. Ultimately, the responsibility will rest with employers to appropriately manage the risks associated with an unregulated workforce,

through implementing appropriate performance management systems, supervision arrangements and robust organisation-wide systems of risk management.

Qualifications

In Australia, National Training Packages provide education, training and qualifications to a nationally-agreed industry standard (benchmark). The Community Services and Health Training Package incorporates qualifications and units of competency for a range of workers in the health and community care services industries. The Health Training Packages have been undergoing review and it is anticipated that the revised training package will be approved for use in 2007. The package includes certificates (II, III and IV) in a range of areas such as dental, paramedic/ambulance, and health services assistants (including operating theatre, allied health, pathology health service assistance, Aboriginal and Torres Strait Islander health workers and a range of technicians). The Community Services Training Package (including qualifications for aged care workers, home and community care workers and disability workers) review has recently commenced. These two packages are often considered as one, as there is considerable overlap and intersection between the two. It is argued that, as the quality standards and process for training package development require the keys stakeholders to be consulted and to approve national training packages, the end product represents a de facto industry standard for training for particular job roles.

The Health Ministers support minimum Certificate III qualifications (in health or community services) for DCWs by 2008. While many DCWs already have appropriate minimum qualifications, it is evident from the jurisdictional progress reports that only two jurisdictions have implemented policy and programs to address the training needs of this section of the workforce and a number of others have indicated that the training needs of other health and community workforce groups have, at this point in time, taken priority.

Without understanding the characteristics of the current workforce, the jurisdictions are hampered in their efforts to identify those requiring additional training, to quantify the amount of training required and to develop evidence-based policy and strategies to achieve the minimum qualification levels.

In formulating policy on this matter, governments might need to consider issues such as:
–   staged or targeted implementation focusing on priority areas;
–   grandfathering arrangements to maximise the return on investment;
–   incentives for employers to sponsor group-training programs;
–   funding training through state-based VET priority systems;
–   tapping into other funding sources (eg. Commonwealth scholarships and grants) to support large scale training;
–   workplace recognition processes as an alternative pathway to qualification; and
–   policy levers that will encourage high levels of compliance over time.

It is clear that across Australia there have been a number of innovative approaches to addressing the training needs of health workforce groups that are instructive and offer valuable learning and opportunities.

Department of Human Services Victoria, Disability Services Division, Learning and Development Strategy

The Victorian Government identified that up-skilling care workers in disabilities services was a priority and essential to delivering quality services in the community sector. The drivers behind targeted training originated from an industry where the majority of the accommodation support workforce did not have the required competencies.

The Learning and Development Strategy was introduced with the aim of creating a learning culture in the Victorian disability sector. This strategy promoted a consistent approach to learning and development for both non-government and government service providers through access to qualifications pathways for staff, with recognition of current competency.

Disability care workers in accommodation services were targeted for up-skilling to the minimum of Certificate III and IV in Community Services (disability work) from the Community Services Training Package. The program was funded through the Commonwealth Traineeship/New Apprenticeship program. The funding was directed to the Department of Human Services, which

developed strategic networks with TAFE and other higher-education providers to facilitate recognition of the current competency process and training as required.

For three years from the time of inception (2001), a state-wide consortium of Registered Training Organisations (RTOs) ran the training program. The program is now run through contracts with registered training authorities in regional areas. Access to Commonwealth funding and flexible traineeship packages resulted in over 1,000 existing and new staff enrolling in the program. All new unqualified employees are enrolled in the Certificate IV disability work program, following a pre-service induction that is competency based, including recognition for current competency to determine the new recruit's pathway towards qualifications.

This model has also been effectively used by community services organisations. Between 2000 and 2004, student enrolments under the traineeship schemes increased 768%.

Success of the program is indicated by the following:
- 2001 – 52% of the disability accommodation workforce was unqualified
- 2004 – 93% of the staff have minimum qualifications or are participating in the traineeship program

- 2001 – no minimum qualifications
- 2005 – Cert IV in Disability Work is the new desired minimum qualification

- 2001 – training was not used as a strategic tool, but was delivered in an ad-hoc manner
- 2005 – 99% of new recruits are completing pre-service induction training

Department of Health and Ageing, Support for Aged Care Training

The DOHA recognises the value of employing sufficiently skilled and trained workers in aged care services and has renewed its commitment to funding training and education for workers in the sector. For example, DOHA runs a program called **Support for Aged Care Training (SACT)** to assist smaller aged care facilities in rural and remote areas, aboriginal communities and indigenous facilities to provide training to aged care workers. This program provides funding towards VET to provide care workers with support to assist them in upgrading their skills. The support covers course fees, travel, accommodation and the costs of backfilling positions while employees are in training.

The SACT program also provides support for continued education to enrolled nurses and front line managers in rural and remote areas. This program has been very successful in addressing a targeted area of care workers in rural and remote areas in aged care. Potentially, this model could be expanded or picked up by State and Territory governments in other sectors where care workers are employed. Incentive programs like this provide both staff and employers with options to up skill. The Minister for Health and Ageing in 2006 has committed an additional $30million to this program for the next four years.

The Australian Government's **Better Skills for Better Care Program** (05-06 guidelines) is another example of how a coordinated effort to up skill a group of workers can be achieved. This program is aimed at up skilling care workers in aged care from a Certificate III to an enrolled nurse (Certificate IV). The aged care facility applies to the DOHA for funding, outlining the number of staff they wish to train, the type of training, where the training will take place, and the training schedule. The funding only covers the course cost, resources, administration costs and GST. However, this is another way in which a pathway can be provided to increase the competency and skills of the care workforce.

In a CS&HTP Council report, it was identified that apprenticeships and traineeships for the Health Training Package have been available for a relatively short amount of time compared to the Community Services Training Package. However, the overall uptake of these traineeships has been consistent with the expansion of the apprenticeship program. Apprenticeships provide incentives for both employees and employers to invest in further training. With the creation of strategic networks to target areas of skills shortages between training authorities, governments and employers, it is possible to make a strategic investment in the workforce and to bring DCWs up to a Certificate III level.

