



Australian College of Nursing

Regulation of the Unregulated Health Care Workforce across the Health Care System

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EXECUTIVE SUMMARY

For the purpose of this White Paper, the term ‘Unregulated Health Care Worker’ (UHCW) will be used to describe the support workforce employed to deliver a range of ancillary nursing and non-nursing tasks within the Australian health care system, particularly the primary, acute and aged care sectors. UHCWs are increasingly undertaking activities that fall within nursing work, leading to a blurring of scope and accountability. A lack of consistency and clarity regarding the UHCW role, supervisory requirements and minimum educational requirements is concerning. Firstly, UHCWs may be working beyond their scope of practice and thus potentially putting their own careers and their patients’ well-being at risk. Secondly, Registered Nurses (RNs) are supervising and responsible for the work undertaken by UHCWs (Duffield et al., 2014a). Thirdly, a lack of publicly available data regarding the UHCW workforce is contributing to an inability for RNs and health at large to make informed decisions surrounding these supportive roles.

There is a common misconception that shortages in the regulated nursing workforce have led to an increased reliance on UHCWs. While UHCWs make up a considerable proportion of the workforce, this is not exclusively due to issues around RN supply. In many instances, employers are choosing UHCWs as they are financially advantageous in comparison to RNs (Department of Health (DoH), 2013a; Duckett et al., 2014).

To address these issues, the Workforce Sustainability Policy Chapter (2018), comprising Australian nurses, with expert knowledge, experience and research around nursing workforce, was established by the Australian College of Nursing (ACN). The Policy Chapter conducted a thorough (albeit informal) investigation of the UHCW role, scope of practice, supervisory and educational requirements within the primary, acute and aged care sectors across Australia. This informal review was required due to the dearth of inconsistent datasets and literature within these sectors.

This White Paper intends to introduce key issues surrounding the UHCW workforce in Australian primary, acute and aged care settings and provide two key recommendations¹ for consideration by the Australian Government. Specifically, that it is imperative for nation-wide inconsistencies regarding the UHCW role and UHCW regulation to be addressed promptly.

¹ These recommendations align with White Papers provided by ACN (ACN, 2016), the Australian Nursing and Midwifery Federation (ANMF, 2016; 2018a; 2018b), and the Aged Care Workforce Strategy Taskforce Report (DoH, 2018).

INTRODUCTION

The number of unregulated workers in Australia's health care system is growing at an exponential rate. This has the potential and increasingly real likelihood of affecting the quality and safety of care provided to the community. This White Paper examines the role of UHCWs in the Australian primary, acute and aged care sectors and looks at the provision of care in these settings. For the purpose of this White Paper UHCWs does not include undergraduate nursing students. The paper begins by defining some key terms. It then outlines the issues for the future of health care delivery and concludes with two key recommendations. This paper also draws on previous work regarding skill-mix and safe staffing practices (Australian College of Nursing (ACN), 2016; International Council of Nurses (ICN), 2018). ACN has consistently held the view that:

- All UHCWs need to be regulated under some form of statutory authority with a nationally consistent scope of practice and educational preparation.
- The introduction of UHCWs into nursing care teams must never be undertaken as a substitution of RNs or Enrolled Nurses (ENs).
- UHCWs should only be employed to support RNs and ENs in the provision of personal care and assisting people with activities of daily living (i.e. to be a 'complementary' staff mix model).
- Nursing care teams must have the appropriate 'skill-mix' to meet patient care requirements adequately.
- The regulation, legislation and policies for Residential Aged Care Facilities (RACFs) should stipulate appropriate staffing requirements for the delivery of direct care.
- RACFs should mandate that a RN be on-site and available at all times.

ACN is committed to providing system-wide strategies that safeguard the public from risks when they are accessing health services. Given that nursing is at the forefront of health care and that RNs are accountable for the tasks they delegate to all other health care workers (Nursing and Midwifery Board of Australia (NMBA), 2016a), it is imperative that the nursing profession participates in and contributes to policy reform regarding safer delegation practices and regulation of the UHCW workforce. This White Paper also calls on Australian governments to engage with ACN, the nursing profession and other expert stakeholders to address ongoing concerns and opportunities regarding the employment of UHCWs.

ACN is unequivocally of the view that the UHCW workforce should be regulated to achieve nationally consistent nomenclature/titles, minimum educational and ongoing professional development requirements and standards for scope of practice. Such regulation is essential to provide a level of safety for all Australians across all health care settings; and for the UHCWs themselves and the RNs responsible for supervising them. Regulation would also ensure a sustainable UHCW workforce that can be utilised consistently and safely across Australian states and territories and all health care settings. ACN believes this should be achieved without compromising safe nurse staffing levels (i.e. ensuring appropriate skills and 'skill-mix') or diluting the qualified nursing workforce (i.e. ensuring UHCWs are not employed in a 'substitution' staff mix model).

