Assistants and support workers: workforce flexibility to boost productivity – Full report

June 2014
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Suggested citation: Health Workforce Australia 2014: Assistants and support workers: workforce flexibility to boost productivity – Full report
## Contents

Key definitions 6

Executive summary: analysis of assistant and support workforce in Australia 7

- Purpose 7
- Scope 7
- Methodology 7
- Context 8
- Findings 9
- The proposed way forward 10

Introduction 13

- Purpose of this paper 13
- Project scope 13
- Terminology 14
- The analysis methodology 14
- Limitations 15

Background 16

- Demand 16
- Supply 16
- Distribution 17
- The reform agenda 17

Current use of assistants 20

- Assistant characteristics and work features 20

Analysis 23

- Evidence for using assistants 23
- Barriers and limitations to using assistants 32

Validity, appropriateness and feasibility 39
Future directions: the proposed way forward 45
Conclusion and recommendations 49
   Policy and practice recommendations 50
   National support to strengthen local implementation 50
   Invest in the assistant workforce 50
   Promote recruitment and retention 51
   Establish national training and education requirements 51
   Use evidence to shape and direct reform 52
   Undertake evaluation and research 52
Appendix 1: List of stakeholders 53
Appendix 2: AIHW Australian hospital statistics 2011–12 54
Appendix 3: Health and community service employment 55
Appendix 4: Services and skills match 57
Appendix 5: Assistant characteristics and work features 58
   Where do assistants work, what are their characteristics, pathways to employment, and training? 58
   Assistant recruitment and retention 61
Appendix 6: Characteristics of assistants – personal care workers (PCWs) 63
Appendix 7: Assistants required – skill shortages and vacancies in residential aged care 64
Appendix 8: Assistant recruitment and retention factors in aged care 65
Appendix 9: Overseas supply for ANZSCO codes 4231 and 4233 66
Appendix 10: Applicable VET training packages for ANZSCO codes 4231 and 4233 70
Appendix 11: Pathways to a nursing or midwifery career in WA 72
Appendix 12: Post-school qualifications in residential aged care and community care workers 73
Appendix 14: ABS role definitions for workers classified under ANZSCO codes 4231 and 4233 83
Appendix 15: Care contribution models 85
Appendix 16: Case study 1– MPA scoping study 97
<table>
<thead>
<tr>
<th>Appendix 17: Assistant workforce – Australian state and territory overview</th>
<th>98</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 18: International Reviews relevant to assistants and Support workforce</td>
<td>107</td>
</tr>
<tr>
<td>Appendix 19: Framework to guide decisions – Support nationally, act locally</td>
<td>109</td>
</tr>
<tr>
<td>Appendix 20: A framework for optimising human resources in healthcare</td>
<td>115</td>
</tr>
<tr>
<td>Appendix 21: Guiding principles – assistant and support workforce (Example only)</td>
<td>116</td>
</tr>
<tr>
<td>Glossary</td>
<td>119</td>
</tr>
<tr>
<td>References</td>
<td>120</td>
</tr>
</tbody>
</table>
Key definitions

Throughout this report ‘assistant’ is used as a generic term to cover all groups nominated in the scope of this analysis, including those key roles below.

‘Assistant’ is a broad term used in this analysis for ease of reading and as the general principles and issues are applicable to all workers who assist or support. It does not denote any industrial term or condition or attachment to a professional discipline, sector, setting or training.

**Assistant:** Assistants work to and under the delegation and supervision of a health professional, take on less-complex treatment or care tasks, and perform administrative or other tasks that would otherwise reduce the time available for more complex direct care by more highly trained practitioners (Health Workforce Australia 2013). For the purpose of this analysis ‘delegation’ means assignment of responsibility to another person (normally from a manager to a subordinate) to carry out specific activities and tasks.

**Support worker:** Support workers undertake a broad range of health or care roles within defined service plans, reporting to a supervisor. They provide person-centred support and consumer-directed care to people in community and residential settings. Work may be carried out under regular direct or indirect supervision or be autonomous (self-directed recovery-oriented support). Support workers may be used interchangeably with assistants in some contexts.

**Personal care worker:** Personal care workers are those workers other than registered or enrolled nurses and hospital orderlies who provide personal care, general household assistance, emotional support and companionship for aged persons and those with disability.

Further terms are covered in the glossary.

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Executive summary: analysis of assistant and support workforce in Australia

Purpose

Assistants and support workers have always been an important part of the workforce. They contribute to health, ageing, disability, mental health and social care in the public, private and non-government sectors.

“These workers represent the largest part of the health care and social assistance workforce, at 50 per cent of the total (CSHISC 2013).”

There is significant potential for this workforce to help meet the challenges posed by workforce shortages, escalating costs and increasing demand and systemic barriers. To date, this potential has not been met.

This paper seeks to establish how the introduction and expansion of assistant roles can assist health care and teamwork and contribute to wider workforce reform to boost productivity.

Scope

‘Assistant’ is a broad term used to cover all workers who assist or support, and includes:

- allied health assistants (AHA)
- nursing support workers and assistants in nursing (AiN)
- personal care workers (PCW) and patient care attendants (PCA)
- medical practice assistants
- peer workers (although the lived experience component is different for this group, many of the issues are similar).

For the purpose of this paper, the analysis includes all workers defined under the Australian and New Zealand Standard Classification of Occupations (ANZSCO) codes 4231 and 4233.2

These assistants work across the range of community to acute care, assisting with basic care through to more complex needs. While this analysis primarily focuses on assistant roles in health, its findings can also be applied to other areas such as aged care and disability care and, indeed, draws on evidence from these areas. The paper does not address industrial or regulatory issues pertaining to assistants and support workers.

Methodology

This paper examines assistants’ contribution to and fit with healthcare teams and the broader workforce reform agenda.

It analyses the available evidence relating to the assistant workforce, including:

- the characteristics of the Australian assistant workforce
- current Australian assistant workforce roles, scopes of practice and models
- tested models for the most efficient and effective use and skills mix in healthcare teams
- the barriers and enablers to large-scale and consistent uptake of this workforce.

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2 All allied health assistants may not be captured under the therapy aides code 42331 but are included in this analysis.
The information is investigated against:

- the contribution and validity of the assistant role in services and teams
- the appropriateness of assistant roles and functions
- the feasibility of introducing and expanding assistant roles in terms of cost, supply and training.

The analysis then explores how assistants contribute to:

- boosting productivity and flexibility
- delivering more effective, efficient and accessible service
- building workforce capacity and skills development.

**Context**

Skills shortages, cost pressures and changing demand are driving new thinking on how health and social care are managed. Addressing workforce issues is a critical part of this new thinking. Larger numbers of health workers alone will not solve the existing problems of poor distribution of providers and skills across underserved communities (Health Workforce Australia 2011b).

**Demand**

The changing burden of disease related to preventable long-term chronic and complex conditions and population ageing has driven an increase in demand for health services.

An illness-oriented health system is largely relied upon as the first point of care. This is reflected in a 7.4 per cent rise in hospital separations for people aged 85 and over in 2011-12, compared with the average overall increase of 4 per cent in the same period (see Appendix 3).

The drivers of demand will continue to make the health workforce the largest employment industry in Australia (CSHISC 2012). The design of the future workforce must be based on client needs.

**Supply and distribution**

Health and community services currently employ 1,375,000 health and social assistance workers (12 per cent of the population). This is predicted to increase to 1,778,000 workers by 2016-17. A conservative estimate predicts a further increase of 427,000 workers by 2025 (CSHISC 2013).

Labour studies estimate an increasing need for assistants, particularly in the aged care industry. However, there are shortages in supply. Sixty per cent of aged care workers will retire in the next 10 years and volunteer numbers are declining.

Health Workforce 2025 (HW2025) projected distributional shortfalls in doctors and overall shortfalls in nursing numbers, particularly in aged care and mental health.

There is also a mismatch between the location and deployment of the workforce and where the growing need for care exists (HWA 2012a). This is driven by the trend towards increasing specialisation to manage the most complex but relatively lower volume populations.
The case for reform

Worldwide skills shortages and a need to contain costs and manage increasing and changing demand are driving a major rethink of how care is organised, delivered and sustained. Health Workforce Australia (HWA) is focusing on how to use the total health workforce to its full potential to meet the current challenges.

Increasing productivity is a key to delivering and sustaining a nationally self-sufficient health workforce. Among other things, this requires greater flexibility, capacity, efficiency and effectiveness. It also demands improvements to access, responsiveness and safety of services. Reduction in acute and chronic demand can be delivered through such mechanisms as prevention and early intervention.

The future health and care workforce will require more generalist skills and shared competencies for cross-sector care and improved ways of using clinician experience to best effect.

A priority for government, non-government and private organisations is to use the total workforce to its full potential for both depth and breadth of services, and to address increasingly costly systemic barriers and impediments to workforce change.

Assistants will be integral to these approaches. However, their roles in health have often been established in the absence of clear guidelines and tools; they are often under-utilised and their value and contribution has not been sufficiently recognised. Their contribution to the future workforce has not been fully explored or supported.

Findings

Barriers and challenges to reform

Barriers and challenges exist to making the best use of assistants. These include:

- perceptions around their impact on quality and safety
- concerns about regulation
- concerns about supervision and delegation
- concerns about skill level and training
- lack of clarity around their roles and functions
- the unpreparedness of organisations and professionals to use the role of assistants and at the same time review the roles of other team members
- supply issues, including recruitment, retention, and job satisfaction
- lack of evidence about the cost-effectiveness of using assistants as a single group
- a continuation of piloting assistant roles, where evidence of their use and impact is not shared.

Reforms to use and expand this existing workforce in the most productive way must address these barriers.

The value of the assistant workforce

Assistants should not just be a means to an end, but a group of importance and interest in their own right across health, aged care and disability services.

The evidence suggests that, within sound models of practice, when assistants are provided with appropriate training and support, they can enhance:
• service delivery and allow for a re-focus of delivery to areas of need
• workforce flexibility and team efficiencies
• client outcomes.

They bring important attributes that are valued by clients and carers. Their core attributes as helpers and enablers, companions, facilitators and monitors are specific to their practice and operate as a bridge between themselves, clients and professionals. These generalist skills can be used to create efficiencies and flexibility within and across teams, and community or acute care.

With appropriate training, skills development, governance and supervision they can take on a range of tasks and responsibilities from basic clinical work to support functions. They can work within single disciplines or in multidisciplinary teams.

In the community and home-care sectors, they can work with remote supervision to contribute to delivering primary health care and early intervention to reduce demands on the acute health system.

The role of assistants is feasible to implement in terms of cost, supply and training.

**The proposed way forward**

Assistants should be recognised and used as a:

• valued workforce that helps manage skill and time shortages, supports more effective use of professionals, enhances service breadth and depth, and enables more active participation by clients in their care and continuity of care
• safe workforce that is trained and actively supported by organisations and supervising professionals
• flexible workforce that offers the best choice of staff to deliver certain aspects of care, and provides an essential balancing role for more efficient and effective interdisciplinary teamwork
• cost-effective workforce that is affordable within the right skills mix, agreed governance, and leadership arrangements, and where untapped sources of supply can be supported.

It is recommended that reform should be pursued through six main aspects:

• support stronger local implementation
• invest in the assistant workforce
• promote recruitment and retention
• establish national training and education requirements
• share the evidence to shape and direct reform
• undertake evaluation and research.

**National support to strengthen local implementation**

This analysis provides high-level guidance for developing and implementing assistant roles.

*Support nationally, act locally* is a step by step guide using the available evidence. Its purpose is to strengthen employer’s decision-making to achieve flexibility, good governance and workforce affordability, and at the same time manage the variation between jurisdictions. This guidance will:

• start from local context and requirements for change
• determine the relevant model of care and evidence-based principles underpinning it
• determine current and future skills mix using a capability approach
• determine which contributions assistants are required to make and the subsequent changes in other roles to capture net productivity
• agree, document, orient and train the whole workforce in local governance arrangements
• use available case studies to ‘push the boundaries’ and support the change
• use team metrics to demonstrate whole-of-workforce change in productivity or service access and responsiveness
• harness the professional and distributed leadership capacity to actively address the barriers to introducing assistants
• ensure assistants are not required to undertake work for which they are not trained.

Reform, at the local and national levels, has the best chance of success when it includes initial service analysis and takes a structured approach to change, leadership and stakeholder engagement.

**Invest in the assistant workforce**

Reform must capitalise on the existing workforce and tackle uncertainty by:

• providing support to clarify roles and arrangements for governing safety and quality
• offering assistants access to continuous practice development
• authorising and acknowledging assistants as an integral part of the workforce design by:
  » using a mix of generalist and single-discipline roles and both task and assigned workloads
  » ensuring responsibilities are as important as roles
  » articulating different levels of assistant scopes of practice (full, expanded and advanced), aligned with the local context
  » using partial role substitution, complementation and supplementation to optimise care and resource use
• aligning workforce roles and placements with models such as consumer-directed care, the wellness (or active service) model and early intervention
• improving skills in delegation, supervision and confirmation of competency to practice
• improving arrangements for supervision of generalist or combined roles
• investing in a team culture which values the development of assistant roles.

**Promote recruitment and retention**

A transparent and rewarding career structure must be developed to promote the assistant role as a valuable one and career choice in its own right.

This requires articulation into expanded roles as well as pathways into professional qualifications.