The model used by Victoria's Disability Services tapped into an existing funding program (the New Apprenticeships Program) and worked with the Commonwealth Government to shape the program

to meet the needs of the specific sector, working through issues of access to traineeships, part-time casual employment and other barriers. This approach produced real results.

Summary

On present indications and based on the information reported to the Taskforce, it is evident that the targets supported by Health Ministers for the introduction of minimum qualifications and suitability checks for unregulated DCWs in the health and community sectors are unlikely to be achieved without further policy direction and support at the jurisdictional level, and national coordination of data collection, to ensure a viable national data set.

The quality and availability of robust data about the characteristics of the direct care workforce has impeded progress and commitment by the jurisdictions in this matter, even though these measures would facilitate quality and risk management, and would provide a foundation for better utilisation of the direct care workforce in the delivery of services. In turn, the availability and ability to collect data is impeded by the lack of a consistent nomenclature to assist in identifying the direct care workforce.

The study undertaken by the National Institute of Labour Studies into the Aged Care Sector shows that in the current context a large-scale national project to identify and characterise the direct care workforce would need considerable resources and high-level support, but would be beneficial in developing both State and national pictures of this section of the care workforce. This in turn would allow a more-integrated approach to workforce policy, particularly with respect to planning further role development.

Ideally, there should be a standardised mechanism for identifying and collecting data on the direct care workforce. This would require standardisation of the nomenclature for identifying DCWs. The Taskforce is not in favour of imposing another layer of national nomenclature on top of what is already a confusing system. Although the information reported to the Taskforce suggests that at present there is limited congruence between ANZSCO and current job titles, this classification is an obvious choice as it has recently been revised through broad consultation and is widely used by governments, the ABS and the AIHW. Job titles consistently mapped by the ANZSCO would allow for easier identification of target groups through HRIS (eg. payroll systems) and would provide greater opportunities for linking databases and for comparative analysis against other occupations.

With respect to implementing suitability checks for DCWs, there are clear indications from governments and industry that ensuring the suitability of workers is increasingly part of normal recruitment practices. Where there are populations that are particularly at risk (eg. children, frail and dependent elders and those with disabilities), the trend is to introduce legislative measures supported by clear government policy and guidance to ensure that appropriate and mandated suitability checks are performed. In the absence of statutory and policy levers, employers have a clear duty of care to ensure that DCWs are both suitable and competent to do the job.

Implementing minimum Certificate III qualifications for the direct care workforce presents a number of benefits, but also a number of challenges. Robust data and a mechanism for ongoing data collection would certainly assist in understanding the scale of activity and the nature of the investment required to up-skill these workers. For full implementation, however, there would need to be commitment by the various government departments with portfolio responsibility at the jurisdictional level, supported by policy and resources.

Deciding who should bear the costs of training will be a further challenge, particularly in an environment of competing workforce training needs. If the burden lies with individuals and employers alone, there is unlikely to be wide uptake of training opportunities. There is, however, a number of avenues for sourcing funding support and for cost sharing between individuals, employers and governments where all stand to share the benefits.

The Victorian *Learning and Development Strategy* provides a successful and instructive template for implementation in a particular community service sector. The Taskforce favours the features of this strategy, especially the focus on recognition of current competence and prior learning, and the strong and mutually-beneficial partnerships between industry and training organisations.

As there is increasing national pressure to develop and broaden the skills of the health workforce, achieving minimum qualifications for DCWs remains an appropriate goal. With uniform training and

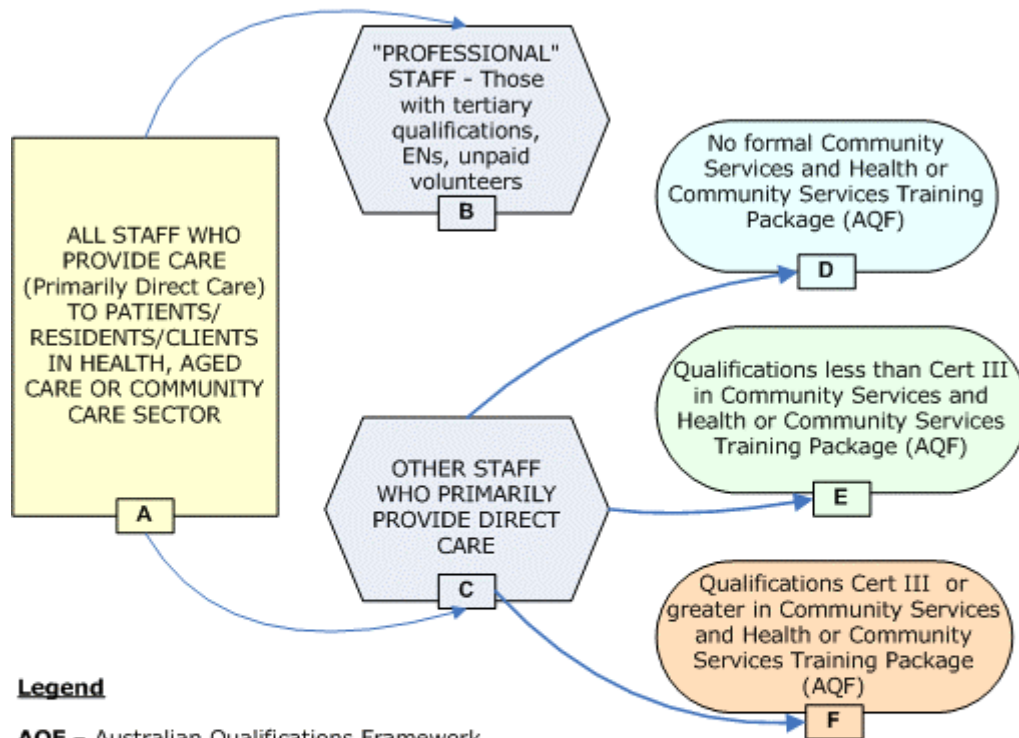qualifications, employers will be assured of the competence levels of their beginning workers, and there will be a solid base on which to build further skills and workforce capability as DCWs take on more of the work previously undertaken by registered professionals. Undoubtedly, this will assist with broader national strategies to better utilise the skills of the whole of the health workforce.