DEFINITIONS

Nursing care

Nursing care describes the unique and specialised role of RNs employed in the nursing profession. The World Health Organization (WHO) describes nursing as follows:

“Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people”
(WHO, 2019a; p. online last updated 2019).

A more detailed description of clinical nursing provided by Virginia Henderson was notably adopted by the International Council of Nursing (ICN) in 1969:

“The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge”
(Henderson, V., 1966; p. 15).

It should be noted that this is not the most recent ICN definition for nursing. However, for the purposes of this paper, it provides a clear description of the specific role of the nurse in the delivery of clinical care.

Primary health care

Primary health care is the frontline of Australia’s health care system and encompasses a large range of providers and services across the public, private and non-government sectors. It can be provided in the home or in community-based settings such as in general practices, other private practices, community health, local government, and non-government service settings (for example, Aboriginal Community Controlled Health Services). It includes health care services not related to a hospital visit but rather focused on health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions. Services may be targeted to specific population groups such as Senior Australians, maternity and child health, youth health, people living in rural and remote areas, Aboriginal and Torres Strait Islander people, refugees, and people from culturally and linguistically diverse or low socio-economic backgrounds.

At a clinical level, primary health care is typically the first point of contact an individual has within the health system over a health concern, usually with a General Practitioner (GP), and can require a team of health professionals working together to provide comprehensive, continuous and person-centred care. While most Australians will receive primary health care through their GP, primary health care providers also include nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, Aboriginal health workers and UHCWs (Australian Institute of Health and Welfare (AIHW), 2016b; DoH, 2015; 2013b).

Acute care

Acute care environments encompass health systems (organisations, institutions and resources) and service providers who address acute care needs of individuals and populations. These environments are typically located in a hospital ward or unit setting which address a range of clinical health care functions that require timely or rapid intervention, including emergency medicine, trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care and short-term inpatient stabilisation (Hirshon et al., 2013; WHO, 1998; 2013).

Aged care

Aged care environments encompass three main settings: the nursing home; RACFs; and community-based aged care. Community-based aged care delivers programs such as the 'Commonwealth Home Support Programme' and 'Home Care Packages Programme' to support the continued independence of senior Australians in the community and to assist older frail individuals to remain in their homes for longer (AIHW, 2018).

Patient acuity

Patient acuity describes the level of severity of patient illness. Major and critical issues facing the primary, acute and aged care sectors are an ageing population, ageing nursing workforce, increased prevalence of chronic disease, and changing consumer expectations that collectively influence patient acuity. This concept has a profound effect on the complexity of care required and a critical role in the stability of the work environment. High acuity patients have medical conditions that are unpredictable and require significant attention and more frequent observation. Such observation is well-documented to be the role of a qualified RN and could not be achieved by UHCWs, because they do not have the education or training to understand the pathophysiology of what they are observing. Senior Australians generally present with higher acuity because of higher rates of cognitive impairment, chronic disease, co-morbidities and poly-pharmacy.

Health literacy

The extent to which an individual has the ability to gather, process and understand basic health information and services in order to make optimal health decisions is known as health literacy. WHO defines health literacy as, *'...the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health'* (WHO, 2019b; p. online last updated 2019). Health literacy is an important factor in ensuring health and safety of people, as poor levels of health literacy contribute towards poorer health outcomes. Australian, state and territory Health Ministers endorsed the Commission's National Statement on Health Literacy as Australia's national approach in 2014 (Australian Commission on Safety and Quality in Health Care (ACSQHC), 2019). Factors that make up or effect a person's health literacy include communication skills and professional knowledge of laypersons and professionals, as well as the culture and demands of the health care and public health systems.

Nurse sensitive indicators

Nurse Sensitive Indicators (NSI) are a measure of nursing care performance and align with the clinical care standards outlined in Version 2 of the National Safety and Quality Health Service Standards (NSQHSS). The American Nurses Association (ANA) defines NSIs as *'...those indicators that capture care or its outcomes most affected by nursing care'* (Mueller & Karon, 2004; p. 2471). Examples of NSIs include harm from falls, pressure injuries, medication errors, hospital acquired infections and recognition of the deteriorating patient. Prevention of these involve expert nursing care, where critical thinking and analysis underpins the specific individualised care plan developed in collaboration with the patient/resident/consumer and their family. This ensures a rigorous clinical governance process is in place to measure nursing care provided and hold organisations accountable for the care that is delivered to individuals in their facilities.