As a priority, work must be undertaken with relevant agencies to develop the supply pathways for recruitment and retention that:

• identifies relatively untapped sources that do not take from the existing health workforce, such as second-career seekers, volunteers wishing to formalise their expertise, and declining industries
• streamlines pathways and develops national benchmarks
• targets recruitment of assistants from overseas to match the increasing ethnic background of the ageing population
• ensures recruitment processes identify agreed attitudes and behaviours as the most important elements of competency for these roles
Establish national training and education requirements

An industry-wide process should be facilitated to determine whether a certificate III is desirable as a minimum level of qualification for all assistants, together with the variety of pathways to achieve that.

National agreement on elements of the HLT and CHC qualifications should take into account:

- the best combinations of core and elective units for individual settings
- common pathways of competencies, so that workers can move across sectors and respond appropriately to comorbidity and complexity
- this could be a common foundation certificate III, which is upgraded through a modular approach for additional technical skills for different sectors
- the assessment of certificates of attainment for local service needs and recruitment
- national data sets on modes of assistant deployment and training levels.

This is to ensure professionals know the scope of practice and capability of their assistant workforce, and what to delegate and authorise.

Delegation and supervision units should be part of core curricula in undergraduate clinical education. Simulated learning environments can be used to build acumen and adeptness in delegation, supervision and monitoring, and to adjust the appropriate responses to complex care needs.

Incentives for low paid workers should be determined that encourage them to engage in skills development (United Voice 2013).

Use evidence to shape and direct reform

Sectors and organisations must use the available evidence to promote and implement reform.

National repositories should be created to share the evidence, including:

- existing and tested implementation resources building on the work of jurisdictions and employer organisations
- case studies that demonstrate the benefits and uses of assistants
- case studies of the leadership and capability required to sustain the most productive use of assistants. These should be aligned with HWA Health LEADS Australia, the national common health capability resource and jurisdictional guides.

Undertake evaluation and research

Where assistants are introduced to a team or their role is enhanced to improve their contribution, team metrics should be used to:

- assess a whole-of-workforce baseline, ongoing productivity and client outcomes
- determine the cost-effectiveness of different types of skill mix and their impact on healthcare settings
- determine a threshold of optimal staffing mix below which care is compromised and above which there is no significant effect on quality outcomes.

Longitudinal studies should be conducted on where and how assistants are deployed to understand their use better and to measure the impact of retention strategies. National data sets specific to assistants should be created.
Introduction

Purpose of this paper

Assistants and support workers participate in health, ageing, disability, mental health and social care in public, private and non-government sector. They are located in metropolitan, rural and remote areas and in all settings.

They have a diverse range of roles and competencies, providing support to qualified professionals and to clients (Lizarondo et al. 2010).

Importantly, assistants represent the largest occupation group of the healthcare and social assistance workforce, comprising 50 per cent of the total (CSHISC 2013). The potential for this workforce to ease the burdens on the health and social assistance sectors is therefore, significant.

There is an urgent need for policy that focuses on these workers and their current and future contribution to healthcare and social care in Australia.

This paper presents an analysis on which such policy can be grounded. It looks at how assistants and support workers can be part of a response to whole-of-workforce reform and systemic change that addresses:

• workforce shortages
• growing demand for services
• escalating costs.

To do this, the paper identifies:

• the characteristics of the Australian assistant workforce
• current Australian assistant and support workforce roles, scopes of practice and models
• tested models for the most efficient and effective use and/or skills mix in healthcare teams
• the barriers and enablers to large-scale and more consistent uptake of this workforce.

While the aim of this paper is to assist the policy discussion on the assistant and support workforce, it acknowledges the extensive work already undertaken on the assistant and support workforce by the Australian jurisdictions and the private and non-government (NGO) sectors.

Project scope

Assistant roles span a continuum of care within the healthcare and social assistance sectors. They include:

• assistants (working under delegation and supervision and largely in health)
• support workers (working within defined person-centred or consumer-directed care plans in the community or in residential care, either autonomously or with supervision)
• care workers in the community (working autonomously).
This analysis primarily focuses on the first two roles for two reasons: these roles are relatively well defined and they offer scope for improved productivity. The models, scopes of practice and deployment of other workers, such as Home and Community Care (HACC) workers, community care workers, and aged and disability carers, have contributed important knowledge.

The analysis includes assistants:

• who are formally trained under vocational education and training, as well as those receiving workplace training
• in the public, private and non-government sectors
• in all settings, such as the community, residential aged care, rehabilitation, and subacute and acute care.

Irrespective of setting and titles for this workforce group, the main focus of this analysis includes:

• allied health assistants (AHA)
• nursing support workers and assistants in nursing (AIN)
• personal care workers (PCW) and patient care attendants (PCA)
• medical practice assistants
• peer workers (although the lived experience component is different for this group, many of the issues are similar).

For the purpose of data analysis, the Australian and New Zealand Standard Classification of Occupations (ANZSCO) codes used are 4231 (aged and disabled carers) and 4233 (nursing support and personal care workers, including therapy aides 423314). AHAAs and community care workers have also been included, although they are not clearly identified under these codes.

Assistants are not regulated under the National Registration and Accreditation Scheme. The Standing Council on Health made an in-principle decision to implement a national ‘negative licensing’ system for unregistered health practitioners. This will strengthen state and territory health complaints mechanisms via a proposed single national code of conduct for non-registered health practitioners. Regulation in each state and territory will give statutory powers to enforce the code by investigating breaches and issuing prohibition orders.

The analysis therefore does not address regulatory or industrial issues.

**Terminology**

‘Assistant’ is a broad term used in this analysis for ease of reading and because the general principles and issues are applicable to all workers who assist or support. It does not denote any industrial term or condition or attachment to a professional discipline, sector and setting, or to training.

**The analysis methodology**

Key questions and information are drawn from the peer-reviewed and grey literature (see Appendix 1) and shaped by the views and considerations of the public, private and NGO stakeholders who use assistants (see ‘Stakeholder list’ Appendix 2).

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3 See Glossary.
4 See: Decision Regulatory Impact Assessment: Options for regulation of unregistered health practitioners (Communiqué: August 2013). The Australian Nursing and Midwifery Federation (ANMF) has specifically called for registration of this workforce in the interests of public safety and in line with policy of The Royal College of Nursing (RCN) UK. The UK does not have an enrolled nurse category as exists in Australia; the roles of healthcare assistant (HCA) or healthcare support worker (HCWW) are well established; a further role of assistant practitioner has also been developed to respond to increasing complex demand. None of these is registered. In November 2013 the UK government announced it would not be registering its assistant and support workforce.
The information is investigated against three criteria:

- the contribution and validity of the role in services and teams
- the appropriateness of the roles and functions
- feasibility in terms of cost, supply and training.

The analysis then explores how assistants contribute to:

- boosting productivity and flexibility (HWA 2013a)
- more effective, efficient and accessible service delivery (HWA 2012b, Domain 1)
- building workforce capacity and skills development (HWA 2012b, Domain 2).

Evidence is drawn from:

- peer-reviewed research on the assistant role. There is a small but growing body of research in the Australian context, which also draws heavily on the UK and Canadian experience
- grey literature from local projects and pilots in profession-specific roles (nursing or allied health), generalist (often rural) and expanded roles. These projects introduce new models of care or strongly developed concepts waiting for funding. See examples from ACT Health, the Department of Health Victoria, the Tasmanian Department of Health and Human Services, Queensland Health and SA Health (Appendix 17)
- Strategies used by government, private and not-for-profit sectors to establish and use assistants (see Appendix 17). These include:
  » policy directions and strategies for more permanent integration of assistants into healthcare teams
  » innovation strategies to balance risk management and implementation of reform
  » implementation support for employer-led change
- anecdotal evidence of perceived safety and quality issues which impede the uptake and use of assistants in all settings (National Allied Health Advisors Committee 2012).

Limitations

Little attention has been paid to assistants in the workforce literature. Assistants are often included indirectly as a consequence of examining professional roles.

For this reason the methodology has been designed to strike a balance – taking care to avoid overstating or being selective, and at the same time treating the available evidence with the attention it deserves.

There is a hierarchy of evidence in which expressed opinions are not as useful in shaping policy and practice but are clear indicators of the range of views and issues to be resolved.

5  See NSW Health 2012; and HWA 2012c for Queensland Health models of care reform.
6  See, for example, Department of Health Victoria 2010; 2011.
7  WA Government 2008, Discussion paper: allied health assistants has a good summary of state and territory projects. See also: NSW Health 2012; Department of Health Victoria 2011; Queensland Health 2013; and WACHS 2008.
Background

This project investigates the use of assistants in the context of escalating health expenditure (Grattan Institute 2013). The cost of delivering healthcare in 2000-01 was $77.5 billion rising to $130 billion in 2010-11 (AIHW 2012a). This is combined with workforce shortages and increasing demand for services related to the population’s health needs.

These drivers require a major rethink of how care is organised, delivered and sustained. Larger numbers of workers alone will not solve existing problems of poor distribution of health providers across underserved communities (HWA 2011b), or match evolving needs with delivery of the right care from the right person in the right place, first time (HWA 2012a; Department of Health Victoria 2011) and across sectoral boundaries.

Demand

The changing burden of disease related to preventable long-term chronic and complex conditions and population ageing has driven an increase in demand for health services. By 2036 about 24 per cent of the population will be over the aged of 65 years; the fastest growing cohort is over 85 years (AIHW 2007). In Australia these trends account for a high financial burden and years of healthy life lost due to disability.

Demand is influenced further by fragmented access to health services, changes in consumer preferences (including consumer-directed care) and the emergence of new technologies. Clients report difficulties in navigating services and service gaps, insufficient services, and unmet needs such as lack of early risk identification and follow-up to prevent deterioration, which is often seen as a lower priority.

An illness-oriented health system is largely relied upon as the first point of care: ‘One of the biggest challenges for today’s professional workforce is that it was developed and trained to work around single episodes of care in a hospital’ (Imison and Bohmer 2013). This places unsustainable pressure on acute and general practice health services and can result in longer admissions (‘bed blockers’) and premature assessment for residential aged care. This is shown in a 7.4 per cent rise in hospital separations for people aged 85 and over in 2011-12, compared with the average overall increase of 4 per cent in the same period (see Appendix 3).

Supply

Health and community services currently employ 1,375,000 health and social assistance workers (12 per cent of the population). This is predicted to increase to 1,778,000 workers by 2016-17 (see Appendix 3). A conservative estimate identifies a further increase of 427,000 workers by 2025 (35 per cent), with an increased reliance on vocational education and training (VET)-qualified workers (CSHISC 2013).

Reduced funding growth may affect projected numbers but the nature of the demand will continue to drive high employment (where currently it is the largest employment industry in Australia) and spur the need for decisions about a sustainable and productive skills mix (CSHISC 2012).

Labour studies and environmental scans estimate an increasing need for assistants, particularly in the aged care industry. But there are associated shortages in supply. Sixty per cent of aged care workers will retire in the next 10 years. There is also a predicted decline in the 2.6 million volunteers and unpaid carers who provide a critical amount of social care and practical support (Productivity Commission 2011; National Institute of Labour Studies 2012; CSHISC 2012).

8 Source: former Department of Education, Employment and Workplace Relations.
10 Community Services and Health Industry Skills Council (CSHISC) conducts an annual environmental scan.
Health Workforce 2025 (HW2025) projected distributional shortfalls in doctors and overall shortfalls in nursing numbers, particularly in aged care and mental health. A range of policy responses has been developed to enhance productivity, decrease demand and improve retention for workforce reform. One focus of HWA’s investigations is nursing retention and productivity.

The future health and care workforce will require more generalist skills and shared competencies for cross-sector care. Assistants will be integral to that approach. The future supply of assistants may be boosted from second-career seekers, volunteers wishing to formalise their expertise, and relatively untapped sources in declining industries.

Distribution

There is a mismatch between the location and deployment of the workforce and where the growing need for care exists (HWA 2012a). This is driven by the trend towards increasing specialisation to manage the most complex but relatively lower volume populations (see Appendix 5).

The future workforce should be based on client need, otherwise the model of care will be driven by the available and currently configured workforce (Imison and Bohmer 2013). This has been seen in the case of acute care and has sometimes resulted in continued ownership of roles but an inability to supply the service. Public health priorities now emphasise planned primary healthcare, prevention and early intervention to reserve acute care for when it is really needed (Segal and Bolton 2009; Commonwealth of Australia 2013).

The reform agenda

Increasing productivity is one key way in which to deliver and sustain a nationally self-sufficient health workforce. This relies on improving flexibility, capacity, efficiency and effectiveness, as well as on reducing the need for care and improving the access, responsiveness and safety of services (Productivity Commission 2005).

A priority for government, non-government and private organisations is to use the total workforce to its full potential for both depth and breadth of services, and to address increasingly costly systemic barriers and impediments to workforce change.

Multiple factors including workforce pressures limit the extent to which clinicians use their experience to best effect. Professional staff often spend a high proportion of their time performing duties that do not require their level of qualification or expertise – at the expense of responding to more complex needs (Oelike et al. 2008). In addition, some assistants may not be used optimally; and many roles can be undertaken by more than one provider, creating opportunities for role overlap (Nancarrow 2004).