Appendices

Appendix 1. Scope of project

<u>The Direct Care Workforce</u>

```
ALL STAFF WHO
PROVIDE CARE
(Primarily Direct Care)
TO PATIENTS/
RESIDENTS/CLIENTS
IN HEALTH, AGED
CARE OR COMMUNITY
CARE SECTOR
  A
```

```
"PROFESSIONAL"
STAFF - Those
with tertiary
qualifications,
ENs, unpaid
volunteers
  B
```

```
No formal Community
Services and Health or
Community Services Training
Package (AQF)
  D
```

```
OTHER STAFF
WHO PRIMARILY
PROVIDE DIRECT
CARE
  C
```

```
Qualifications less than Cert III
in Community Services and
Health or Community Services
Training Package (AQF)
  E
```

```
Qualifications Cert III  or
greater in Community Services
and Health or Community
Services Training Package
(AQF)
  F
```

Legend

AQF – Australian Qualifications Framework

E - Cert I/II qualifications that would be included are:
      Health Training Package qualifications
      No appropriate qualifications at Cert II level
      Community Services Training Package
      Certificate II in Community Services Support Work

F - Cert III & IV qualifications referred to that would be included are:
      Health Training Package qualifications
      Certificate III in Health Service Assistance (Client/Patient Services)
      Certificate III in Health Service Assistance (Allied Health Assistance)
      Community Services Training Package
      Certificate III in Aged Care Work
      Certificate III in Home and Community Care
      Certificate IV in Aged Care Work
      Certificate IV in Service Coordination (Ageing and Disability)

Appendix 2. ANZSCO definitions

4 421715 Residential Care Officer - Provides care and supervision for children or disabled persons in-group housing or government institutions.

4 423311 Hospital Orderly (Patient Services Assistant, Wardsperson) - Assists with provision of care to patients in a variety of health, welfare and community settings by ensuring wards are neat and tidy, lifting and turning patients and transporting them in wheelchairs or on movable beds, and providing direct care and support.

4 423312 Nursing Support Worker (Assistant in Nursing, Nurses Aide (NZ)) - Assists with the provision of care to patients in a variety of health, welfare and community settings, often within a nursing team.

4 423313 Personal Care Assistant - Provides support and assistance to patients in a variety of health, welfare and community settings.

4 423314 Therapy Aide (Therapist's Assistant) Assists therapists in providing therapy programs and in the direct care of their patients in a variety of health, welfare and community settings. Registration or licensing may be required.

4 423111 Aged or Disabled Carer (Home Support Worker, Personal Care Worker, Personal Carer) - Provides general household assistance, emotional support, care and companionship for aged or disabled people in their own homes.

ASCO definitions

3421-15 Residential Care Officer - Provides care and supervision for children or disabled persons in group housing or government institutions.

6313-17 Aged or Disabled Person Carer (Home Support Worker) - Provides general household assistance, emotional support, care and companionship for aged or disabled people in their homes.

6313-19 Therapy Aide (Therapist's Assistant) - Provides assistance to occupational, divers ional or physiotherapists in therapy programs and care of their patients.

6314-11 Personal Care Assistant - Assists with the care of patients in a range of health care facilities, or in the client's home.

6314-13 Nursing Assistant (Nurses' Aide) - Assists registered nurses in hospitals, nursing homes and other health care facilities, in the provision of patient care.

Appendix 3. Phase 1 survey and instructions

Instructions

DCWs SURVEY - BACKGROUND
What is the project about?

The National Nursing and Nursing Education Taskforce (N[3]ET) is currently undertaking work to review progress by states and territories on Recommendations 7 and 35 from the National Review of Nursing Education (2002) *Our Duty of Care*. The recommendations are:

Recommendation 7: Care workers not covered by regulation
To ensure quality and safety in the health, aged and community care sectors, all workers without relevant recognised training who are employed to provide direct care should have:
a) a common national nomenclature
b) a minimum competency level of Certificate III from the appropriate Community Services or Health Training Package
c) an appropriate suitability check.

Recommendation 35: Training places for Certificate III
To ensure that those workers involved in direct care work in the health, aged and community care sectors achieve a level of at least Certificate III in the appropriate Community Services or Health Training Package by 2008, a strategy should be developed to expand workplace assessment and the number of training places for Certificate III in the appropriate training packages.

The N[3]ET requests your assistance in compiling data on the direct care workforce in your jurisdiction.
The work is divided into two phases:
Phase 1 - the most commonly used job titles (nomenclature),
Phase 2 - the most common qualifications for DCWs,
the current situation with regard to suitability checks for these workers, and
implementation strategies for meeting the 2008 target for Certificate III qualifications.
Data gathered from the jurisdictions will inform a report to Health and Education Ministers on the progress by states and territories on the recommendations.

Scope of survey

This survey excludes professional health workers (health workers with a tertiary qualification and or professional registration), enrolled nurses, workers that are not employed (volunteers and students in clinical placements), and health workers whose primary role is to provide services indirectly to clients/patients/residents (administration clerks, environmental service/support and food service workers).
The below diagram is designed to assist in identifying which DCWs to include in the data collection;
C - Other staff that primarily provide direct care

Definitions

For the purposes of recommendations 7 & 35, the following definitions have been used:
DIRECT CARE
Applies to workers who are employed to provide "hands on" care, support or assistance to patients/clients/residents. "Hands on" care may include assistance with Activities of Daily Living (ADLs) such as eating, showering or dressing, mobilising, assisting with self-medication, and support activities such as divers ional therapy.

HEALTH
Health services raise awareness of health issues and promote health; diagnose and treat illness and injury; and provide rehabilitation and palliative care (Community Services and Health Industry Skills Council 2005).
The Australian and New Zealand Standard Industrial Classification (ANZSIC) divides the health industry into three sectors: hospitals; medical and dental services; and other health services. For example, mental health services may be provided in a hospital, or other health services (Community Services and Health Industry Skills Council 2005).