Unregulated Health Care Workers

UHCWs are designated health care workers who support the delivery of nursing care by assisting people with personal care and activities of daily living (ACN, 2016a). Specifically, they are workers *'...whose roles include carrying out non-complex components of personal care for consumers that have traditionally been within the scope of practice of regulated health professionals; and may also,*

or otherwise, be provided by family, volunteers or significant others' (NMBA, 2007; p. 18). Their role covers aspects of traditional nursing care, with work ranging from domestic and maintenance tasks (e.g. housekeeping, laundry, gardening, household maintenance, social companionship, diversional activities, shopping, transport); through to assisting people with intimate personal care (e.g. hygiene, continence, skin problems and wounds, medications, assessing and monitoring health and capacity, mobility, other aspects of daily living for frail and dependent people); and working and supporting health professionals working in operating theatre settings, outpatient clinics, and other acute care units.

Confusion around terminology/nomenclature for the UHCW role exists within health care environments and the community (Duffield et al., 2014a). This is because UHCWs are employed across a wide range of primary, acute and aged care settings under a plethora of work titles. UHCWs work in acute clinical care settings – in hospitals, day procedure centres and in primary care centres; the slow stream rehabilitation sector; residential aged care and residential disability care sectors; in community home care, public health and aged care. They also work with ambulance services and they are privately contracted by individuals to work in homes. In addition, some of the titles used to describe UHCWs include: aged care worker, care support employee, health care assistants, health service assistants, personal care assistants, personal care attendants, auxiliaries or auxiliary nurses, resident care assistants, birth assistants, psychiatric aides, and (more commonly) Assistants in Nursing (AINs) which is an award definition under certain nursing awards. Many other titles exist in the literature both internationally and across Australia. The International Standard Classification of Occupations (ISCO) 2008 categorises all these UHCWs under the occupation title of 'Resident Care Workers in Health Services' (International Labour Organization (ILO), 2012). The title UHCW will be used throughout this paper.

A National Code of Conduct for Health Care Workers was introduced in 2015 by The Council of Australian Governments (COAG), however for unregulated health professionals this is largely determined by each state and territory (COAG, 2015), and implementation rates have varied across Australia. In addition, scope of practice for UHCWs is largely dependent on individual health services and units of competency completed as part of their training qualification. Whilst there is no consistent national qualification for UHCWs in Australia (Health Workforce Australia, 2014), most employers stipulate a minimum Vocational Education Training Qualification at the Australian Qualification Framework Level 3; with either a Certificate III in Health Services Assistance (HLT32512) or Certificate III in Individual Support (CHC33016). As a result, there is variability in educational preparedness amongst the UHCW workforce. This means there are inconsistencies in the recruitment of UHCWs for specified roles. It is important to note that while UHCWs are employed under individual contracts, the RN on duty is responsible and accountable for the activities they assign and delegate to the UHCW (NMBA, 2013). ACN has been advocating for regulation of UHCWs since 2016 (ACN, 2016a), calling for a minimum level of education, a defined scope of practice, and national codes, standards and guidelines.

Skill-mix and skills

The terms 'skill-mix' and 'skills' are often used interchangeably, despite having different meanings. While 'skills' refer to an individual's abilities and level of performance to complete certain tasks, 'skill-mix' is related to staffing and refers to the number of nurses and their level of knowledge and skills on each ward and on every shift (Brennan & Daly 2009; Fagerström, Kinnunen & Saarela 2018). 'Skill-mix' varies by the nature of each patient's needs and can significantly impact patient outcomes. A richer skill-mix is one where there is a greater number of RNs to other staff including UHCWs, ensuring more hours of nursing care are provided by qualified and appropriately trained RNs. Staffing with a richer skill-mix is ideal to achieving better patient outcomes for the consumer/patient/resident.

THE CURRENT SITUATION

The increasing ageing population means that demand for primary, acute and aged care service is also increasing and therefore the need to provide a skilled nursing and UHCW workforce in these settings is becoming more critical.

UHCW profile

UHCWs are estimated to make up a considerable portion of the Australian clinical workforce across all three health care settings, with 70 per cent representing the aged care workforce (HWA, 2014). Researchers rely on estimation, as there is no single data source to capture and report the full extent of the UHCW workforce (Australian Nursing Federation (ANF) 2009). Information such as the prevalence, distribution, characteristics, and qualifications of the UHCW workforce within different care settings is not easily or accurately available. Information is often not comparable across jurisdictions due to inconsistencies in nomenclature, scope and qualifications. This is a continued source of concern, requiring urgent action to be taken by the Australian Government to assist future workforce planning and provide the necessary protective measures for safeguarding all Australians accessing care.