Changing models of care and consumer need have driven changes in workforce roles. These more dynamic role boundaries (see Figure 1 overleaf) have been typified as:

- diversification – new work or new ways of performing work or redistribution of tasks
- specialisation – adoption of increasing levels of expertise in a specific discipline by a select group of the profession
- horizontal substitution – role overlap with roles of another with similar training and expertise
- vertical substitution – profession delegation of tasks to others such as assistants (Nancarrow and Borthwick 2005).
HWA focuses on whole-of-workforce reform and multiple policy levers for a spectrum of change. This encompasses both the horizontal and vertical workforce change identified above. It uses changes in scopes of practice (see Figure 2) and a more balanced skills mix to meet the pressures of demand, supply and costs. Shifts across the whole workforce are required to achieve this.
The exchange or overlap of roles and activities is a critical component of this change. Where reform of one work group is pursued, such as reserving clinicians for the most complex activities, other parts of the workforce, such as assistant roles, must also be redesigned to take up the less complex work. This is essential to make the shifts possible and achieve workforce flexibility.

The assistant workforce has always been an important part of healthcare delivery. It is now being considered for its contribution in achieving whole-of-workforce reform.

It can do this by helping to:

- move from profession-centred care to consumer-centred approaches
- create real efficiencies via interdisciplinary teamwork and making better use of clinicians’ time (supplementation and complementation)
- re-balance who does what, at what cost and availability; this uses substitution or task redistribution for activities previously undertaken by others (role enhancement or/and role enlargement)
- provide more direct services (with a range of levels of practice aligned with complexity of need)
- build workforce flexibility and adaptability to change, including use of new and generalist roles (innovation).
Current use of assistants

The assistant role is characterised by multiple definitions, descriptions (Lowe et al. 2008) and titles (Nancarrow and Mackey 2005; Australian Nursing and Midwifery Federation 2009) (see Glossary). These vary according to the setting, sector, and individual workplaces (Kumar et al. 2008; Department of Health Victoria 2011; NSW Health 2010) and do not identify the level of skill and knowledge of the assistant role as a discipline in its own right (Kumar et al. 2008).

This variance has prevented a practical comparison of the role. It has also made it difficult to map and track where assistants work and what they do across jurisdictions (Australian Nursing and Midwifery Federation 2009; National Allied Health Advisors Committee 2012).

A single definition is likely to reduce the adaptability of assistant use, but the variability limits the confidence that professionals have in the assistant workforce and their willingness to delegate tasks to assistants (Kumar et al. 2008).

Assistants are therefore, defined by:

• the authorisation of the organisation that employs them
• their training
• the scope of practice, roles and delegated nature of their work
• the service standards and protocols under which they work.

Assistant characteristics and work features

See Appendix 5 for a more complete analysis of where assistants work and the features of their work.

Where assistants work

Assistants work in health, ageing, disability, mental health and social care in public, private and non-government sectors; and in rural, remote and urban settings. They cover allied health, nursing and a range of community social or support services. They have a diverse range of roles and competencies. The private and non-government aged care sectors (particularly residential aged care) have probably been the largest user of nursing support and personal care workers. In health, assistants work across the continuum of primary health, community health, and subacute and acute care.

Key issues are as follows:

• There is no evidence that assistants should be excluded from any one setting if the drivers are clear and their management, training and support are properly structured, with the right skills and staff mix and governance (delegation, confirmation of competence and supervision) (Spillsbury et al. 2013; NSW Health 2010).
• In the past, the emphasis was on the utility of assistants to manage rural and remote needs. This is now seen as equally important for metropolitan service models.
• Assistants should not just be a means to an end, but a group of importance and interest in their own right (Bach and Heron 2006; Bach, Kessler and Heron 2006) across the health, aged care and disability spectrum.

Characteristics of assistants

Most assistants are women who work part-time. The median age is between 47 years and 50 years in aged care (National Institute of Labour Studies 2012), although they are younger in the health sector (see Appendix 6). An increasing number are born overseas (35 per cent in residential aged care and 28 per cent in community services) (National Institute of Labour Studies 2012).
Key issues are as follows:

• The assistant workforce is generally looking for flexible working conditions.

• Assistants specifically enjoy the caring aspect of the role. Attitudes and behaviours are increasingly seen as key requirements for recruitment, where skills and knowledge can be taught (DEEWR 2012; Moran et al. 2011).

• The ageing profile of the assistant workforce will become a supply issue without active recruitment of a younger cohort into this valued role.

Pathways to employment

There is no minimum entry educational requirement to employment. People enter the assistant workforce from a variety of backgrounds, including degree-qualified or higher-education students.

Key issues are as follows:

• There are relatively untapped pathways to employment (including via the recent decline in the manufacturing and automotive industries) which should be streamlined as a priority.

Qualifications and training

Assistants are covered by the VET sector.

Certificate qualifications for assistants are attained under the Australian Qualifications Framework (AQF), designated:

• HLT in health – allied health and nursing
• CHC in aged care and health and community services.\(^{11}\)

The relevant educational attainments include certificates II, III and IV.

Key issues are as follows:

• There are many certificate III qualifications for each specific sector and subsector; mobility across sectors often requires training in other certificates.\(^{12}\)

• Vertical career pathways exist from certificate III and IV into professional diploma and bachelor programs\(^{13}\) (see nursing example in Western Australia: Appendix 11).

• Not all assistants have a vocational qualification, but models that combine formal and informal training and ongoing workplace development opportunities are seen as best practice (Rural Division Clinical Education and Training Institute 2010).

Recruitment

Vacancies are mainly used to assess potential workforce imbalances for this group (see Appendix 7). Increasing reliance will be placed on VET-qualified workers and generalist roles to meet growing demand (Appendix 3). This demand outstrips growth in the registered workforce, compounded by a constraint on public health and community spending (CSHISC 2013).


\(^{12}\) Note: there are currently 117 CHC certificate III qualifications (CHC 30112 to CHC31008) and 31 HLT certificate III qualifications (HLT 30212 to HLT 33112) which may be selected as relevant.

\(^{13}\) Describing a pathway to becoming an enrolled or division 2 nurse completing a HLT 43407 (Cert IV in Nursing), HLT 51607 Dip Nursing or HLT 61107 Advanced Diploma of Nursing. Then professional advancement via Bachelor of Nursing (registered nurse qualification).
Key issues are as follows:

- There is a need to both recruit more assistants and ensure they have the most appropriate skills to contribute to the whole-of-workforce reforms.
- Assistants and support workers are projected to have one of the largest increases in employment of any occupational group. There are estimates of the need for ‘an additional 750,000 direct care givers within just one generation’.
- The emphasis on primary healthcare, the increases in home care packages (Commonwealth of Australia 2013) and the National Disability Insurance Scheme will increase demand for personal care workers and disability support staff (DEEWR 2012). The challenge is to use our scarce resources well and identify and streamline supply options across all sectors (CSHISC 2013).

Retention

The retention and turnover rates of assistants vary according to location, sector and discipline (United Voice 2013). Overall, the aged care workforce is relatively stable, with generally long tenure (a third of residential direct care workers and a quarter of community direct care workers have been in the sector for 15 years or more). However, workers frequently move between aged care organisations (National Institute of Labour Studies 2012).

In health the turnover seems to be higher, particularly in rural and regional areas (CSHISC 2013).

Key issues are as follows:

- The most common reasons for turnover and lower retention rates (see Appendix 8) highlight:
  - the flexibility sought by assistants
  - the desire for more challenging work
  - limited career pathways
  - undervalue by their employer, where the clinician perception is that assistants are not only unqualified but also untrained (Skills for Health 2011)
  - poor private and not-for-profit sector pay and conditions despite the recent wage case
  - difficulties in providing in-home care often as a lone worker (DEEWR 2012).
- Assistants should be:
  - retained for their experience
  - recognised as providing value in their own right
  - offered further career opportunities as part of an expected pipeline into professional qualifications.

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15 Fair Work Decision of 1 February 2012, for aged care community sector workers.
Analysis

This section seeks to determine how assistants can contribute to whole-of-workforce reform and increased productivity and capacity by:

- releasing professionals to work to their full scope of practice
- supporting cost-effective ways to deliver more services (Moran et al. 2011)
- harnessing their intrinsic flexibility to be more responsive to demands within and across services (Spillsbury et al. 2013).

The analysis brings together:

- evidence of contributions assistants make to clients, services and workforce
- barriers and limitations to the use of assistants
- examination against the three analysis criteria outlined in the methodology
- proposed management of the barriers to assistant workforce reform.

Evidence for using assistants

Sound evidence exists about what roles assistants take, how they work and the contributions they should be supported to make. Effective use of assistants requires both active uptake of that evidence and a comprehensive understanding of the combination of these three aspects.

Assistant roles

The assistant’s role is to provide any type of support to the qualified professional and to the client (Lizarondo et al. 2010). Their generalist assistance skills can be and are used across all settings, sectors and disciplines (Department of Health 2008; Lowe et al. 2008) as a regular component of a client’s care experience and recovery (Moran 2008).

There is strong agreement on assistant roles in providing indirect care and clinical support care including:

- general practice support
- administration
- recording of data
- coordination
- equipment management
- personal care
- home support
- socialisation
- carer support.

There is less agreement in relation to direct care (Kumar et al. 2008) and delegated clinical roles (Munn, Tufunaru and Aromataris 2013).

These vary between and even within organisations (see Appendix 14).
Activities not part of assistants’ scope of practice are assessment, prescription, interpretation, stand-alone clinical judgments and independent planning and modification of treatment (Kumar et al. 2008; Spillsbury et al. 2013).

Where there is agreement on assistants’ full scope of practice, this drives better inclusion in models of care and service reform. It gives assistants a common client-care focus with the professional staff and increases their capacity to contribute to the effectiveness of care provided by the team (Munn, Tufunaru and Aromataris 2013). However, some professions are more reluctant to delegate activities and roles than others (Lizarondo et al. 2010; Queensland Health 2013).

**How assistants function**

Assistants work under the delegation and supervision of clinicians and other professionals. They are guided by protocols and act within these at all times (Australian Nursing and Midwifery Federation 2009).

They may work geographically independently with remote support and supervision, but in the health sector they are never autonomous (Lowe et al. 2008).

Assistants are part of the wider reform agenda and therefore:

- complement and supplement the work of professional staff, working alongside them to enhance or enlarge existing care and service
- carry out direct clinical care as a delegated activity, clinical care support, administration and coordination activities as the most appropriate choice of worker to deliver that level of care (in terms of cost, scope, routineness and capacity) (Imison and Bohmer 2013; Spillsbury et al. 2013; Centre for Workforce Intelligence 2013; SDO Network 2011)
- act as partial substitutes, taking on activities or tasks previously done by a professional that do not require that level of expertise, releasing or relieving professionals for more complex tasks (Spillsbury et al. 2013)
- function as a combination of all of the above (Dubois and Singh 2009).

The assistant workforce is valued for its flexibility, by which is meant:

- An assistant’s core attributes as helper and enabler, companion, facilitator and monitor are quite specific to their practice. While the technical components of the role vary, these attributes are central to the role and operate as a bridge between the assistant, client and professional (Moran et al. 2011).
- Assistants’ generic skills can be transferred across settings (Moran et al. 2011), contributing to an efficient skill mix in teams and allowing assistants to easily adapt to other contexts, industrial structures and programs.
- Assistants’ flexible capacity to provide relief, role overlap, substitution and task redistribution are vital to optimise care and resource use (Nancarrow 2004).

Evolution of the role is usually driven by professionals, based on:

- local population needs and service demands
- professional support needs
- the skills of the assistant
- the confidence and willingness of the supervisor (NSW Health 2012).

Currently, assistants work at the following three levels: trainees or aides, full scope of practice, and expanded scope of practice.
Trainees or aides

Trainees or aides\(^{16}\) manage the fundamentals of care. They work at a simple or lower risk level, addressing low acuity but high intensity or routine needs. They work under a task delegation model.

Full scope of practice

Full scope of practice covers:

- administrative and organisational support
- facilitation and coordination on behalf of the team, service or client
- delegated clinical care
- indirect care (monitoring progress, escorting clients and preparing for clinical procedures).

Assistants may undertake delegated tasks or a combination of assigned and delegated tasks. Quality and safety are ensured through supervision and confirmation of the assistant’s competency. Additional qualifications and experience allow further role and skills development, supporting more complex conditions, changes in model of care, and rapid team responses. This occurs within the scope of practice and is organisation-specific or setting-specific.

Advanced scope of practice

Advanced scope of practice covers tasks within accepted competencies of the discipline, but with increased scope. This reflects emergent service and reform needs.

An advanced role (Munn, Tufunaru and Aromataris 2013; Queensland Health 2013) is defined ‘as a role that is within the currently recognised scope of practice for that profession, but that through custom and practice has been performed by other professions. The advanced role would require additional training, competency development, as well as significant clinical experience and formal peer recognition’ (Australian Physiotherapy Association 2009).

Advanced allied health assistants (AAHA) are roles ‘working beyond the skills base or level of responsibility normally expected for an Allied Health Assistant’ (International Centre for Allied Health Evidence 2013). This describes a greater depth of practice.

Assistants working at this level are more likely to work under assigned and delegated models to harness their advanced scope and allow them to be full contributors to interdisciplinary teams (Lizarondo 2010; International Centre for Allied Health Evidence 2013; ACT Health 2013).

Advanced scope tasks might include (Queensland Health 2013):

- developing and running therapeutic groups following a professional assessment
- managing one’s own caseload
- being a team leader of other assistants
- undertaking standard tests and screens
- recommending treatment changes according to guidelines and based on results from standard tests.

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\(^{16}\) Although it is recommended assistant training should commence at full scope (Queensland Health 2013).
Assistants have also moved from working solely in a single discipline to:

- generalist positions working within multidisciplinary teams to a lead supervisor (for example across a geriatric evaluation and management unit or a community chronic disease program)\(^{17}\)
- blended roles, such as in allied health and nursing teams, working flexibly from one position at different times with both disciplines (Spillsbury et al. 2013; Stanmore, Ormrod, Waterman 2006; Queensland Health 2013).