COMMUNITY SERVICES
Community services consist of two broad sectors: children's services and community care. Community care includes aged care, and residential and non-residential care (Community Services and Health Industry Skills Council 2005).
Children's services are not included for the purpose of reporting on recommendations 7 & 35.

Phase 1 – Common National Nomenclature
Phase 1 is about job titles. DCWs in the health and community services sectors have different job titles. The Australian Standard Classification of Occupations (ASCO) is the most commonly used system of classification and is used by the Australian Bureau of Statistics (ABS). Titles for DCWs may also be drawn from a number of sources including industrial agreements or job descriptions. Phase 1 is to ascertain whether or not there is a common national nomenclature for this group.

ASCO
ASCO is a skill-based classification, which encompasses all occupations in the Australian work force. An 'occupation' is a set of jobs with similar sets of tasks. An occupation in ASCO is a collection of jobs, which are sufficiently similar in their main tasks to be grouped together for the purposes of the classification (Australian Bureau of Statistics. 1997).
Below are listed the most common ASCO codes (job codes) and job titles for the direct care workforce in health, and community care sector (including aged care). This information provides a profile of the types of roles and job titles that comprise the direct care workforce in state/territory government funded/owned health, communicate care services.

ASCO

Health		Community Care (including Aged Care)	
ASCO No	ASCO Title	ASCO No	ASCO Title
6313-19	Therapy Aide (Therapist's Assistant)	3421-15	Residential Care Officer
6314-11	Personal Care Assistant	6313-17	Aged or Disabled Person Carer (Home Support Worker)
6314-13	Nursing Assistant (Nurses' Aide)	6313-19	Therapy Aide (Therapist's Assistant)
6314-11		Personal Care Assistant	
6314-13		Nursing Assistant (Nurses' Aide)	

Definitions

3421-15 Residential Care Officer - Provides care and supervision for children or disabled persons in group housing or government institutions.
6313-17 Aged or Disabled Person Carer (Home Support Worker) - Provides general household assistance, emotional support, care and companionship for aged or disabled people in their homes.
6313-19 Therapy Aide (Therapist's Assistant) - Provides assistance to occupational, divers ional or physiotherapists in therapy programs and care of their patients.
6314-11 Personal Care Assistant - Assists with the care of patients in a range of health care facilities, or in the client's home.
6314-13 Nursing Assistant (Nurses' Aide) - Assists registered nurses in hospitals, nursing homes and other health care facilities, in the provision of patient care.

Australian and New Zealand Standard Classification of Occupations (ANZSCO)

There is currently a review of ASCO codes and the revised edition (ANZSCO) will replace the existing ASCO Second Edition and the New Zealand Standard Classification of Occupations (ANZSCO) 1999. The final structure of the new classifications will be available to the public in advance of the release of the full ANZSCO publication scheduled for July 2006. This information is still in its draft form and may change by the release of the full ANZSCO publication.
Below are listed the most common ANZSCO codes (job codes) and job titles for the direct care workforce in health, and community care sector (including aged care).

ANZSCO

Health		Community Care (including Aged Care)	
ANZSCO No	ANZSCO Title	ANZSCO No	ANZSCO Title
4 423314	Therapy Aide (Therapist's Assistant)	4 423314	Therapy Aide (Therapist's Assistant)
4 423313	Personal Care Assistant	4 421715	Residential Care Officer
4 423312	Nursing Support Worker (Assistant in Nursing, Nurses Aide (NZ))	4 423111	Aged or Disabled Carer (Home Support Worker, Personal Care Worker, Personal Carer)
4 423311	Hospital Orderly (Patient Services Assistant, Wardsperson)	4 423313	Personal Care Assistant
4 423312		Nursing Support Worker (Assistant in Nursing, Nurses Aide (NZ))	

Definitions

421715 Residential Care Officer - Provides care and supervision for children or disabled persons in-group housing or government institutions.
Directions to complete survey
4 423311 Hospital Orderly (Patient Services Assistant, Wardsperson) - Assists with provision of care to patients in a variety of health, welfare and community settings by ensuring wards are neat and tidy, lifting and turning patients and transporting them in wheelchairs or on movable beds, and providing direct care and support.
4 423312 Nursing Support Worker (Assistant in Nursing, Nurses Aide (NZ)) - Assists with the provision of care to patients in a variety of health, welfare and community settings, often within a nursing team.
4 423313 Personal Care Assistant - Provides support and assistance to patients in a variety of health, welfare and community settings.
4 423314 Therapy Aide (Therapist's Assistant) Assists therapists in providing therapy programs and in the direct care of their patients in a variety of health, welfare and community settings. Registration or licensing may be required.
4 423111 Aged or Disabled Carer (Home Support Worker, Personal Care Worker, Personal Carer) - Provides general household assistance, emotional support, care and companionship for aged or disabled people in their own homes.

Directions to complete Phase 1

Phase 1 of the survey is to be completed by the state or territory Chief Nurse or by the appropriate nominee(s).
Once submitted, an email response with all details provided would be sent back to the person who submitted the information to verify the response.
This survey is available online as an eForm. A print friendly version of the survey is available and it is advised to print and review the survey prior to commencing online data entry, as the form cannot be saved once started.

If you have any problems in completing the survey, please do not hesitate to contact Erin Statz in the N[3]ET Secretariat on (03) 9616 8137.

References

Australian Bureau of Statistics. (1997). Australian Standard Classification of Occupations. Second Edition, Australian Bureau of Statistics.
Community Services and Health Industry Skills Council (2005). Industry Skills Report, Australian National Training Authority: 92.

Phase 1 survey

Please review Background information prior to commencing the survey

Phase 1 – Common National Nomenclature
Part One - HEALTH
1. In your jurisdiction, does 'health' include the following types of services?

Yes/No
Hospitals
Medical centres
Dental services
Community health centres
Baby clinics

a) Please list any other types of programs, services or facilities included in 'health' in your jurisdiction.
2. In the following table please rank the occupational titles of DCWs (as defined in the background document) in your jurisdiction.
a) Rank them from (1) Most Common, to (20) Least Common,
b) If a title (in the table) is NOT USED, please record NU (Not Used) beside it.