Primary care sector

The health care system in Australia faces a number of ongoing challenges, including the provision of effective and coordinated care, an ageing population, rising prevalence of some health risk factors such as obesity and physical inactivity, and increased incidence of chronic conditions and multiple comorbidities. Significant variations may relate to geography, community and population characteristics, socio-economic circumstances, infrastructure, health status, and workforce mix and availability. Health services in rural and remote areas are particularly dependent on primary health care services. These challenges present a significant burden to the community and require a skilled workforce to address them.

Acute care sector

In the acute sector, it has been reported that one in nine patients suffer a complication soon after hospital admission and that these complications are costing in excess of \$4 billion a year for Australian public hospitals and more than \$1 billion a year for private hospitals (Duckett et al., 2018). These complications can be related back to inadequate care. Having an appropriately skilled and monitored workforce is therefore essential, and there must not be an increased reliance on UHCWs to meet service demand (Duffield et al., 2014b).

Aged care sector

Increasingly business models are being deployed where nurses are being utilised only for 'legislative requirements', with UHCWs fulfilling most of the traditional care elements. In 2019, the percentage of RNs working in aged care decreased by more than 6 per cent since 2003, and UHCWs were used to fill the shortfalls (Australian Ageing Agenda, 2019). This is of serious concern considering that an increasing number of people entering RACFs are presenting with higher care needs (Willis et al., 2016), and UHCWs have a limited and varied degree of training and preparation.

Interestingly, the Royal Commission into Aged Care Quality and Safety recently heard that more than 50 per cent of Australia's aged care workers have no dementia training despite the majority of those in nursing homes living with the disease (DoH, 2019). At a time of increasing health and aged care service demand, retaining the number of nurses should be a key priority and ACN's position is that regulation of RACFs should mandate a requirement that an RN be on-site and available at all times to promote safety and well-being for residents (ACN, 2016b; 2016c). Despite these facts, the current Aged Care Act 1997 (Cth) has failed to establish and legislate safe staffing levels and 'skill-mix' in this setting.

Staffing, 'skill mix' and outcomes

There is significant evidence base that links higher levels of qualified RN staffing to improved patient outcomes, including reduced rates of mortality, and it will be the 'safer care' provided by RNs that will 'save money' in the long term (Duckett et al., 2014). This is particularly relevant in the acute and aged care sectors, where some of the biggest challenges faced are due to poor staffing levels, fewer RNs, increased patient acuity (Allard et al., 2016; Chenoweth et al., 2014; Gao et al., 2014; Henderson et al., 2016; King et al., 2013), and ongoing reduced funding (Ansell et al., 2016). Therefore, the Australian government is urged to undertake policy reform; to provide minimum safe RN staffing levels, and appropriate skills and 'skill-mix' in all health care settings; as well as to amend the *Aged Care Act 1997* (Cth) to mandate safe staffing and 'skill-mix' levels.

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In terms of the deployment of the UHCW workforce in Australia, there are currently two models; substitutive (replacement of RN model) and complementary (additive to RN model) staff mix models. ACN believes that the UHCWs should be deployed to provide support only, and never as substitutes for RNs or ENs. The staff mix model employed has a direct impact on 'skill-mix'. The literature demonstrates that having an adequate 'skill-mix' of staff available is more important than having a specific number of nurses on duty (Duffield et al., 2011; 2015; Jacob et al., 2015; Roche et al., 2012).

Furthermore, with regard to the relationship between the EN and RN, the Nursing and Midwifery Board of Australia (NMBA) states in the Enrolled Nurse Standards for Practice that: The EN works with the RN as part of the health care team and demonstrates competence in the provision of person-centred care. Core practice generally requires the EN to work under the direct or indirect supervision of the RN. At all times, the EN retains responsibility for his/her actions and remains accountable in providing delegated nursing care. The need for the EN to have a named and accessible RN at all times and in all contexts of care for support and guidance is critical to patient safety. This determination was based on the evidence that arose from the most recent EN Standards Review. Given that the EN has a two-year Diploma qualification, the need for access to, support from and supervision by RNs for the UHCWs is critical, evident and much greater. The staffing and 'skill-mix' of RNs to UHCWs must increase to reflect the true acuity of the consumer/patient/resident population.

An important factor in staff mix models is patient acuity (see Definitions section) as this is the major determinant of the complexity of care required. As the population ages and rates of chronic disease and co-morbidities increase, so too does patient acuity in this cohort. High acuity patients can present with medical conditions that are unpredictable, require significant attention and more frequent observation. Such consumers/patients/residents can only be safely managed by RN staffing.