The generalist and the advanced assistant requires more developed competencies in communication, teamwork, problem-solving and sound judgement, planning and organisation, and the ability to think ‘outside of the box’. These expanded or advanced roles provide a career path and greater potential to attract workers (ACT Health 2013). They have been trialled in several jurisdictions.

**Assistants’ contribution**

The roles assistants adopt and the way in which they work is determined by the type of care provided by their employing organisation. The interplay of local context, scope of practice and ways of working, plus qualifications and competencies, is summarised in Table 1 and underpins the contributions assistants make.

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17 NSW Health reports 43.9 per cent of AHA working across more than one discipline in rural and 18.2 per cent in metropolitan services (NSW Health 2012).
### Table 1: Determining factors for assistant roles and functions

<table>
<thead>
<tr>
<th>Context, drivers, and models of care</th>
<th>Scope of practice</th>
<th>Competencies and qualifications</th>
<th>Roles and tasks (delegated by task or assigned workload)</th>
<th>Contributors</th>
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</thead>
<tbody>
<tr>
<td><strong>Workforce drivers:</strong></td>
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<tr>
<td>• Shortages</td>
<td>Scope:</td>
<td>Competencies:*</td>
<td>Example functions:</td>
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<tr>
<td>• Maldistribution</td>
<td>• Direct clinical care</td>
<td>• Attitudes</td>
<td>Conduct and supervise individual and group exercise programs;</td>
<td>Service: breadth</td>
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<td>• Attraction</td>
<td>• Clinical care support</td>
<td>• Skills</td>
<td>practice and instruct practical tasks, for example transfers, meal preparation, gait, personal care and hygiene, dressing, washing, nursing care, basic wound care, medication management, catheterisation, application of stretches and heat, assistance in preparing splints, social and emotional support, listening and reinforcing goals</td>
<td>Service: volume</td>
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<td>• Skills development and mix</td>
<td>• Coordination, navigation and linkages</td>
<td>• Experience</td>
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<td>Service: timing</td>
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<td>• Cost containment</td>
<td>• Admin, data, environment and equipment</td>
<td>• Knowledge</td>
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<td>Service: gaps</td>
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<tr>
<td><strong>Service drivers:</strong></td>
<td>Levels of function:</td>
<td>Qualification streams:</td>
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<td>Client: efficiencies</td>
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<tr>
<td>• Service capacity and capability</td>
<td>• Aide or trainee assistant</td>
<td>• AQF</td>
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<td></td>
<td>• Full scope; development based on experience within scope of practice</td>
<td>• HLT</td>
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<td>• Advanced assistant (eg AHAA)</td>
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<td>• Certificate III</td>
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<td>• Certificate IV – expanded scope or AHAA</td>
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<td></td>
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<td>• On-the-job training and continuous development</td>
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<td><strong>Client drivers:</strong></td>
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<td>• Evidence-based model of care</td>
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<td>• Contemporary philosophy</td>
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<td><strong>Ways of working:</strong></td>
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<td>• Releasing professionals: partial substitution</td>
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<td>• Complement or supplement service enlargement or enhancement</td>
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<td>• Workforce of choice for routine or less complex activities</td>
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<td><strong>Work to:</strong></td>
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<td>• A single discipline supervisor on task allocation basis</td>
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<td>• In a multidisciplinary team supervised on a task allocation basis only (generalist)</td>
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<tr>
<td>• As an integral member of interdisciplinary team with assigned workload to trained scope of practice</td>
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<td><strong>Determined by:</strong></td>
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<tr>
<td>• Context and drivers</td>
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<td>• Education and training</td>
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<td>• Employer authorisation</td>
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<td>• Governance</td>
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<td>• Organisational supports</td>
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<td>• HP skills in delegation and supervision</td>
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<td>• Culture</td>
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<td>• Interdisciplinary team work</td>
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<tr>
<td><strong>Capabilities:</strong></td>
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<tr>
<td>• Flexibility and transferability</td>
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<tr>
<td>• Core attributes: helper, enabler, facilitator, monitor</td>
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<tr>
<td>• Breadth of general and common capabilities contributes to efficient skills mix and adaptability to different settings</td>
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<tr>
<td><strong>Contact and informal carers, organise and schedule appointments, link information, navigate services</strong></td>
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<tr>
<td><strong>Promote cross-agency work, record data, general organisation, housekeeping and admin duties</strong></td>
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*Appendix 13: NCHCR
Client outcomes

The evidence on the contribution of assistants to client outcomes is limited and sometimes conflicting – between a positive contribution (Spillsbury et al. 2013; Stanmore, Ormrod, Waterman 2006), an uncertain contribution (Buchan and Dal Poz 2002), and a poor or adverse outcome (usually associated with a substantial reduction in numbers of registered nurses) (Griffin and Sines 2012; Duffield et al. 2007). This is because the roles are highly context-specific, largely defined by the clinicians who delegate them, and may lack the appropriate supports. Therefore ‘it is difficult to ascertain exactly what it is … that [assistants] may contribute to … outcomes of care’ (Moran et al. 2011; Buchan and Dal Poz 2002).

Where assistants are introduced as part of a change in skills mix (Nancarrow et al. 2010), the team is reported as being able to deliver:

- some care or service (where the alternative is no service or a long waiting list) (Moran et al. 2011; HWA 2012c)
- more face-to-face time to attend to the fundamentals of care through conversation and support, which clinicians are less able to provide as they have become increasingly specialised (Spillsbury et al. 2013; Kessler et al. 2010):
  - “[O]ne patient’s last days were very much enhanced by his conversations with the HSA … they have time to do the little things that nursing staff can get too busy to do” (Department of Health Victoria 2011)
  - “The introduction of a physiotherapy assistant to intensive care provided time and patience for patients to gain confidence in their abilities” (Conti et al. 2007)
- a reduction in immobility resulting in lower skin-breakdown rates, ventilator days per patient and ventilator pneumonia rates, and fewer complications overall (Lizarondo 2010; Griffin and Sines 2012; Conti et al. 2007)
- positive functional improvements and psychosocial outcomes (Griffin and Sines 2012) through spending more time on hygiene, toileting, transfer support and patient communication (Kumar et al. 2008)
- more frequent surveillance and observation (Griffin and Sines 2012).

The direct clinical care that assistants can safely undertake within their scope and training is well documented (NSW Health 2012; Moran et al. 2011; NSW Health 2010; Ramsay Health Care 2012; Queensland Health 2013) (see Appendix 15 for case studies).

The literature on adverse patient outcomes generally concerns the links between registered nursing levels and patient outcomes, rather than the impact from a skill mix that includes assistants (Griffin and Sines 2012; Buchan J and Dal Poz M 2002).

The ability to identify and measure the contribution that a single staff grouping makes to clients is limited (Buchan, Ball and O’May 2000; Kumar et al. 2008).

Client complaints as part of regulatory oversight in aged care have shaped a clearer picture of what works well for clients.

Service outcomes

Assistants work effectively to contribute to the process of client care (Lizarondo 2010). Clients see assistants as visible, available and approachable (Kumar et al. 2008). Assistants are most often in contact with clients and carers (although clients still prefer to engage with clinicians on specific issues) (DEEWR 2012; Productivity Commission 2011; Spillsbury et al. 2013, Griffin and Sines 2012).
Assistants are therefore able to provide:

- greater intensity of care and practice at exercises or tasks that promote increased recovery, independence and confidence (Kumar et al. 2008; Stanmore, Ormrod and Waterman 2006):
  
  » “...they have time to do the little things that nursing staff can get too busy to do.”
  
  » “...no longer feel we are providing patchwork nursing...”
  
  » “...the introduction of the HAIN role has made a huge difference to my life as a nurse on a busy ward” (Department of Health Victoria 2011)

- increased participation in decision-making around clients’ care preferences and needs, shown by reduction in client complaints (Department of Health Victoria 2011; CSHISC 2012):
  
  » “[P]atients indicated that they benefited from the one-on-one contact that was provided by the [a]ssistants; nursing staff reported a decline in patient complaints” (CSHISC 2012; Department of Health Victoria 2011)

- advocacy for patients and better team communication (Segal and Bolton 2009; Lizarondo et al. 2010).

There is also evidence that assistants can:

- pick up on the less obvious anxieties, concerns and needs of clients because they have more time to talk, are more approachable and often bring a steadiness and maturity (Spillsbury et al. 2013)

- improve links for some specific client groups, especially where assistants are drawn from the local community with diverse backgrounds and cultural mixes (Lowe et al. 2008; Kessler et al. 2010).

Assistants contribute to better service or care capacity (NHS Education for Scotland 2010) by:

- giving clients more direct face-to-face time with healthcare staff (Nancarrow et al. 2010)

- providing a cost-effective way to deliver safe, skilled care and enhanced service responsiveness, especially where there are otherwise inadequate levels of staffing (Rural Division Clinical Education and Training Institute 2010; Griffin and Sines 2012)

- helping to reduce waiting times, where the most complex clients can be prioritised for clinicians and assistants can focus on less complex clients who have capacity for restoration. (Moran et al. 2011)

- balancing scopes of professional clinical staff with their flexible roles and versatile functions to meet the local context, conditions and needs (Moran et al. 2012; National Allied Health Advisors Committee 2012):
  
  » “[T]he intrinsic value of the support workforce is its flexibility that enables it to successfully accommodate different settings, industrial structures and service needs” (National Allied Health Advisors Committee 2012)

- increasing observational capacity, giving nursing staff ‘another pair of eyes’ (Kessler et al. 2010).

There is some ambiguity about the extent and nature of this contribution to capacity (Spillsbury et al. 2013). A better understanding of the common elements of assistant roles would help in assessing whether the expectations of service managers are met (Moran et al. 2011).

**Workforce outcomes**

As with other workforce groups, the evidence of the contribution assistants make to productivity as a single group is limited (Lowe et al. 2008). However, the evidence is clear about this group’s important contribution to overall team productivity and capacity.
Assistants improve productivity by reducing the burden on other staff. The direct clinical care they perform reduces clinicians’ workload, enabling them to:

- work on more complex or ‘higher level professional activities across a greater number of patients’ (Lowe et al. 2008)
- reduce the number of hours spent on supervision and administration for low-level patients
- reduce the time spent on routine tasks (Kessler et al. 2010; National Allied Health Assistant Working Group 2012; Kumar et al. 2008).

Furthermore, assistants are best placed to meet clients’ basic care needs:

“It’s about having the right skills for the right tasks… A team would not be a team if everyone was of the same band, it would be inappropriate. Some interventions require a very high level of specialist skill and some don’t. Some require more routine interventions or some are of less technical nature and so it seems entirely appropriate and right that any team should have a mixture of people and be able to service the needs of the community appropriately… Financially there is a driver for less expensive workers but it’s got to be based on skills needed and on the risk, managing the risk (senior manager)” (Spillsbury et al. 2013).

“We’ve got much more-complex cases now with continuing care ... that I think that we need healthcare assistants for hands-on clinical work which they’re very good [at]. So they can do quite a lot of preventative work, for example, I mean you know skin care, leg care, preventing ulceration, all the things that are important to prevent leg ulcers developing and they’re the ones to do those things (caseload holder)” (Spillsbury et al. 2013).

Assistants also provide an increased skills base to contribute to a broader spread of services. They can easily switch from one role or job to another due to the generalist nature of their skills, and can deliver a wide range of services (Francis 2013). This creates more capacity for the health system to respond to early intervention and prevention needs (HWA 2012a; HWA 2012c), rather than just immediate acute care needs that clinicians in short supply must focus upon.

Appropriately trained assistants can work beyond the level of simple, routine tasks with stable patients, and are often delegated more responsibility when clinicians are not available, particularly when working alone in clients’ homes (Spillsbury et al. 2013).

Assistants can increase capacity for different workload models. For example, in residential aged care the use of assistants allows the team to adopt a resident-focused workload model for continuous care, rather than one organised by tasks. This increases the interaction time with residents, improves continuity of care and ensures less time is spent ‘travelling between tasks’ (Department of Health Victoria 2010; Bowers et al. 2001).

When assistants are used as part of the team, there is increased satisfaction for all staff (Lowe et al. 2008). Nursing staff report a positive shift in their role when they are freed up to perform expert tasks and assistants deliver basic care needs (Kessler et al. 2010). This reduced pressure leads to more reasonable nurse workloads, reduction in overtime and better teamwork (Buchan and Dal Poz 2002).

Assistants contribute to effective management of ward environments, including maintaining a consistent emotional climate (Griffin and Sines 2012). They bridge communication between patients and doctors and nurses, keeping them up-to-date with progress (Kumar et al. 2008), which speeds up accessibility and delivery of care (Stanmore, Ormrod and Waterman 2006).

**Types of service models**

A typology of twelve service models in which assistants work has been developed. This covers the range of care contributions in health and draws on learning from other sector models (see Table 2). It is not a comprehensive list, nor are the models in any order of priority. Case studies are provided for all twelve (see Appendix 15) (HWA 2012d).
Each of these models represents the local context and drivers; the level or range of activity provided by assistants; and their training and governance. They demonstrate the variety, responsiveness and flexibility that assistants are capable of producing as part of a team.

The models are defined by who assistants work with and/or the contextual drivers for which they are used. They are described in more detail in Appendix 15.