If more space is required to record commonly used titles, use the spare spaces in the table below

Common occupational titles	Rank	Common occupational titles	Rank
Care Assistant		Carer	
Cast Technician		Hospital Assistant	
Nursing Assistant/Nurses' Aide		Orderly / Medical Orderly	
Patient Services Assistant		Personal Care Assistant/ Worker	
Personal Care Giver		Plaster Orderly	
Porter		Support Worker	
Therapy Aide/Therapist's Assistant		Ward Assistant	
Wards person			

3. If there are any difficulties in gathering the data, please describe.

Phase 1 – Common National Nomenclature
Part Two - Community Care (including aged care)

1. In your jurisdiction, does the 'community care' include the following types of services?

Yes/No
Residential care facilities
HACC programs
Disability services
Mental health services
Veteran's home care
Community aged care packages
Non residential care facilities
Adult day care
Respite

a) Please list any other types of programs, services or facilities included in 'community care' in your jurisdiction.

2. In the following table please rank the occupational titles of DCWs (as defined in the background document) in your jurisdiction.
a) Rank them from (1) Most Common, to (20) Least Common
b) If a title (in the table) is NOT USED, please record NU (Not Used) beside it.
c) If more space is required to record commonly used titles, use the spare spaces in the table.

Common occupational titles	Rank	Common occupational titles	Rank
Accommodation Support Worker		Allied Health Assistant	
Assistant in Nursing		Care Assistant	
Care Service Employee		Carer	
Community Care Worker		Community Support Worker	
Disability Service Officer		Nursing Assistant/Nurses' Aide	
Personal Care Assistant		Personal Care Giver	
Personal Care Worker		Residential Aged Care Worker	
Support Worker		Therapy Aide/Therapist's Assistant	

3. If there are any difficulties in gathering the data, please describe.

Appendix 4. Phase 2 instructions and survey

Instructions

<u>What is the project about?</u>

The National Nursing and Nursing Education Taskforce (N[3]ET) is currently undertaking work to review progress by states and territories on Recommendations 7 and 35 from the National Review of Nursing Education (2002) *Our Duty of Care*. The recommendations are:

Recommendation 7: Care workers not covered by regulation

To ensure quality and safety in the health, aged and community care sectors, all workers without relevant recognised training who are employed to provide direct care should have:
a) a common national nomenclature
b) a minimum competency level of Certificate III from the appropriate Community Services or Health Training Package
c) an appropriate suitability check.

Recommendation 35: Training places for Certificate III

To ensure that those workers involved in direct care work in the health, aged and community care sectors achieve a level of at least Certificate III in the appropriate Community Services or Health Training Package by 2008, a strategy should be developed to expand workplace assessment and the number of training places for Certificate III in the appropriate training packages.

The N[3]ET requests your assistance in compiling data on the direct care workforce in your jurisdiction.

The work is divided into two phases:

Phase 1 - the most commonly used job titles (nomenclature), (completed December 2005).

Phase 2 - the most common qualifications for DCWs,

The current situation with regard to suitability checks for these workers, and

implementation strategies for meeting the 2008 target for Certificate III qualifications.

Data gathered from the jurisdictions will inform a report to Health and Education Ministers on the progress by states and territories on the recommendations.

<u>Scope of survey</u>

This survey excludes professional health workers (health workers with a tertiary qualification and or professional registration), enrolled nurses, workers that are not employed (volunteers and students in clinical placements), and health workers whose primary role is to provide services indirectly to clients/patients/residents (administration clerks, environmental service/support and food service workers).

The below diagram (See Appendix1) is designed to assist in identifying which DCWs to include in the data collection;

C - Other staff who primarily provide direct care

<u>Definitions</u>

For the purposes of recommendations 7 & 35, the following definitions have been used:

RELEVANT RECOGNISED TRAINING

Refers to an industry specific qualification under the Australian Qualifications Framework (AQF) at Certificate III (or above) from either the Health or Community Services Training Package. Workers without relevant recognised training are those workers who do not have at least a Certificate III from either the Health or Community Services Training Package (see also definitions of "direct care"

SUITABILITY CHECK

A suitability check may be done as an employment or pre-employment process to determine if a candidate has the appropriate skills, qualifications, experience or qualities (such as "good character") for the position. For the purpose of this report suitability check relates specifically to checks done to verify the bona fides of a potential employee and/or processes to determine whether a prospective employee poses a risk to the safety or welfare of vulnerable groups of clients/patients/residents. Suitability checks of this type may include:
• Conducting referee checks
• Requiring self declaration of convictions, employment details
• "Police checks"

HEALTH

Health services raise awareness of health issues and promote health; diagnose and treat illness and injury; and provide rehabilitation and palliative care (Community Services and Health Industry Skills Council 2005).

The Australian and New Zealand Standard Industrial Classification (ANZSIC) divides the health industry into three sectors: hospitals; medical and dental services; and other health services. For example, mental health services may be provided in a hospital, or other health services (Community Services and Health Industry Skills Council 2005).

COMMUNITY SERVICES

Community services consist of two broad sectors: children's services and community care. Community care includes aged care, and residential and non-residential care (Community Services and Health Industry Skills Council 2005).

DIRECT CARE
Applies to workers who are employed to provide "hands on" care, support or assistance to patients/clients/residents. "Hands on" care may include assistance with Activities of Daily Living (ADLs) such as eating, showering or dressing, mobilising, assisting with self-medication, and support activities such as diversional therapy.

Note: A suitability check may be applied at the individual level (all staff are required to have a check) or may be part of a risk management approach where certain segments of the workforce have different suitability requirements proportional to the risks posed to the client group/setting, or the process may involve random auditing of certain number (for example; 5% of the relevant worker population).
Children's services are not included for the purpose of reporting on recommendations 7 & 35.

Phase 2 – Qualifications, Suitability Checks and Implementation Strategies
Phase 2 is about qualification levels of DCWs, suitability checks, and the implementation strategies to meet the 2008 deadline for all DCWs having a minimum level of Certificate III from a relevant recognised training package.