Economic considerations

Significant evidence and research over the years has shown that employing an adequate number of RNs relative to UHCWs leads to a reduction in accidents and cost of complications, as well as an improvement in quality of care in RACFs (Bail et al., 2013; McCloskey & Diers, 2005). One such study conducted in Australia, using NSW hospital discharge data for public hospitals of people aged 50 and over, over one year, found that a higher proportion of RNs and lower workloads have been associated with decreased levels of key complications (Bail et al., 2013). Modifying staffing 'skill-mix' of RNs and workload may reduce or prevent common key complications in dementia patients including incontinence, urinary tract infections, pressure ulcers, pneumonia and delirium, which in turn reduces the costs associated with these preventable complications.

Other studies have found that inadequate nurse staffing can increase health care costs by 40 per cent (McCloskey & Diers, 2005), and contribute to adverse events which cost approximately \$4 billion per year (Armstrong & Reale, 2009). Registered nursing care is positively associated with a reduction in adverse events including pneumonia. Pneumonia has been shown to increase length of stay in hospitals by 75 per cent, which means a 220 per cent increase in the probability of death, and an 84 per cent increase in costs (Armstrong & Reale, 2009). This highlights potential financial savings for the health care system and the economic value of employing RNs across health and aged care sectors (Duffield et al., 2014b; Twigg et al., 2013).

Further, research consistently shows that people receiving skilled and adequate palliative and end of life (EOL) care in RACFs and within the community have fewer hospitalisations, shorter lengths of hospital stay, reduced use of Intensive Care Units and fewer visits to Emergency Departments (Palliative Care Australia (PCA), 2017), which translates to lower health care costs, as well as positive patient and family experiences. RNs play a pivotal role in offering palliative care services, including the administration of medications to provide comfort during the end stages of life (Wilson et al., 2014).

Management and prevention of NSIs, such as harm from falls, pressure injuries, medication errors, hospital acquired infections and recognition of the deteriorating patient, require nursing care where critical thinking and analysis underpin the specific individualised care delivered to a resident (Henneman et al., 2012). Research in Canada has linked more RNs in the staff mix to better patient outcomes, and the presence of more experienced RNs to lower mortality rates (Duffield et al., 2006). Similarly, a European study has found that the more UHCWs present relative to RNs, the higher the mortality rates, patient dissatisfaction and poorer the quality and safety of care is (Aiken et al., 2017). Additionally, studies in the US (Dall et al., 2009; Martsolf et al., 2014) concluded that employing relatively more RNs leads to greater economic value because the higher wages of RNs are offset by the reductions from length of hospital stay, use of intensive care, as well as fewer costly adverse events such as hospital acquired infections and lower readmission fees.

Scope of practice and educational requirements

Another concern is the lack of consistent guidance for UHCWs as to conduct and education. The scope of practice of UHCWs is largely dependent on the requirements of individual health services. Such lack of consistency makes appropriate delegation and supervision of care by RNs unpredictable, despite the RN retaining overall accountability for the provision of quality, coordinated care (Roche et al., 2016). Without consistency, providers cannot ensure appropriate levels of supervision (ACN, 2016b; 2016c). It is therefore imperative that appropriate standards and guidelines are in place to facilitate the safe management of UHCWs in acute, primary and aged care settings.

Further, most consumers/patients/residents do not have high or adequate health literacy (see Definitions). They are unable to understand clinical terms or convey their issues in a way that allows them to make optimal decisions about their health. A major contribution of RNs is their ability to communicate with patients and spend time with them to understand their needs and bridge the gap in their health literacy by communicating with other health professionals responsible for the care of these consumers/patients/residents. However, due to inconsistencies in their training and education, as well as an inconsistent level of understanding in core knowledge and clinical content, UHCWs are unable to communicate adequately with or on behalf of consumers/patients/residents. Further, the health literacy of UHCWs in some instances is limited due to lack of/limited ongoing professional development or minimal standards of training in health. This can increase risk of abuse and neglect in patients.

A 2015 review of the Registered Training Organisations (RTOs) raised concerns about the quality and consistency of qualifications awarded by RTOs (Australian Skills Quality Authority (ASQA), 2015). The educational level of much of the UHCW workforce is difficult to pinpoint, as there are so many different titles, roles and work settings. In most settings, there are no specific levels of educational preparation required to do the work. Reforms following that review include a requirement that all certificate training must undertake a minimum 120-hour workplace placement, with competencies assessed in the workplace.

Additionally, the Aged Care Workforce Taskforce (ACWT) has identified that the current education and training skills and qualification framework does not align with work practices, consumer-focused care and leadership required in the industry (DoH, 2018). While vocational education at Certificate III or IV level in aged care for UHCWs is supported by many providers, there is evidence that this support is not industry wide; and that it may not be adequate for the role these care workers have.