Table 2: Models of assistant care contribution

<table>
<thead>
<tr>
<th>Model</th>
<th>Example</th>
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</table>
| Model 1: Personal Care Worker (PCW or PCA)                          | Catholic Homes, Victoria  
PCW in residential aged care: improving teamwork for client outcomes; managing the workload; relieving professionals; enlarging or enhancing the service in the home |
| Model 2: Allied Health Assistant                                     | NSW Health (2010)  
Relieving professionals; cost-efficient teamwork; enlarging and enhancing the service in the home |
| Model 3: Assistant in Nursing and Personal Care: Private Health      | Anglican Retirement Villages NSW – specialist palliative care, care coordinator  
Enhancement of service; continuity of care; early intervention |
| Model 4: Advanced Assistant                                          | ACT Health – community services discharge coordinator  
Delegated – assigned workload; coordination and linkages facilitation; assistance |
| Model 5: Blended (Combined) Role                                     | Ovens and King Continence Service Victoria – blended nursing and allied health  
Generalist support for access to incontinence services |
| Model 5B: Multidisciplinary Role                                    | Queensland Health – community rehabilitation model (Kumar et al. 2008)  
Generalist support for access and responsiveness |
| Model 6: Assistant in Nursing (AIN) in Public Acute Care            | Austin Health Victoria, Tasmania, ACT Health  
Support for acute nursing teams: better service quality; efficiencies over time; demand management related to increased acuity and complexity |
| Model 7: Assistant Traineeship Discipline-Specific                   | ACT Heath – podiatry (Moran et al. 2012)  
Cost efficiencies; developing the assistant through a traineeship approach |
| Model 8: Medical Practice Assistant                                 | Metro Brisbane North Medicare Local (see Appendix 16)  
Offset GP workforce pressures; increase efficiency and responsiveness of primary healthcare services |
| Model 9: Assistant in Rural and Remote                               | Murrumbidgee NSW and WACHS (Australian Workforce Productivity Agency 2012)  
Workforce shortages; service gaps |
| Model 10: Clinical Support Officer                                  | NSW Health – clinical support officers  
Relieving registered nurses of the average 12 per cent of hygiene and clerical work; relieving nurse managers of their 40 per cent administrative duties |
| Model 11: Community Care Worker                                      | SA Country Health  
Continuity of care; alert system for early intervention; covering gaps – service enlargement; supplementing or freeing up professionals |
Barriers and limitations to using assistants

The available sources of evidence reveal that:

- The use of assistants is a ‘contentious space’, which is as much about a lack of attention to implementation (via effective change and risk management) and professional culture as it is about policy.
- There is limited sharing of the available knowledge between disciplines, sectors and settings (Lowe et al. 2008), which points to the need for a framework to assist this transfer and drive uptake of the use of assistants (NHS Education for Scotland 2010).
- Assistant positions are mostly implemented as a time-limited pilot, rather than building on the available evidence of what works from the perspectives of safety, quality, productivity and sustainability.

Quality and safety

Perceived adverse outcomes for vulnerable clients are cited as a consequence of not regulating assistants:

“There is a sizeable proportion of the health workforce, who work outside [these] comprehensive regulatory safeguards and who have the potential because of their roles, to place the care and treatment of people in these systems at risk” (Australian Nursing and Midwifery Federation 2009).

Three processes are critical to the management and assurance of quality and safety: delegation and supervision; clarity of roles, responsibilities and tasks; and linkages between training, experience and safe work demands.

Delegation and supervision

Assistant roles are shaped and managed by delegation and supervision (Queensland Health 2010; Moran et al. 2011; Ramsay Health Care 2012) to:

- recognise and work within the limits of assistant competence and scope of practice
- ensure adequate knowledge and skills to provide safe clinical care
- confirm competence to practice
- integrate assistants successfully into models of care and teamwork
- clarify roles for clients and carers.

Delegation and supervision are part of a skill set, irrespective of whether they are applied to more junior clinicians, professional students or assistants. If this skill set is under-developed or non-existent (Queensland Health 2010), the following continue to operate as inappropriate barriers:

- unwillingness by certain professionals to delegate specific tasks (Queensland Health 2013)
- lack of confidence and necessary skills to delegate, supervise and confirm competence (Queensland Health 2013)
- lack of acceptance that supervision can be indirect or remote
- poor knowledge of available delegation and supervision guidelines
- a fear of litigation (Kumar et al. 2008; Lizarondo 2010) and confusion about responsibility and accountability
- lack of information about the assistant role, competencies and qualifications attained (Griffin and Sines 2012)
- perception that supervision is an additional role in a pressured workload (ACT Health 2012)
- fear that the use of assistants will erode professional roles, which drives role protection (ACT Health 2012; Stanmore, Ormrod and Waterman 2006).
Clarity of roles, responsibilities and tasks

Clinicians often talk of ‘blurring’ of roles and link this to compromised quality and safety. For example, one clinician stated there are ‘questions asked by staff such as what their limitations are, what [assistants] are allowed to do, and what they could ask the [assistants] to do for them’ (ACT Health 2012).

Confusion arises when roles evolve based on individuals’ skills, instead of being designed by the organisation to meet service needs and models of care (Skills for Health 2011). These issues are exacerbated when clinicians are not confident about their own scopes of practice and are therefore unable to delegate effectively (Department of Health Victoria, 2010; Queensland Health 2010; Nancarrow and Mackey 2005; Nancarrow 2004).

Processes that can provide clarity are not universally pursued:

“We cannot wait to improve care on the back of regulation that may or may not happen in the next five years… It is time for lead stakeholders in the development of the HCA and AP roles to come together and set some standards so that we all speak a common language and agree what is an accepted standard in relation to the development of these roles. HCAs and APs need to be a part of these discussions” (Vaughan 2008).

In general, assistants report being very clear about their roles, scopes of practice and the activities they most frequently perform (Spilsbury et al. 2013; Lizarondo 2010; Stanmore, Ormrod and Waterman 2006). They tell clinical staff what their role and scope are when there is uncertainty. They note that permanent staff members are more likely to have a good understanding of their role and function:

“Once you work with AiNs for a while you know the tasks and duties they can undertake competently. AiNs are very good workers, use their initiative and know their scope of practice. They are very good at reporting back to the RN” (Spilsbury et al. 2013).

Blurring of roles is often viewed positively where it means role-sharing. This provides flexibility to reframe the work and skills mix (Nancarrow et al. 2010), however it depends on clarity around roles, scopes and functions of both assistants and other team members.

Linking training, experience and safe work demands

The determination of assistant roles and responsibilities is mostly triggered by professionals’ and clinicians’ judgment and attitudes. Due to the differing views on scopes of practice, this may make an assistant’s work inconsistent or even unpredictable (Spilsbury et al. 2013; Nancarrow 2004).

Assistants who are experienced members of the team are valued for the stability they create. However, they may be asked to do more complex tasks than they are trained for. Assistants cite unrealistic workloads, requests to perform tasks for which they have no training, or instructions not to use methods (such as lifting equipment) that they have been trained for (Spilsbury et al. 2013).

The onus is on the organisation to support proper mandatory training, governance and preparation for the risks assistants face, especially as lone workers in the home or when geographically isolated with ‘fly in fly out’ professional support.

The failure of services in Mid Staffordshire NHS Foundation Trust has been cited as a reason to regulate assistants in order to manage safety and quality (see Appendix 18). Registration has been considered in the UK and ruled out (see Appendix 18) in favour of other means of assurance.

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18 In the UK, HCA is a health care assistant and AP is an assistant practitioner.
Use and recognition of assistants

The way assistants are used and recognised has an impact on their attraction and retention. Case studies are largely the only evidence of assistants’ viewpoints (see Appendix 15).

Assistants know they are valued by clients for their contribution to care (ACT Health 2012; Rural Division Clinical Education and Training Institute 2010). While less complex tasks are appropriately delegated by clinicians, some assistants feel they are also under-used, which prevents them from employing their full range of skills (Cavendish 2013).

Assistants conclude that the job would be more satisfying with:

• good clinical leadership and willingness to seek out better ways to deliver patient care
• better assistant–supervisor relationships (Spillsbury et al. 2013), less resistance from clinicians to a team-based model of care (HWA 2012c), and better delegation and supervision (HWA 2012c)
• greater consistency of work value across organisations (for example, some assistants work in maintenance and monitoring of stable patients, while others in the same organisation work well beyond this level) (ACT Health 2012; Spillsbury et al. 2013)
• extra on-the-job training leading to an increased scope that is not revised when other staff shortages occur and priorities are re-ordered
• the freedom to work more independently with an assigned workload (United Voice 2013; Stanmore, Ormrod and Waterman 2006)
• the right training and time to develop the skills to contribute most fully (Kumar 2008; ACT Health 2012), supported by the right orientation and preparation for both professional and assistant staff (ACT Health 2012).

On the other hand, where clinicians have been involved in introducing or expanding the contributions of assistants, their value is recognised as essential to a team-based model:

“We could not deliver the services if the HCAs were not involved.”

“Assistants are key to our future and in moving forward but they will be working in very different ways compared to days gone by and will be much more skilled in future.”

“I often see [the] HCA as being quite a core member of the team. They tend to stay and be a very stable influence within the team … and [the role] is relied on [in] a lot of ways to support the work of other members of the team” (Spillsbury et al. 2013; ACT Health 2012).

In addition, those who value assistants can also see the possibilities of assistants undertaking more activities within their trained scope, such as observations (vital signs) and checking blood glucose levels (ACT Health 2012).

Despite these positive aspects, the role of assistants in the health sector does not seem to be an attractive career choice (Spillsbury et al. 2013) and has not translated into consistent best use of assistants. This may be driven by clinicians’ perception that they are not only unqualified but also ‘untrained’ and ‘unskilled’:

“As a HCSW, I am constantly undermined at times by other healthcare professionals who I feel do not value and understand the role that the HCSW makes within today’s healthcare. … We should not have to justify our role all the time. I may not be qualified in the terms of registration, however, I am qualified, i.e. have had the training, been deemed competent to provide an effective quality and safe care to patients – and we do a very good job” (Skills for Health 2011).
Contention arises when registered nurses (RNs) and enrolled nurses (ENs) view the introduction of assistants as a way of replacing their roles, rather than as assets to be deployed according to the needs of the ward and patients. For this reason, some feel assistant hours should not be counted in actual workload staffing models (ACT Health 2012).

**A skilled and trained workforce**

A prevailing perception is that assistants are unqualified, untrained and unskilled.

Where an assistant holds a certificate of training, the difference in delivery of that training across registered training organisations (RTOs) has led to a lack of clarity in:

- how the educational preparation matches the service model
- the workplace experience included in that course and therefore, job readiness.

This ultimately affects clinician’s confidence to delegate responsibility for tasks and activities.

Contrary to this perception there are increasing rates of assistants completing certificate III and IV qualifications (see Appendix 12) (Martin and King 2008; DEEWR 2012; National Institute of Labour Studies 2012).

While there are no mandated or minimum entry qualifications for assistants, certificate III in a relevant health (HLT) or community care (CHC) qualification is generally supported by employers as a desirable entry-level qualification (DEEWR 2012). Appendix 10 outlines the applicable training packages for nursing and allied health in health, aged care, disability and community care. For allied health assistants, the level usually sought is certificate IV.

Where assistants do not have formal qualifications, they can still be valued and skilled workers. On-the-job training in the workplace may be both practical and theoretical. Ward RNs who train their assistants to their own standards of practice see this as of great value (ACT Health 2012).

In 2012, 88 per cent of the direct-care workforce had a post-secondary-school qualification (National Institute of Labour Studies 2012). In residential aged care 65 per cent of assistants were at certificate III level and 20 per cent had a further certificate IV qualification (National Institute of Labour Studies 2012). In community home and aged care, just under 70 per cent hold a relevant certificate III or certificate IV qualification (National Institute of Labour Studies 2012).

Eighty per cent of employers always or often employ qualified personal care workers and rarely employ unqualified people without relevant and mostly three years’ experience (DEEWR 2012). One public sector jurisdiction reports that approximately 70 per cent of assistants have some formal educational attainment and 42 per cent have a certificate in AHA (NSW Health 2012).

In 2013, the Community Services and Health Industry Skills Council (CSHISC) undertook a significant project to streamline training packages to ensure consistency with contemporary skills needs and to reflect emerging service models and new roles.

Appropriate development of this workforce will focus on competencies that assistants will use as part of a team approach. These include risk factor identification for deterioration and early intervention under protocols and safe medications management in the home.
Future supply

Attracting future workforce from industries in decline such as automotive and manufacturing will be an important aspect of future supply.

Attraction to the assistant role is likely to depend on the following factors:

- a transparent career structure (with articulation to both expanded assistant roles and to professional qualifications and roles)
- workforce development to build assistant scopes of practice, particularly in light of policies to deliver greater care in the home (Kumar et al. 2008)
- agreement on the appropriate levels of substitution in the skills mix for the productivity gains needed and a clear recognition of what is meant by productivity in this context
- roll-out of the entitlement model to subsidised funding for VET qualifications and any implications for consistency in quality of training
- identification of pathways and training as a priority for people seeking second careers
- greater focus on work placements and work experience to ensure links between VET programs and services and to entrench supervision resources (CSHISC 2013)
- development of a set of core competencies for generalist role training.

Organisational preparation for effective inclusion of assistants

More evidence is needed on how organisations can change their skills and staff mix to deliver their needs (Buchan and Dal Poz 2002).

A one-size-fits-all approach is inappropriate as change depends on resource availability, context, drivers, service models, custom and practice (Buchan and Dal Poz 2002).

Organisations balancing risk management and the need for flexibility face the following problems:

Models of care and the available workforce

Practitioner preferences and needs have traditionally determined the nature of change in models of care (HWA 2012c).