Directions to complete Phase 2
Phase 2 of the survey is to be completed by the state or territory Chief Nurse or by the appropriate nominee(s).
Once submitted, an email response with all details provided will be sent back to the person who submitted the information to verify the response.
This survey is available online as an eForm. A print friendly version of the survey is available and it is advised to print and review the survey prior to commencing online data entry, as the form cannot be saved once started.

If you have any problems in completing the survey, please do not hesitate to contact Erin Statz in the N[3]ET Secretariat on (03) 9616 8137.

References
Community Services and Health Industry Skills Council (2005). Industry Skills Report, Australian National Training Authority: 92.

Phase 2 DCWs Survey

Please print and review the Background Information prior to commencing the survey

1) THE SURVEY HAS THREE PARTS:

a) Qualifications & suitability checks in 'Health'
b) Qualifications & suitability checks in 'Community Care', and
c) Implementation
2) EXCLUSIONS:

a) Health workers with university qualifications and/or professional registration (e.g., nurses, midwives, physicians),
b) Enrolled nurses,
c) Volunteers, and students on clinical placements,
d) Administration staff, environmental service/suppport staff and food service workers.
3) COMPLETING THE SURVEY:

To be completed by the Chief Nursing Officer or nominee
a) The survey is available as an electronic document, a print version is available on the N3ET website.
b) A confirmation email will be returned to the person who submits the information in order to verify the jurisdictional response.
c) Help can be sought from the N3ET Secretariat on (03) 9616 8137.

For more detailed information on this survey please review the Background Information - Phase 2.
Part One - HEALTH
Based on the results of **Phase 1,** the health sector in the ACT includes the following services/programs: H*ospitals,Subacute facilities,Rehabilitation facilities,Mental health services,Dental services, Cancer Stream,Aged Care and Rehabilitation Stream,Health Protection Services,Health Centres,Drug and Alcohol Services,Health First (phone advices service),Health Promotion,Women's Health, and Registration Board Secretariat.*

In health, DCWs in these facilities/services are most commonly refered to as: *Wardsperson, Ward Assistant, Aged Care Workers, Speciment Collector, Therapy Aide/Therapists Assistant.*
Qualifications

Based on the above findings in Phase 1, this section requests data on the qualifications of 'DCWs' in health in The Australian Capital Territory. Workers without relevant recognised training are those workers who do not have **at least a Certificate III from either the Health or Community Services Training Package**. More detailed information on 'direct care', 'health' and the training packages can be found in the Background Information. You can attach source documents for this sections by selecting the link at the end of this section.

1. The actual number (i.e., head count and not equivalent full time) of DCWs in 'health':

a) Total number of DCWs in 'health':	

Breakdown	Number
b) **No formal qualifications**	
c) **Qualifications of less than a Cert III (Cert I or II)**	
d) **Qualifications of Cert III or above (IV or diploma)**	

e) Calculate (d) as a % of the total direct care workforce (a):	%

This % value will be used in Part Three, question one.

Option

If you are not able to provide actual numbers of DCWs in 'health' please provide an indication (e.g., per cent of total direct care workforce).

Breakdown	Percentage %
f) **No formal qualifications**	
g) **Qualifications of less than a Cert III**	
h) **Qualifications of Cert III or above (IV or diploma)**	

i) Estimated coverage (%) of total DCWs with qualifications of Cert III or above (Cert IV or diploma):	%

If unable to provide information in question 1 (e), this % value will be used in Part Three, question one.

2. What is the basis or source of the information provided? For example, legislative requirements, reports, standards related to qualifications. Please be specific with regards to which section of the 'direct care health workforce' that source relates to.

Suitability check

3. Is there a system in place for suitability checks for all DCWs in 'health'?
If yes, please complete 3 (a, b, c)
If no, please complete 3 (d or e)
a) Are there regulatory, legislative and/or industrial regulations in your jurisdiction that require a system of suitability checks for DCWs in 'health'?
b) If yes please specify and provide source (e.g., web address, full citation):
c) If yes, do these regulatory, legislative, and/or industrial regulations in your jurisdiction which impact on the work of DCWs extend to privately owned and funded health services?

d) If no, and there is a policy or strategy in place to implement suitability checks for DCWs, please briefly outline the key points including exclusions or exemptions such as grand parenting arrangements:

e) If no, and there is no policy or strategy in place to implement suitability checks for DCWs, please describe the jurisdictional response to Recommendation 7 – Care workers not covered by legislation Part C - an appropriate suitability check from the National Review of Nursing Education (2002) *Our Duty of Care* report:

 4. Please outline the approach to monitoring and compliance for suitability checks (i.e., legislation, statutory regulation, industry regulations, government policy, levers such as funding and incentives, etc

Attach any source documents for Part One – Health here.

Part Two - Community Care (including aged care)

Based on the results of **Phase 1,** the community care sector in the ACT includes the following services/programs: *HACC programs,Mental health services,Community aged care package,Veterans home care,Non-residential care facilities, Adult day care, Respite, Drug and Alcohol,Maternal and Child Health,Dental Services,Women's Health, Health Promotion, Equipment and Prosthetics, Home Support,Child and Parenting, Independent Living Centre, Migrant Health,Older Peoples Health,Victim Services, and Diabetes Support.*

In community care, DCWs in these facilities/services are most commonly refered to as: *Therapy aide/therapists assistant, and Allied Health Assistant.*

Qualifications

Based on the above findings in Phase 1, this section requests data on the qualifications of 'DCWs' in community care in The Australian Capital Territory. Workers without relevant recognised training are those workers who do not have **at least a Certificate III from either the Health or Community Services Training Package.** More detailed information on 'direct care', 'community care' and the training packages can be found in the Background Information. You can attach source documents for this sections by selecting the link at the end of this section.

1. The actual number (i.e., head count and not equivalent full time) of DCWs in 'community care':

a) **Total number of DCWs in 'community care':**	

Breakdown	Number
b) *No formal qualifications*	
c) *Qualifications of less than a Cert III (Cert I or II)*	
d) *Qualifications of Cert III or above (IV or diploma)*	

e) *Calculate (d) as a % of the total direct care workforce (a):*	**%**

This % value will be used in Part Three, question one.