Workforce attraction and retention

Of the three major health sectors, aged care settings are most likely to be experiencing difficulties in attracting and retaining an RN workforce due to ‘...lack of competitive wages’ (DoH, 2018). RNs working in acute care are paid significantly more to do the same work. Additional challenges include limited or poor educational opportunities, lack of opportunities for career development, poor management of RACFs, and excessive regulation of scope of practice (Productivity Commission 2011a; 2011b). The issue of loss of experienced nurses is profound, as it has been predicted that there will be a shortage of 109,490 nurses by 2025, which is a 28 per cent shortfall on estimated demand. However, by retaining one in five nurses, the predicted shortage can be prevented (DoH, 2013a).

Acuity and patient choice

An increase in Australia's population means that at times primary, acute and aged care services are at or beyond capacity. We no longer have patients who are traditionally treated as passive recipients of care – there is an increased focus on patient choice. Today health consumers, their families and friends have strong and strident opinions about care partnerships as well as about the safety and quality of care that is expected in health care.

In recent times there has been a greater focus on aged care and patient choice. The ageing population is increasing rapidly and as a result, the acuity of Senior Australians in aged care has increased over time (Parliament of Australia, 2002). This is due to the prevalence of multiple comorbidities, polypharmacy, and some level of cognitive impairment in the ageing population. In the aged sector alone, 75 per cent of people living in RACFs are aged 85 years or older; 50 per cent suffer from some form of dementia; 87 per cent require high-level care; and 80 per cent are known to have a mental health condition (AIHW, 2016a). Data also shows that there has been a substantial increase in the number of individuals in RACFs (Bond-Smith et al., 2018).

Despite the fact that much of the literature in aged care focuses on the consumers' freedom of choice (Australian Human Rights Commission (AHRC), 2012), in reality the acuity of these individuals is very high and the level of individual choice for those who require high-level care, including nursing care is often limited, particularly in rural and remote settings. UHCWs are often the main or single point of contact for care and supervision in primary and aged care settings. When the care that is being provided by UHCWs in primary and aged care environments is examined, there can be no doubt that it falls firmly within the definition of nursing care (as per Definitions section). UHCWs are neither appropriately trained nor possess appropriate knowledge and critical thinking to understand when care needs are changing or deteriorating, and when care needs require urgent attention. From a public safety and quality perspective, this is unacceptable.

In order to fulfil high level care needs of Senior Australians and provide true choice, presence of RNs in an appropriate 'skill-mix' and with adequate staffing levels is required (ICN, 2018). Such a requirement does not preclude the use of UHCWs, but it raises concern around how UHCWs are capable of providing nursing care without adequately qualified nursing supervision and support. Further, future residents should be made aware of the resident to RN ratio (skill-mix) and skill level within a facility, in order to make informed decisions about their care (Access Economics, 2009).

ICN (2018) also urges that RNs not be substituted with less qualified workers in the interest of patient safety. Better patient outcomes are known to be achieved within a staff mix model of richer 'skill-mix' (more hours of care provided by RNs). In fact, the increased reliance on UHCWs (in a substitutive model whereby RNs are replaced by UHCWs), can result in work environments with poorer or diluted skill-mix levels, which in turn can reduce RN job satisfaction and affect patient care outcomes negatively (Duffield et al., 2014a; 2018; Twigg et al., 2016). Further, there are adverse effects to patient outcomes such as mortality, respiratory failure, cardiac arrests, infections and falls (Aiken et al., 2012; Duffield et al., 2015; Kane et al., 2007; Lankshear et al., 2005; Needleman, 2016; Rafferty et al., 2007; Wise et al., 2014). On the other hand, when more hours of care are provided by RNs rather than UHCWs (in a complementary model), patients are likely to have fewer days of hospitalisation, lower rates of urinary tract infection, gastric haemorrhage, pneumonia, shock, and cardiac arrest (Needleman et al., 2002).

End of Life Care

People receiving EOL care in the last six months of life incur significant costs as a result of increased health service use. Hospitalisations account for 80 per cent of the total cost of EOL care (Reeve et al., 2018). With the growth of advanced care directives (i.e. an individual's expressed wishes for EOL care) and the legalisation of voluntary assisted dying in Victoria, it is evident that there is a strong consumer movement towards people having more control over their EOL care. There is growing evidence that Senior Australians are coming into nursing homes/aged care settings at a more advanced stage of their illness and that their length of stay from admission to death is reducing. This is because an increasing number of Senior Australians are opting to stay in their home for longer and are choosing not to move into aged care settings.