Roles and tasks have been retained, but at a higher level of practice. New models of care cannot be driven just by the available workforce. Workforce redesign and work redesign must go hand in hand (Imison and Bohmer 2013).

Given workforce shortages, it is considered that using clinicians to provide care that is neither acute nor complex may not be the best use of resource. These should be delegated to workers with more appropriate levels of skill (Spillsbury et al. 2013; Nancarrow 2004).

There needs to be understanding that regulatory boundaries can limit opportunities to enhance roles or substitute one type of worker for another, especially across sectors (Sibbald, Shen and McBride 2004).
Professional responsibility for assistants

Some professionals believe they cannot delegate to an assistant because:

• they are ‘accountable’ for any activity related to patient care and therefore have to perform all the activity themselves (Munn, Tufunaru and Aromataris 2013)
• they are insecure about their ‘liability’ when using assistants (Kumar et al. 2008; HWA 2012c).

It is essential that employers help professionals understand their responsibilities when working with assistants. Employers should support their workforce with clear workplace guidelines and protocols about delegation, supervision and feedback, as well as clear job descriptions for both parties. Some jurisdictions have developed guidelines (see Appendix 17: WA, NSW and Victoria). Undergraduate education curricula must prepare professionals for their roles in delegation, supervision and confirmation of competency.

The professional remains responsible for overall management of patient care and outcomes, if the assistant completes the delegated activity as requested. The professional satisfies their responsibility if:

• both parties have a clear and documented understanding of the delegated task.
• they have confirmed that the assistant has the knowledge and skill level required to perform the delegated task.
• they provide an appropriate level of supervision and feedback.
• they only delegate tasks that fall within the guidelines and protocols of the workplace.
• they delegate in compliance with regulatory and professional bodies in terms of standards of practice and patient care, and state and local policy directives.
• they appropriately review the delegated tasks.

The assistant is responsible for completing the delegated activity in accordance with the direction from the professional, and state and local policy directives and their training.

Delegation of a task (such as showering a client) does not remove the option for the professional to occasionally undertake that task.

Cost-effectiveness

There is a lack of evidence of cost-effectiveness of interventions associated with a skills mix which includes assistants and the wider impacts of that change on healthcare settings (Kumar et al. 2008; Sibbald, Shen and McBride 2004). Organisations cannot assume that changing skills mix will automatically reduce costs.

However there is evidence that:

• Substituting low-cost workforce for higher-cost professionals may be offset initially by more supervision and less volume or speed of delivery – but long-term gains in efficiencies may be seen (Sibbald, Shen and McBride 2004).
• Higher ratios of qualified nurses to unregistered staff are associated with higher direct costs, but may be offset by greater efficiencies and enhanced quality of care (Sibbald, Shen and McBride 2004). Caution should be taken with studies that compare fully nurse-staffed areas with areas registering understaffing of nurses rather than with different skill mixes that include assistants (Buchan and Dal Poz 2002; Griffin and Sines 2012).
• well-integrated teams have slightly lower service costs, but higher numbers and different types of disciplines in the team are directly associated with increased costs (Nancarrow et al. 2010).
Research in the UK examined the relationship between workforce configuration and the costs and outcomes of older peoples’ intermediate care services (Nancarrow et al. 2010). In this study, over 60 per cent of teams employed an occupational therapist, physiotherapist, at least one support worker, a nurse and an administrator. Fewer than 20 per cent of teams employed a medical practitioner, pharmacist or podiatrist.

It found that the ‘variations in costs and patient outcomes in relation to staffing models indicated potential for savings from more effective use of staff’ as follows:

- Positive outcomes were significantly associated with five key variables for patients who:
  - had care delivered by a higher proportion of support workers
  - were treated by staff from a team with fewer senior staff
  - were treated by fewer different types of practitioners
  - were treated by staff who belonged to a larger team
  - had increasing amounts of face-to-face contact

- Staff outcomes showed greater satisfaction and less intention to leave associated with smaller team sizes and better team and management structures and styles.

- Service outcomes, such as costs and length of stay, were impacted as follows:
  - The larger the team the greater the costs.
  - Costs per patient increased as the number of different practitioners involved increased (steeply at first, then declining).
  - The proportion of professional staff of around 63 per cent is associated with decreasing cost. After this any increase is associated with the costs starting to rise again (Nancarrow et al. 2010).
  - No staffing variables were associated with length of stay, but increased use of technology was associated with reduced length of stay.

- Another UK study found that in reality the overall number of health assistants as a percentage of the total nursing and support staff in a community team was more likely to be 25 per cent (or one assistant to every three clinicians) to as low as under 13 per cent or as high as 40 per cent (Spillsbury et al. 2013). Equivalent data are not available for Australian health services.

Skills mix and outcomes

Health needs and evidence-based models of care should determine the types of skills mix needed and their likely impacts (Imison and Bohmer 2013; Sibbald, Shen and McBride 2004).

There is no common starting point for determining the best skills mix or ideal thresholds associated with indicators of cost and quality. These are context-specific and depend on ‘resource availability, regulatory environment, culture, custom and practice’ (Buchan and Dal Poz 2001; Department of Health Victoria 2010).

A variety of methods is used to determine the right size and mix of nursing teams such as the number of nurses per occupied bed day, an acuity–quality method, and a time–task/activity method (Hurst K 2002).

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20 Intermediate care is defined as services to prevent avoidable admissions to and facilitate discharge from hospital and prevent admission to long-term residential and nursing care.
These generally do not account for assistants in the mix\textsuperscript{21} or the multidisciplinary or interdisciplinary team models of care. Nor do they consider the conditions under which workers’ skills are used to best value, looking instead at numbers and types of workers (Dubois and Singh 2009).

Both Victoria and California have used staffing and patient ratios to determine appropriate workloads, safety and quality without an evidence base (Department of Health Victoria 2010; Dubois and Singh 2009). Increasingly these ratios are seen as a ‘blunt instrument’ for the complexity of needs and community preferences, requiring more sophisticated decision-making processes and sensitivity to contextual factors (Department of Health Victoria 2010; Moran et al. 2011; Buchan and Dal Poz 2002; Dubois and Singh 2009; Hodgkinson et al. 2013; Sibbald, Shen and McBride 2004; Buchan, Ball and O’May 2000).

While the need for sufficient professional staff is not in doubt, defining what is sufficient is context-specific. There needs to be clearer guidance around the threshold of optimal staffing levels below which care is compromised and above which there is no significant effect on quality outcomes (Department of Health Victoria 2010).

**Validity, appropriateness and feasibility**

This analysis of assistants has been conducted against the following criteria:

- validity of their roles in services and teams
- appropriateness of their roles and functions
- feasibility of their participation in terms of cost, supply and training.

The analysis has focused on identifying:

- ways to actively manage the range of perceived barriers and real limitations
- further development and research needed to support the best use of assistants.

**Validity**

The use of the assistant workforce is valid as an integral part of both team and service skills mix because of:

- evidence of its part in:
  - service (process) outcomes
  - team productivity and efficiencies
  - some client outcomes (where there are explicit arrangements, education and governances to support them)
- its contribution to:
  - the management of skills and time shortages
  - containment of costs
  - better use of technology
  - delivery of service model changes
  - a different skills mix, which enables a competencies-based approach to whole-of-workforce redesign

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\textsuperscript{21} Where nursing hours per patient per day staffing methods are used, some percentage of assistant time must be included in order to measure team impact on patient outcomes (Twigg et al. 2010; Garland and Glenn 2010; Twigg et al. 2011) notwithstanding the comments on more effective methods of ensuring the right skills mix.
• its flexibility through transferable core attributes (helping, assisting and enabling)
• the stability it provides in an environment of considerable change, which gives professionals and clinicians the adaptability to respond (Spillsbury et al. 2013)
• its ability to undertake task and partial role substitution and supplementation, thus streamlining and avoiding duplication of coordination and some interventions.

To reinforce the validity of the assistant role, clinicians must:
• recruit assistant staff with attitudes and behaviours relevant to the role
• take a constructive and empowering approach to inclusion of assistants, moving from ‘us and them’ and any tentativeness about letting go
• support assistants to work to their full scope
• recognise that the quality of supervision has the potential to ‘make or break’ both the introduction and broadening of the assistant role (Lowe et al. 2008; Kumar et al. 2008; Lizarondo et al. 2010; Munn, Tufunaru, Aromataris 2013)
• recognise that changes in skills mix fail when evidence for practice and the models of care are not the drivers (Imison and Bohmer 2013; Sibbald, Shen and McBride 2004).

Organisations must work with their clinical leadership to support the introduction of assistants into the workforce mix. Successful implementation requires consistency (Sibbald, Shen and McBride 2004) in the following:
• authorising priorities for the use of assistants in the model of care and establishing a shared understanding across the workforce, managers and employees (cavendish 2013)
• planning how to use the mix to drive a new way of working and discontinue the old ways
• establishing protocol-driven care to bridge the transfer of tasks from one group to another
• managing human resources through supporting middle managers, consulting with key stakeholders and providing appropriate incentives to retain assistants (dubois and singh 2009; sibbald, shen and mcbride 2004)
• measuring team productivity to support revision of roles and the skills mix of the care team (Sibbald, Shen and McBride 2004).

Further considerations

Further consideration should be given to:
• further research into the most cost-effective options in which assistants are part of the skills mix and team and the impact this has on client outcomes and experience
• collation of validated resources to prevent further duplication including:
  » implementation resources
  » case studies of the uses and benefits of assistants within different contexts and settings
  » case studies of client and carer narratives.
Appropriateness

Assistants are an appropriate and integral part of the healthcare team.

They make a balanced skills mix possible through:

• a better mix of generalist, clinical and support workforce to provide a more readily available and continuous range of basic interventions and coordination
• a responsive range of scopes of practice to needs, as both a single profession and as multidisciplinary generalists
• acceptability to clients and carers, as long as the assistant’s role, training and supervision is communicated and understood

Assistants are the most appropriate workers to undertake certain activities and roles where:

• they are best placed to provide the regular fundamentals of care (Spillsbury et al. 2013; Nancarrow et al. 2010)
• the use of a clinician would be inefficient on a day-to-day basis (Imison and Bohmer 2013; Spillsbury et al. 2013; Centre for Workforce Intelligence 2013; SDO Network 2011; Queensland Health 2013).

For assistants to be used appropriately, the following conditions must be met:

• Any changes to roles across the team should use general principles of job design for both assistants and professionals (Skills for Health 2011). This means giving up some activities and creating expanded and meaningful roles for professionally qualified staff who are freed up by the use of assistants.
• Any methodology for skills mix change must be based on context, drivers and models of care, and the team’s capacity to meet client needs (acuity/complexity), safety and quality.

One example is the New Zealand Care Capacity and Demand Management model. This is a partnership-based approach that is client-centred and manages and minimises variation across an organisation using quality data (DHB Shared Services, undated). Its components are:

• mix and match – a match of resource requirements to patient needs, acuity and complexity using evidence and data
• variance response management – a process allowing the whole hospital to see timely information on changes in resource allocation across the organisation, and the capacity created to offer help outside workers’ normal location
• culture change – driven by using indicators of effective teamwork and partnerships across the organisation, district health boards and the New Zealand Nursing Organisation.

Safety and quality can be effectively risk-managed without recourse to registration. This requires organisational commitment, professional willingness and clinical leadership, culture shifts, good diagnostics and standards (Griffin and Sines 2012; Spillsbury et al. 2013).
Best practice delegation and supervision (see Appendix 17) (Queensland Health 2010; Department of Health WA 2008; Nancarrow et al. 2012; WA Country Health Service 2008; HWA 2011a) include:

- training and guidelines for delegation, supervision, monitoring and recognition of competency, for supervisors and delegates as appropriate
- negotiation of roles and documented scopes of practice for clinical governance
- agreed codes of conduct and protocols of care
- embedding of scopes of practice in position descriptions, team workbooks, assessments and manuals (Spillsbury et al. 2013):
  - “We’ve done a lot of work around … [c]larifying what they could do, what was reasonable for them to do, and where they might develop their role further” (Spillsbury et al. 2013)
- support structures for the use of remote supervision using e-health technology
- reflective practice and mentoring
- active development of the relationship between assistants and clinicians
- reasonable steps to ensure that those who are delegated responsibility have the qualifications, experience, knowledge and skills to provide the care required
- communication of sufficient information about the patient and the treatment they need
- provision of a specific supervisor for assistant roles across a multidisciplinary team or a combined role for a nurse and allied health practitioner (Nancarrow et al. 2010).

Clear clinical and organisational governance includes:

- matching elements of the HLT and CHC qualifications and assistant scope of practice to the local and emerging models of care
- providing support to reach a certificate III during employment if it has not been achieved prior to entry
- ensuring familiarity in working with assistants:
  - “[O]nce you work with AiNs for a while you know the tasks and duties they can undertake competently … and they are a really important role as part of the skills mix” (Queensland Health 2013)
- providing explicit guidelines for delegated and assigned workloads, use of care protocols, and referrals
- revising roles that are underpinned by new protocols, training and confirmation of competency
- implementing mechanisms for the clinician and assistant to reflect on practice
- actively clarifying discussions and documenting agreements to set boundaries and parameters of scope of practice and effective teamwork (Sibbald, Shen and McBride 2004) and carefully managing role-sharing.