Option

If you are not able to provide actual numbers of DCWs in 'community care' please provide an indication (e.g., per cent of total direct care workforce).

Breakdown	Percentage %
f) *No formal qualifications*	
g) *Qualifications of less than a Cert III*	
h) *Qualifications of Cert III or above (IV or diploma)*	

i) *Estimated coverage (%) of total DCWs with qualifications of Cert III or above (Cert IV or diploma):*	%

If unable to provide information in question 1 (e), this % value will be used in Part Three, question one.

2. What is the basis or source of the information provided? For example, legislative requirements, reports, standards related to qualifications. Please be specific with regards to which section of the 'direct care health workforce' that source relates to.

Suitability check

3. Is there a system in place for suitability checks for all DCWs in 'community care'?
If yes, please complete 3 (a, b, c)
If no, please complete 3 (d or e)
a) Are there regulatory, legislative and/or industrial regulations in your jurisdiction that require a system of suitability checks for DCWs in 'community care'?
b) If yes please specify:
c) If yes, do these regulatory, legislative, and/or industrial regulations in your jurisdiction that impact on the work of DCWs extend to privately owned and funded health services?
d) If no, and there is a policy or strategy in place to implement suitability checks for DCWs, please briefly outline the key points including exclusions or exemptions such as grand parenting arrangements:
e) If no, and there is no strategy in place to implement suitability checks for DCWs, please describe the jurisdictional response to Recommendation 7 – Care workers not covered by legislation Part C - an appropriate suitability check from the National Review of Nursing Education (2002) *Our Duty of Care* report:
4. Please outline the approach to monitoring and compliance for suitability checks (i.e., legislation, statutory regulation, industry regulations, government policy, levers such as funding and incentives, etc
Attach any source documents for Part Two – Community Care here.

Part Three - Implementation

The purpose of the following questions is to report to the Health & Education Ministers on jurisdictional progress towards an implementation strategy to meet the 2008 deadline (more information on the N[3]ET website or in the Background Information).

1. Pulling together information provided by your jurisdiction in part one and two regarding qualifications in health and community care sectors, what is the current overall state coverage (per cent of total) of Certificate III qualifications?

	Health	Community Care
Percentage (%) of Cert III or greater coverage		

This question refers to the results of Part One, question 1 (e or i) and Part Two, question 1 (e or i).

2. Is there a strategy in place to ensure that all DCWs identified in this survey have a minimum qualification of Certificate III by 2008 (i.e., grand parenting)?
a) If yes, briefly outline the key points to this strategy:
b) Outline the approach to monitoring and compliance:
c) If no, please outline the jurisdictions response to Recommendation 35 from the National Review of Nursing Education (2002) *Our Duty of Care* report.
3. Are there any barriers that would hinder/prevent compliance with regard to all workers gaining the relevant minimum Certificate III qualifications by 2008?
4. If access to training places is an issue, what strategies are in place to overcome this barrier?
5. Outline the approach to monitoring and compliance (e.g., legislation and statutory regulation, industry regulations, government policy, levers such as funding and incentives, etc.) specific to DCWs having a minimum qualification of Certificate III.
 If you have any further comments or information to add please use this space below.
Attach any source documents here.

Contact Details

1. Is the survey complete?
2. Contact Name (first, last)
3. Contact Phone Number (area code)
4. Contact Email
5. If more than one person has completed this survey, please include additional contact details.

Appendix 5. Working with children checks

The following information is from the Australian Government's National Institute of Family Studies Child Protection Clearinghouse of police checks and clearances and outlines current developments with respect to working with children across the full spectrum of care settings including health care. These requirements will apply to DCWs working in these settings:

ACT
The ACT government released a discussion paper for the creation of a screening scheme that stipulates minimum standards for broadly identified child-related occupations and activities. It was proposed that this could be the function of a Commissioner for Children and Young People as outlined in the Position Paper: For a proposed Australian Capital Territory Commissioner for Children and Young People from the ACT Chief Minister's Department, 2004. Criminal history check application forms are covered by the ACT Police Department.
At present there are no legal statutes that require people working with children to undergo a police check, although individual organisations may have their own policies in this regard.

New South Wales
The NSW Commission for Children and Young People is responsible for the Working with Children Check, which covers police checks. This checklist aims to create workplaces where children are safe and protected, and where the people who work with children are appropriately screened.

Northern Territory
The Northern Territory has no requirement for a criminal record check but conducts referee checks at the time of employment as a way to ensure suitability. In South Australia, some agencies have instituted their own suitability checks however there is no state-wide policy in place, even for public employees.

The Northern Territory Government has released draft legislation for the creation of a screening scheme that stipulates minimum standards for broadly identified child-related occupations and activities. The Police Department provides information on criminal history checks.
At present there are no legal statutes that require people working with children to undergo a police check, although individual organisations may have their own policies in this regard.

Queensland
The Commission for Children and Young People and Child Guardian (Queensland) is responsible for the blue card (criminal history checks) for people wanting to commence employment or volunteer work with children, and covers police checks.

South Australia
South Australia has not yet put forward specific legislation on the issue of police clearances and checks. A National Police Certificate Application Form is available on the website of the South Australia Police Department.
At present there are no legal statutes that require people working with children to undergo a police check, although individual organisations may have their own policies in this regard.

Tasmania
The Commissioner for Children Tasmania released a consultation paper in early 2005 discussing proposals for the government to introduce policies and procedures for Tasmanian organisations to screen individuals who seek to work with children in a voluntary or paid capacity. Criminal history record checks are provided by the Tasmanian Police Department.
At present there are no legal statutes that require people working with children to undergo a police check, although individual organisations may have their own policies in this regard.

Victoria
The Victorian Parliament has enacted the Working with Children Check to provide a screening process for individuals who seek to work with children in a voluntary or paid capacity. This will be implemented gradually over five years from mid-2006. The Victoria Police provides a service to individuals and organisations in Victoria wishing to obtain national police

certificates for employment, voluntary work and occupation related licensing or registration purposes. Criminal history record checks are provided by the Police Department.
At present there are no legal statutes that require people working with children to undergo a police check, although individual organisations may have their own policies in this regard.