Whilst this is highly positive in enabling people to stay at home longer, it nevertheless indicates that when many people are admitted to an aged care setting, they are coming in for EOL care. Skilled and dignified EOL care requires: precision symptom management, careful titration of pain management, and compassionate management of family and loved ones (Becker, 2009). This is clearly the domain of nurses and patients who are in need of this level of care require specialised RN input, supervision and support. However, Senior Australians are receiving EOL care by UHCWs with no or minimal training in dignified EOL care to ensure the wishes of these individuals are respected (i.e. advanced care directives).

As part of this, palliative needs of residents within nursing homes and RACFs also need to be considered. WHO defines Palliative Care as *'...an approach that improves the quality of life of consumers and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'* (PCA, 2017; p. 1). Palliative care is for people of any age who have a serious illness that cannot be cured. It offers a support system to help people to live their life as fully and as comfortably as possible until death and to help families cope during this illness and in their bereavement. People are approaching the 'end of life' when they are likely to die within the next 12 months, which includes a majority of RACF residents. This highlights the need for access to palliative care trained RNs to supervise UHCWs and ENs in the nursing home and RACF settings.

THE FUTURE

Along with Australia's growing population, the ageing demographic is going to increase and Senior Australians are already expressing a preference to remain in their homes longer. Consequently, there will be an increased emphasis on nursing care provided in the community and within primary health care, both of which mean that the acuity of older people entering aged care settings will continue to increase. In the future, there will be a need for RN and EN staff and support care workers who are skilled in providing EOL care and family/carer support.

More importantly, in the future there will be a need for a more sensitive approach to the personal needs of some groups in the primary, acute and aged care sectors who continue to face disadvantage that affects both their mental and physical health and their opportunities for social and economic engagement within their communities. ACN recognises the unique needs of Aboriginal and Torres Strait Islander peoples. Equally, due regard must also be given to the unique needs of culturally and linguistically diverse (CALD) groups and lesbian, gay, bisexual, transgender and intersex (LGBTI) people in order to provide appropriate, safe and individualised care. As diversity within Australian society increases, there will be no standardised approach that fits all. Therefore, the educational needs of the health workforce will always be determined by the communities in which they serve. There will be a need to be more liberal and sensitive about these issues and therefore it is imperative that innovative models of care and best practice models are developed to address them (Pezzullo, 2018).

Workforce needs

Given the complexity of care required by primary health care consumers, the current 'skill-mix' of the nursing workforce is inadequate to meet current and projected care needs in the primary, acute and aged care sectors. In addition to concerns around skills and 'skill-mix', Australia has a retention issue. In the aged care setting alone, the Productivity Commission estimated that the number of nurses and personal care attendants must quadruple by 2050 to meet the demand for aged care services (Productivity Commission, 2011a; 2011b). ACN believes that overall improvements in the aged care system and workforce reform will increase retention of the current workforce, therefore minimising the need to create a new workforce.

Aged care facilities

The Aged Care Workforce Strategy Taskforce (DoH, 2018) led by Professor John Pollaers OAM identified 14 strategic actions for the current and future workforce. While ACN endorses all actions, particular emphasis for this white paper is focused around:

Strategic Action 3 – Reframing the qualifications and skills framework – addressing current and future competencies

Strategic Action 4 – Defining new career pathways including how the workforce is accredited

Strategic Action 6 – Establishing a new industry approach to workforce planning, including skills modelling.

ACN holds the view that care delivered in RACFs must be and can only be led by RNs, due to the growing prevalence of co-morbidities associated with physical and cognitive decline, polypharmacy, and greater professional accountability, which requires care that is more complex. The RN scope of practice enables the high-level clinical assessment, clinical-decision making, nursing surveillance and intervention, service coordination, and clinical and managerial leadership required to meet desired outcomes and to ensure the provision of high-quality care. RNs provide frontline leadership in the delivery of nursing care and in the coordination, delegation and supervision of care provided by ENs and UHCWs (NMBA, 2016b). The continuous presence of an RN is essential to ensure timely access to effective nursing assessment and comprehensive nursing care, and to the evaluation of that care. RNs work within an integrated team of licenced health professionals and are able to communicate, engage and advocate on behalf of patients/residents.

ACN does not dismiss the vital role that UHCWs have in caring for Australians. However, ACN maintains that these workers need to be registered and supervised. This would ensure robust clinical and corporate governance, a greater accountability for the work undertaken by UHCWs, leading to better patient/resident/consumer outcomes.

The community aged care sector in Australia is undergoing a major shift, in line with the diverse needs and expressed wishes of the Australian public, particularly Senior Australians. As a result, the aged care workforce needs to be better prepared. In general, our future primary health and aged care sectors will require:

- Workforce development that is planned and provides for a health workforce with appropriate skills and health professional group mix
- A health workforce that has the appropriate qualifications and experience to provide safe, high quality care across the continuum
- Workforce development activities in place that improve quality and safety in ways that are coordinated and efficient
- Care that meets community expectations and standards of performance are clearly communicated
- A workforce that is supported through education, development and mentoring
- A workforce that is flexible and agile and working to their scope of practice
- A workforce comprised of a multidisciplinary team where teamwork is promoted and fostered (Pezzullo, 2018).