Projects have the best chance of success when they are performed after an initial service analysis, and take a structured approach to change, leadership and stakeholder engagement (Nancarrow et al. 2012; Department of Health Victoria 2011; National Allied Health Advisors Committee 2012). The result is health professionals’ confidence in their ability to provide delegation and supervision and in assistants’ capacity to perform particular tasks (National Allied Health Assistant Working Group 2012).

To assist workforce reframing, organisations should use the wealth of existing frameworks, including the Health LEADS Australia framework, the National Common Health Capability Resource (HWA 2013b) and complementary profession-specific capability resources.

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Further considerations

Further consideration should be given to:

• supporting the work of CSHISC (2013) to find the best combinations of core and elective units (HLT and CHC training packages for qualifications) for individual settings and common pathways of competencies for mobility across sectors\(^{23}\)

• examining options for a transportable core or foundation certificate III

• ensuring greater consistency of delivery of TPs across registered training organisations (RTOs)

• recognising professionals’ skills in confirming service needs with a certificate of attainment

• understanding core and elective modules for better delegation and supervision

• providing options for managing the cost implications of training for individuals and organisations\(^{24}\)

• supporting national data sets on modes of assistant deployment and training levels

• ensuring that undergraduate clinical education curricula include delegation and supervision

• using simulated learning environments to build acumen in delegation, supervision and monitoring and to adjust the appropriate responses to complex care.

Feasibility

Using the existing assistant workforce is feasible, but health services must capitalise on investment through the most productive models.

For the workforce to be sustainable, the full scope of practice and roles must be harnessed in a way that gives assistants a valued career structure that supports retention.

Strategies to increase attraction and retention (National Institute of Labour Studies 2012; CSHISC 2013) will involve:

• identifying relatively untapped sources, which do not take from the existing health workforce such as:
  
  » volunteers or unpaid carers who may wish to formalise their experience (DEEWR 2012; Lowe et al. 2008; Australian Nursing and Midwifery Federation 2009; National Allied Health Assistant Working Group 2012; National Institute of Labour Studies 2012; Booth et al. 2005)
  
  » people seeking a second career, and with maturity, wishing to ‘give back’ to society (CSHISC 2013)
  
  » industries in decline such the automotive and manufacturing sectors (CHISC 2013)
  
  » students wanting healthcare experience.

• mobilising new workforce development approaches to match emerging service models (CSHISC 2013), including expanding roles within scopes of practice. While ‘vertical’ career opportunities are articulated to support nursing, care should be taken to avoid depleting assistant numbers and lowering the attraction of the assistant role

• working with VET in schools programs and traineeship models (Nancarrow and Mackey 2005; Rural Division Clinical Education and Training Institute 2010)

• paying attention to matching workers of overseas origin with the increasing need for culturally and linguistically diverse assistants (see Appendix 9).


\(^{24}\) Skills SA (DFFE) has capped the funding to both the Certificate III Aged Care and Home and Community Care, which came into effect on 10 October 2013; after this date, access to Skills for All training for individuals became available through full-fee paying programs and was applied to school leavers considering the Certificate III in Aged Care or Home and Community Care as their pathway to a future career.
The feasibility of using assistants as a sustainable part of the response to shortages and other pressures will depend, at a minimum, on:

- ensuring assistants are supported to deliver the service, client and workforce outputs identified in the evidence
- systematically addressing the barriers and limitations discussed
- implementing workforce planning that goes beyond simplistic staff-to-patient ratios.

Planning should determine assistants’ best fit in the local skills mix as well as pursuing quality, safe models to manage complex need (Dubois and Singh 2009).

Further considerations

Further consideration should be given to:

- identifying the most cost-effective skills mix options and balancing growth with consistency, where high turnover and low retention currently exist
- supporting supply pathways from untapped sources
- offsetting the initial costs of training
- clarifying and agreeing on scopes and protocols against the achieved outputs
- fostering and embedding a team-based culture where organisations and professionals value the assistant role
- identifying the number of assistant and support workers that need to be trained per annum to meet the growth in demand (CSHISC 2013)
- ensuring consistency in the quality of training (CSHISC 2013)
- supporting worker mobility through streamlining of TPs in line with changing service requirements
- providing ongoing training for assistants to be part of person-centred care and interdisciplinary teamwork models, where responsibilities are more important than just delegated tasks.
Future directions: the proposed way forward

Australia must harness the existing assistant workforce and make it integral to wider workforce reforms.

This will involve:

- actively adopting the existing evidence and productive models to implement roles sustainably
- actively managing the barriers and limitations to implementation of assistant roles
- using existing and effective strategies to ensure assistants can make a fit-for-purpose contribution to healthcare and be used dynamically over time.

This approach will maximise the skills of our clinicians, meet client needs, assure quality and safety, and create a valued career path for assistants.

An implementation guide has been developed to assist local choices and decisions for the most appropriate and productive assistant models. It is aimed at managing inconsistency between sectors and jurisdictions while preserving local diversity (CSHISC 2013). It seeks to avoid ‘reframing the future’ each time a team takes on an assistant (Rural Division Clinical Education and Training Institute 2010).

This guide is published as Support nationally, act locally (Imison and Bohmer 2013) and it brings together:

- the evidence of the contribution of assistants to service processes, team efficiencies and client care
- considerations to effectively integrate the role within the skills mix of a healthcare team
- how to systematically address the barriers and limitations to better harness the assistant workforce
- clarity for organisational and clinical leadership (see Figure 3).

This is only a guide, but it may be used as a set of logical steps that systematically takes the prospective service manager through a checklist of considerations. It identifies the tools that are available to support local decisions, but it is not a one-size-fits-all approach.

It has been tested by a group of nursing directors in aged care in Victoria Health for its utility. Appendix 19 reflects that particular area of work as an example.

Support nationally, act locally comprises six interdependent elements, framed as a checklist of actions with supporting resources (see Appendix 19):

**Element 1**

Determine context, drivers and needs.

**Element 2**

Identify the local service principles and a clear theory of change.
Element 3

Make decisions on mobilising all staff to their full potential through:

• skills mix – staffing profiles, volume, qualifications and competence levels, discipline mix
• skills management – what contribution is sought in terms of service enhancement, enlargement or redirecting focus.

These two are integrated and interacting in order to secure good outcomes for the workforce and clients. This approach is underpinned by organisational preparedness for capacity to change and implement.

1. Skills mix

Consideration should be given to:

• the number of staff, the quantum of work possible per person and client acuity (lower proportions of staff to patients have been associated with both poor and better outcomes depending on the discipline) (Dubois and Singh 2009)
• the qualifications mix (ratio of most highly qualified to total pool)
• the balance of experience (senior/junior and professional/assistant) (Moran 2008)
• the mix of disciplines for well-rounded care (Dubois and Singh 2009).

The actual roles and skills required are more important for both cost and quality than the grades, qualifications or job titles (Buchan and Dal Poz 2002). Any change in costs related to a position needs to be balanced with the efficiencies created in other parts of the team and with improved quality (Sibbald, Shen and McBride 2004).

2. Skills management

The organisation’s requirements for each role and its service changes should be determined, such as:

• increasing the depth of a job or expanding the role of a worker (role enhancement)
• expanding the breadth of a job and exchanging one type of worker for another (substitution and role enlargement)
• moving a job up or down a traditional ladder (role delegation and flexibility)
• making better use of the clinicians (supplementation and complementation)
• creating a new role and new type of worker or focusing on generalist roles (innovation).

25 For example where the clinical staff is less qualified, a more experienced assistant may enjoy greater independence.
Element 4

Undertake transformational case studies and systematic reviews to identify the value of assistants’ work value as part of healthcare teams. This will inform the organisation’s thinking and push the boundaries.

Element 5

Establish team productivity performance indicators and measures to:
- measure the change from baseline to post-intervention
- understand what contributed to that change in inputs and outputs.

Element 6

Provide a practice environment for effective, efficient and safe use of assistants and support of clinicians (Dubois and Singh 2009).

This underpins skills change and management through cultural and organisational change; human resource management (see Appendix 20); change management capacity; and leadership for sustainable implementation.

It requires a commitment to fully support teams with:
- policies (such as delegation and supervision) and practice direction for individual or team care protocols
- continuing education programs available to all (consider interdisciplinary learning)
- the standards that must apply to balance risk management with flexibility.
Figure 3: Australian assistant and support workforce: Support nationally, act locally

<table>
<thead>
<tr>
<th>Care Contribution</th>
<th>Community Aged care</th>
<th>Community Long-term condition management</th>
<th>Rehabilitation</th>
<th>Subacute care</th>
<th>Acute Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service and workforce enlargement or enhancement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service gaps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service volume</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>low complexity/high intensity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service access/timing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• freeing up clinicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• increasing team skill mix and flexibility*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• workforce of choice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linkages, coordination and navigation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Step 1: Context and drivers

Step 2: Underlying model of care

Step 3: Skills mix and skills management (underpinned by organisational preparedness)

Step 4: Case studies

Step 5: Team productivity measures

Step 6: Organisational preparedness Implementation – leadership and change capacity
Conclusion and recommendations

The assistant workforce is the largest growing workforce group in health and community services in Australia.

There is clear evidence that the assistant and support workforce is an important and appropriate part of healthcare and community teams, with potential for further contribution to both teams and health services more broadly.

The challenges that remain for assistants are:

- integrating them effectively and consistently into interdisciplinary teams
- enhancing support where assistants are lone workers
- delivering good governance for risk management that ensures safety and quality
- harnessing assistants’ flexibility for workforce affordability and sustainability
- identifying and streamlining a sustainable supply of assistants
- undertaking longitudinal research into the best skills mix for acuity, service, client outcomes and workforce
- accepting that a uniform definition or title is unlikely to drive better use of this workforce.

HWA supports the national code of conduct proposed to regulate this workforce. This analysis has established that there are more effective and existing alternatives to registration, as long as they:

- have a clear rationale for implementing the assistant role using local context and drivers
- provide good governance for safety and quality, including delegation and supervision
- harness assistants’ core attributes for flexibility and their generalist functions within teams
- properly prepare and allow assistants to use their full scope of practice
- develop transferability of competencies across the health, aged care and disability sectors.

When implementing assistant roles organisations and jurisdictions must use the available evidence. This will avoid use of time-limited pilots, which are not sustainable. It will support assistants to do the best job possible according to their scopes of practice, contributions and modes of working.

Assistants should be recognised and used as a:

- valued workforce that helps manage skill and time shortages, supports more effective use of professionals, enhances service breadth and depth, and enables more active participation by clients in their care and continuity of care
- safe workforce that is trained and actively supported by organisations and supervising professionals
- flexible workforce that offers the best choice of staff to deliver certain aspects of care, and provides an essential balancing role for more efficient and effective interdisciplinary teamwork
- cost-effective workforce that is affordable within the right skills mix, agreed governance, and leadership arrangements, and where untapped sources of supply can be supported.

When assistants are provided with appropriate training and support, are used effectively, and are fully integrated into teams they can enhance:

- services or changes to service focus
- workforce flexibility and team efficiencies
- client outcomes.
Policy and practice recommendations

National support to strengthen local implementation

This analysis provides high-level guidance (Support nationally, act locally) to support consistent local decision making and best use of evidence in implementing a assistant roles.

Local reform must be led by employers to promote flexibility, good governance and workforce affordability. This reform will:

- identify local context and requirements for change
- determine the relevant model of care and evidence-based principles underpinning it
- determine current and future skills mix using a capability approach
- determine which contributions assistants are required to make and the subsequent changes in other roles to capture net productivity
- agree, document, orient and train the whole workforce in local governance arrangements
- use available case studies to ‘push the boundaries’ and support the change
- use team metrics to demonstrate whole-of-workforce change in productivity or service access and responsiveness
- harness the professional and distributed leadership capacity to actively address the barriers to introducing assistants
- ensure assistants are not required to undertake work for which they are not trained.

Invest in the assistant workforce

Reform must capitalise on the existing workforce and tackle uncertainty by:

- providing support to teams and offering assistants access to continuous practice development
- authorising and acknowledge assistants as an integral part of the workforce design by:
  » using a mix of generalist and single-discipline roles and assigned workload
  » ensuring responsibilities are as important as roles
  » articulating different levels of assistant scopes of practice (full, expanded and advanced), aligned with the local context
  » using partial role substitution, complementation and supplementation to optimise care and resource use.
- aligning workforce roles and placements with models such as consumer-directed care, the wellness (or active service) model and early intervention
- improving skills in delegation, supervision and confirmation of competency to practice and sensible arrangements for supervision of generalist or combined roles
- investing in a team culture that values the development of assistant roles.
Promote recruitment and retention

A transparent and rewarding career structure must be developed to promote the assistant role as a valuable one and career choice in its own right.

This requires articulation into expanded roles as well as pathways into professional qualifications.

As a priority, work must be undertaken with relevant agencies to develop the supply pathways for recruitment and retention that:

• identifies relatively untapped sources that do not take from the existing health workforce
• streamlines pathways and develops national benchmarks
• targets recruitment of assistants from overseas to match the increasing ethnic background of the ageing population
• ensuring recruitment processes identify agreed attitudes and behaviours as these are the most important elements of competency for these roles.

Establish national training and education requirements

An industry-wide process should be facilitated to determine whether a certificate III is desirable as a minimum level of qualification for all assistants, together with the variety of pathways to achieve that.

National agreement on elements of the HLT and CHC qualifications should take into account:

• the best combinations of core and elective units for individual settings
• common pathways of competencies, so that workers can move across sectors and respond appropriately to comorbidity and complexity. This could be a common foundation certificate III, which is upgraded through a modular approach for additional technical skills for different sectors
• the assessment of certificates of attainment for local service needs and recruitment
• national data sets on modes of assistant deployment and training levels.