Western Australia
A Working with Children Check is a new national criminal record check that is compulsory for people who carry out child-related work in Western Australia. Working with Children Checks are very different from a National Police Check conducted by the WA Police, which many employers may currently require of their employees or volunteers. An application form for a police check for volunteers is available from the National Police Check for Volunteers Program, which is part of the Department for Community Development.

Back

Glossary

Australian Qualifications Framework (AQF)	Introduced in 1995, the AQF is a nationally-consistent framework of credentials offered in post-compulsory education and training.
Australian and New Zealand Standard Classification of Occupations (ANZSCO)	There is currently a review of ASCO codes and the revised edition (ANZSCO) will replace the existing ASCO Second Edition and the New Zealand Standard Classification of Occupations (NZSCO) 1999. The final structure of the new classifications will be available to the public in advance of the release of the full ANZSCO publication scheduled for July 2006. This information is still in its draft form and may change with release of the full ANZSCO publication.
	ANZSCO codes (job codes) and job titles for the direct care workforce in health, and community care sector (including aged care) are located in Appendix (2).
Australian Standard Classification of Occupations (ASCO)	The Australian Bureau of Statistics (ABS) and the Department of Employment, Education, Training and Youth Affairs (DEETYA now DEST) produced an occupational classification system incorporated by a number of government departments into their reporting systems and by public and private sectors to store and organise occupation-related information (ABS, 1997).
Community services	Community services consist of two broad sectors: children's services and community care. Community care includes aged care, and residential and non-residential care (Community Services and Health Industry Skills Council 2005).
Direct care worker (DCW)	Applies to unregulated workers who are employed to provide hands-on care, support or assistance to patients/clients/residents. Hands-on care may include assistance with activities of daily living (ADLs) such as eating, showering or dressing, mobilising, assisting with self-medication, and support activities, such as diversional therapy.
Health sector	Health services raise awareness of health issues and promote health; diagnose and treat illness and injury; and provide rehabilitation and palliative care (Community Services and Health Industry Skills Council 2005).
	The 1993 Australian and New Zealand Standard Industrial Classification (ANZSIC) (ABS 1993), which was the current version at the time of this research, divides the health industry into three sectors: hospitals, medical and dental, and other care services. The 2006 version of the classification includes hospitals, medical and other care services, and residential care services (ABS 2006). Mental health services, for example, may be provided in a hospital or other care services, or in a community or residential setting (Community Services and Health Industry Skills Council 2005).
Health workforce	The health workforce provides health care to the Australian people. It ranges from qualified to unqualified workers providing support services in home-based settings through to intensive super-acute hospital-based settings (Australian Health Ministers' Conference 2004).
Recognition of prior learning	Recognition of prior learning is status or credit obtained for courses or subjects on the basis of recognised competencies gained previously through informal/formal training, experience in the workplace, voluntary work, social or domestic activity.
Relevant recognised training	Refers to an industry-specific qualification under the Australian Qualifications Framework (AQF) at Certificate III (or above) from either the Health or Community Services Training Package. Workers without relevant recognised training are those workers who do not have at least a Certificate III from either the Health or Community Services Training Package (see also definitions of "direct care").
	For more information see (appendices) for a full list of relevant recognised training.

Suitability check

A suitability check may be done in the employment or pre-employment process to determine if a candidate has the appropriate skills, qualifications, experience or qualities (such as "good character") for the position. For the purpose of this report, a suitability check relates specifically to checks done to verify the bona fides of a potential employee and/or processes to determine whether a prospective employee poses a risk to the safety or welfare of vulnerable groups of clients/patients/residents. Suitability checks of this type may include:
• Conducting referee checks
• Requiring self declaration of convictions, employment details
• "Police checks"

Technical and Further Education Institutes (TAFE)

In Australia, Technical and Further Education or TAFE institutions are those which offer a wide range of tertiary education and training, generally in vocational fields (such as hospitality, tourism, construction, woodwork, secretarial skills, community work), often at a level of difficulty below that of a corresponding or related higher-education course. The trend is changing, however, so that universities and TAFEs offer a variety of overlapping courses.

TAFE institutes are part of the Vocational Education and Training (VET) system. Private registered training organisations (RTOs) also provide VET.

Training packages

Training packages are a set of nationally-endorsed standards, guidelines and qualifications for training and for recognising and assessing skills. They are developed by industry with the aim of meeting the needs of an industry or group of industries.

Workforce Planning

The process of estimating the required health workforce to meet future health service requirements and the development of strategies to meet those requirements (Australian Health Ministers' Conference 2004).

Vocational Education and Training (VET)

Vocational Education and Training (VET) is the term used to describe the education and training to prepare people for work or to improve the knowledge and skills of people already working. The Commonwealth, State and Territory Governments in Australia support VET. VET is aimed at industry and workplace needs.

Abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ADL	Activities of daily living
AHMC	Australian Health Ministers Committee
AIHW	Australian Institute of Health and Welfare
ANMC	Australian Nursing and Midwifery Council
AQF	Australian Qualifications Framework
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ASCO	Australian Standard Classification of Occupations
CNO	Chief Nursing Officers
COAG	Council of Australian Governments
CS&HTP	Community Services and Health Training Package
DCW	Direct care worker(s)
DEETYA	Department of Employment, Education, Training and Youth Affairs, now DEST
DEST	Department of Education Science and Training
DOHA	Department of Health and Ageing
EN	Enrolled nurse
HRIS	Human Resources Information Systems
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
N^{3}ET /Taskforce	National Nursing and Nursing Education Taskforce
NILS	National Institute of Labour Studies
NRA	Nursing/midwifery regulatory authority
NSW	New South Wales
NT	Northern Territory
NZSCO	New Zealand Standard Classification of Occupations
PC	Personal carers
Qld	Queensland
RACS	Residential Aged Care Services
RM	Registered midwife
RN	Registered nurse
SA	South Australia
TAFE	Technical and Further Education
VET	Vocational Education and Training
Vic	Victoria
WA	Western Australia

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