Primary care

Training UHCWs, particularly those who provide home care, becomes more important as medical and technological advances permit more persons with complex needs to live in the community rather than in specialised institutions. Moreover, UHCWs' frontline role needs to be recognised and valued in service delivery across all health sectors.

However, it is imperative that these workers are regulated to enable them to provide high quality safe care to vulnerable communities that may include young people with disabilities as well as Senior Australians. This is particularly important due to the additional risk of abuse involved for those receiving care at home with limited health literacy, limited mobility, communication and understanding due to frailty and/or disability. Often in these cases, there is limited or no supervision or quality assurance involved in care delivery.

UHCWs must be regulated and nationally consistent nomenclature/titles, code of conduct, professional standards and scope of practice must be developed and implemented.

There are four elements to regulation (Chiarella & White 2013). These are as follows:

1. **Admission to a register based on the preparation and scope of practice of those who are eligible for admission. Such eligibility would include (at a minimum) evidence of meeting set educational standards and criminal record checks. On annual or biannual renewal of registration, this would also include a requirement for mandatory continuing professional development and recency of practice.**
2. **Accreditation of the programs leading to the preparation of those who are eligible to go onto the register. This would include minimum hours, clear curriculum, and clinical preparation requirements.**
3. **The development of guidelines for best practice. These would include a code of conduct, standards for practice and other advisory documents as necessary.**
4. **A clear statutory mechanism for receipt, management, investigation and prosecution of complaints about health care workers who are on the register.**

Leadership across the spectrum

ACN believes it is timely to focus on nurse leaders in any examination of the health care workforce. Strong leadership is key to effective aged care and primary health care service planning and delivery. RNs oversee and provide frontline clinical leadership. They assess, plan, implement and evaluate essential nursing services. RNs working as clinical leaders provide education and guidance to their nurse colleagues and other health workers and engage in consumer advocacy and support (NMBA, 2017).

ACN's (2015) White Paper, *Nurse Leadership*, explains that the term 'Nurse Leader' applies to nurses who work effectively to improve health care delivery whether working at the care delivery or board level. Nurse leaders are individuals who have a broad knowledge of the forces shaping health care and aged care including political, societal and economic factors. Typically, they are equipped with a deep understanding of nurses' working conditions and play key roles in fostering supportive work environments and in the recruitment and retention of an appropriately skilled workforce.

Nurse leaders in executive roles use their nursing knowledge to influence the strategic direction of an organisation and to inform operational planning. Clinical nurse leaders are involved in the coordination, delivery and monitoring of evidence-based practice care and continuous quality improvement activities. Nurse leaders' decisions have a direct bearing on the development of nursing systems and these systems are inextricably linked to meeting the challenges of delivery of quality health care.

RECOMMENDATIONS

In light of the discussion and research presented in this White Paper, ACN has two key recommendations that are essential for the safety and health of Australians:

1. UHCWs must be regulated and nationally consistent nomenclature/titles, code of conduct, professional standards and scope of practice must be developed and implemented.

2. The UHCW workforce must be regulated to achieve nationally consistent, minimum educational and ongoing professional development requirements.

CONCLUSION

The nursing profession must play a key role in policy reform within the primary, acute and aged care sectors, particularly around existing and emerging service and workforce demands. The nursing opinion must be sought when decisions are being made about the sustainability of the nursing workforce and the regulation of UHCWs (who are unquestionably already performing nursing work) across all health care sectors. Direct care nurses and nurse leaders bring a unique perspective of real life, real time concerns and shortfalls currently faced in the primary, acute and aged care sectors. Nurses have witnessed the harm/detrimental effects experienced by those who rely on care from the health and aged care system, which has thus far failed to regulate UHCWs who are increasingly providing nursing care without adequate qualifications to ensure patient safety. As the pre-eminent professional nursing body, ACN is committed to working with the Australian Government and industry to facilitate a sustainable, appropriately skilled and regulated workforce to meet future health care needs of all Australians.

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“The nursing profession is, and has always been, committed to serving and protecting the public through the care we provide. As we move to a future of unprecedented ageing and complexity in our population growth it is imperative we continue to advocate for what is in the best interest of the communities we serve. The regulation of the third tier worker, undertaking nursing duties, is essential now and into the future so all family and friends can be assured that their loved ones receive safe and appropriate care”

**ADJUNCT PROFESSOR KYLIE WARD FACN
CEO, Australian College of Nursing**