This is to ensure professionals know the scope of practice and capability of their assistant workforce, and what to delegate and authorise.

Delegation and supervision units should be part of core curricula in undergraduate clinical education. Simulated learning environments can be used to build acumen and adeptness in delegation, supervision and monitoring, and to adjust the responses to complex care needs.

Incentives for low paid workers should be determined that encourage them to engage in skills development (United Voice 2013).
Use evidence to shape and direct reform

Sectors and organisations must use the available evidence to promote and implement reform.

National repositories should be created to share evidence, including:

- existing and tested implementation resources building on the work of jurisdictions and employer organisations
- case studies that demonstrate the benefits and uses of assistants
- case studies of the leadership and capability required to sustain the most productive use of assistants. These should be aligned with HWA Health LEADS Australia, the National Common Health Capability Resource and jurisdictional guides.

Undertake evaluation and research

Where assistants are introduced to a team or their role is enhanced to improve their contribution, team metrics and longitudinal studies should be used to:

- assess a whole-of-workforce baseline, ongoing productivity and client outcomes
- determine the cost-effectiveness of different types of skill mix and their impact on healthcare settings
- determine a threshold of optimal staffing mix below which care is compromised and above which there is no significant effect on quality outcomes
- track where and how assistants are deployed to understand their use better and to measure the impact of retention strategies.
- National data sets specific to assistants should be created.
## Appendix 1: List of stakeholders

<table>
<thead>
<tr>
<th>Category</th>
<th>Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT Health</td>
<td>People Strategy and Services Branch ACT Health; Office of Chief Nursing; Office of Allied Health Advisor</td>
</tr>
<tr>
<td>Commonwealth Government</td>
<td>Department of Health and Ageing; ACCD – Workforce Policy and Programs; Policy and Data Branch Health Workforce Division</td>
</tr>
<tr>
<td>NSW Health</td>
<td>NSW Ministry of Health - Workforce Planning &amp; Development</td>
</tr>
<tr>
<td>NT Department of Health</td>
<td>Strategic Workforce Planning; Office of Professional Leadership, Nursing &amp; Midwifery; Office of Allied Health Advisor</td>
</tr>
<tr>
<td>Qld Health</td>
<td>Workforce Design and Liaison Unit; Office of Allied Health Advisor</td>
</tr>
<tr>
<td>Private sector</td>
<td>Leading Aged Services Association; Catholic Health Australia; Ramsay Health Care</td>
</tr>
<tr>
<td>Industrial/Professional</td>
<td>Federal ANF; United Voice; Australian College of Nursing</td>
</tr>
<tr>
<td>National agencies</td>
<td>CSHISC; Australia Workforce Productivity Agency</td>
</tr>
<tr>
<td>SA Health</td>
<td>Workforce Reform and Innovation; Chief Nurse, Nursing and Midwifery Office; Office of Allied Health Advisor; SA Health &amp; Community Services Skills Board Inc</td>
</tr>
<tr>
<td>Vic Health</td>
<td>Sector Workforce Planning; Office of Chief Nursing; Office of Allied Health Advisor</td>
</tr>
<tr>
<td>Tasmanian Dept Health and Human services</td>
<td>Workforce strategies; Office of Allied Health Advisor</td>
</tr>
<tr>
<td>WA Health</td>
<td>Workforce Planning; Office of Chief Nurse; Office of Allied Health Advisor</td>
</tr>
<tr>
<td>Peak Bodies</td>
<td>National Allied Health Advisors Council; HWA Allied Health Professionals Committee</td>
</tr>
<tr>
<td>NGO sector</td>
<td>Aged and Community Services Association; HWA NGO and Private Standing Advisory Committee</td>
</tr>
<tr>
<td>International</td>
<td>New Zealand Nursing Organisation; Chief Nurse NZ Health</td>
</tr>
<tr>
<td>HWA</td>
<td>Standing Advisory Committee for Health Professions; Innovation and Reform Advisory Committee (discontinued May 2013) – jurisdictional workforce representatives</td>
</tr>
</tbody>
</table>

Individual key commentators/employers: Prof. Susan Nancarrow Southern Cross University; A/Prof Rosalie Boyce; Adj Prof Judith Catherwood (former) AH Dir Royal Brisbane & Women’s Hospital Qld; Prof James Buchan HWA Specialist Advisor; Karen Cook HWA Specialist Advisor; Prof Karen Grimmer-Somers and Dr Saravana Kumar – iCAHE; Joanna Briggs Institute South Australia


HWA Conference 2013 - Skilled and Flexible: Are assistants a solution to our workforce shortages? Monday 18th November, 120 participants
Appendix 2: AIHW Australian hospital statistics 2011–12

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65–74</td>
<td>1,259,913</td>
<td>1,320,227</td>
<td>1,420,029</td>
<td>1,512,942</td>
<td>1,615,825</td>
</tr>
<tr>
<td>75–84</td>
<td>1,177,456</td>
<td>1,215,814</td>
<td>1,274,183</td>
<td>1,323,230</td>
<td>1,388,415</td>
</tr>
<tr>
<td>85 and over</td>
<td>424,526</td>
<td>458,233</td>
<td>501,006</td>
<td>551,670</td>
<td>592,477</td>
</tr>
</tbody>
</table>

Hospital separations by age group and year

Source: AIHW Australian hospital statistics
Notes: Public and private hospitals included (TAS, ACT, NT did not supply private hospital data in any year).
Appendix 3: Health and community service employment

Figure 2: Projected growth in selected Community Services and Health occupations, 2011–12 to 2016–17

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Additional ‘000 workers, 2011–12 to 2016–17 (projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse</td>
<td>46.8</td>
</tr>
<tr>
<td>Aged and disabled carers</td>
<td>23.9</td>
</tr>
<tr>
<td>Child carers</td>
<td>18.4</td>
</tr>
<tr>
<td>Nursing support and personal care workers</td>
<td>13.6</td>
</tr>
<tr>
<td>Generalist medical practitioners</td>
<td>9.2</td>
</tr>
<tr>
<td>Welfare support workers</td>
<td>8.3</td>
</tr>
<tr>
<td>Education aides</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Source: CSHISC E-Scan 2013
Projected employment growth, November 2012 to November 2017

<table>
<thead>
<tr>
<th>Industry</th>
<th>Projected Employment Change ('000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care and Social Assistance</td>
<td>177.8</td>
</tr>
<tr>
<td>Retail Trade</td>
<td>109.1</td>
</tr>
<tr>
<td>Construction</td>
<td>100.2</td>
</tr>
<tr>
<td>Accommodation and Food Services</td>
<td>66.8</td>
</tr>
<tr>
<td>Education and Training</td>
<td>64.5</td>
</tr>
<tr>
<td>Professional, Scientific and Technical Services</td>
<td>62.8</td>
</tr>
<tr>
<td>Public Administration and Safety</td>
<td>43.2</td>
</tr>
<tr>
<td>Transport, Postal and Warehousing</td>
<td>41.6</td>
</tr>
<tr>
<td>Other Services</td>
<td>38.5</td>
</tr>
<tr>
<td>Administrative and Support Services</td>
<td>26.1</td>
</tr>
<tr>
<td>Arts and Recreation Services</td>
<td>21.8</td>
</tr>
<tr>
<td>Financial and Insurance Services</td>
<td>16.1</td>
</tr>
<tr>
<td>Wholesale Trade</td>
<td>15.5</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>14.2</td>
</tr>
<tr>
<td>Mining</td>
<td>11.5</td>
</tr>
<tr>
<td>Rental, Hiring and Real Estate Services</td>
<td>11.1</td>
</tr>
<tr>
<td>Information Media and Telecommunications</td>
<td>9.6</td>
</tr>
<tr>
<td>Electricity, Gas, Water and Waste Services</td>
<td>3.3</td>
</tr>
<tr>
<td>Agriculture, Forestry and Fishing</td>
<td>-13.5</td>
</tr>
</tbody>
</table>

Appendix 4: Services and skills match

Diagram illustrating the relationship between population health need levels, current workforce trends, and future workforce reform, showing how workforce flexibility can boost productivity.
Appendix 5: Assistant characteristics and work features

Where do assistants work, what are their characteristics, pathways to employment, and training?

Assistants work in health, ageing, disability, mental health and social care. They work in public, private and non-government sectors, in rural, remote and urban settings. They cover allied health, nursing and a range of community social or support services, in a diverse range of roles and competencies.

They are used in all the following settings and ways:

- **Home and Community Care (HACC) and community primary health care (PHC)**
  - working in peoples’ homes, community health teams and day therapy centres
  - focused on daily assistance with personal care, living and socialisation, disability care, chronic condition/ falls prevention/ cognitive decline – risk factor management or restorative care or mental health programs
  - in GP practices as medical practice assistants in both clinical and non-clinical care
  - they may work autonomously and often solo in the home, reporting to a care coordinator; or under delegation and supervision (which may be remote); or as part of PHC interdisciplinary teams.

- **Residential aged care**
  - as a PCA, PCW or an AHA
  - located in one site (or within a large aged care organisation)
  - traditionally working on task delegation, but this model is changing to a resident-centred model (and use of assigned delegated workload) to harness their full scope of practice and be a full contributor to the problem-solving team.

- **Sub-acute: Rehabilitation (including spinal cord injury), gerontology/ geriatric evaluation and management units and palliative care.**
  - can be generalist supporting a team or combined nurse/ allied health practitioner, or as a single-discipline support, or both
  - have a lead supervisor or single-discipline supervisor
  - in one institutional location or community (for example ‘ rehab in the home’), working within team protocols and guidelines and supplementing or partially substituting
  - often working in full-scope roles developed specifically for the setting, or advanced roles because of the nature of the team-trust relationship and care needs.

- **Acute care**
  - Nursing (NSW Health 2010) and allied health assistants are found in all levels of hospitals – principal referral to large, medium and small, specialist women’s and children’s, psychiatric and rehabilitation, to small non-acute and multipurpose services
  - clinical support officers relieve nurses of administration (an average of 12 per cent of nurse duties)
  - all may work
    - across or on one inpatient medical/surgical/general ward
    - in ICU, critical care or emergency departments
    - in outpatients
    - in discharge coordination
there are varying levels of agreement on where and how assistants should work in acute; this depends on the quality of the professional leadership, culture of acceptance and extent of support. A variety of examples is quoted throughout this analysis. Positions are established on a case by case basis rather than consistent application, based on type of contributions needed and evidence. The categorisation of service settings and models mostly relates to the kind of delegation, independence, and supervision they have (Kumar et al. 2008).

There is no evidence for excluding use of assistants in any one setting if the drivers are clear and the management, training and support are properly structured within the right skills/staff mix and governance (ie delegation, confirmation of competence and supervision) arrangements (Spillsbury et al. 2013; NSW Health 2010). Past emphasis has been on the utility of assistants to manage rural and remote needs. This is now seen as equally important for metropolitan service models.

The private and non-government aged care sectors have probably been the largest users of the nursing support and personal care workers, demonstrating different drivers and business models as seen in Table 1 below. Some public sector jurisdictions now have deliberate strategies to ‘grow their own’ assistant workforce, eg NSW and Victoria (Department of Health 2013) or in Queensland via introduction of models of care (HWA 2012c).

Table 1: Number of employed nursing support and personal care workers by sector and industry

<table>
<thead>
<tr>
<th>Industry</th>
<th>Commonwealth Government</th>
<th>State and territory government</th>
<th>Local government</th>
<th>Private sector</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care and social assistance</td>
<td>20</td>
<td>13,409</td>
<td>24</td>
<td>53,193</td>
<td>66,646</td>
</tr>
<tr>
<td>Hospitals</td>
<td>14</td>
<td>12,080</td>
<td>0</td>
<td>5591</td>
<td>17,685</td>
</tr>
<tr>
<td>Residential care services</td>
<td>0</td>
<td>1,097</td>
<td>18</td>
<td>37,562</td>
<td>38,677</td>
</tr>
<tr>
<td>Other healthcare and social assistance services</td>
<td>6</td>
<td>232</td>
<td>6</td>
<td>7346</td>
<td>7,590</td>
</tr>
<tr>
<td>Other industries(a)</td>
<td>113</td>
<td>488</td>
<td>331</td>
<td>2,617</td>
<td>3,857</td>
</tr>
<tr>
<td>Total</td>
<td>133</td>
<td>13,897</td>
<td>355</td>
<td>55,810</td>
<td>70,503</td>
</tr>
</tbody>
</table>

Source: ABS Population of Census and Housing, 2011

What are the characteristics of assistants?

The majority of assistants are female and work part-time. The median age for personal care attendants (PCAs) in residential aged care is 47 years (noting that a large proportion start after 40 years of age). The median age for community aged care direct care workers is 50 years (National Institute of Labour Studies 2012) (see Appendix 6). By 2012, the proportion of the workforce that was born overseas had increased to 35 per cent in residential facilities and 28 per cent of community services (National Institute of Labour Studies 2012). There is some increase in the number of younger workers entering the allied health assistant workforce, but this is occurring as the supervising allied health professionals are increasingly working part-time (Lowe et al. 2008).

The assistant workforce is generally looking for flexible working conditions. Assistants want to combine work with family and /or study responsibilities; seek part-time work post-family responsibilities; or are students and professionals seeking experience and paid employment during their studies (National Institute of Labour Studies 2012).
Most assistants specifically enjoy the caring aspect of the role. This is increasingly seen as the key requirement for this role and the focus of recruitment. Skills and knowledge can be taught (DEEWR 2012) once employed.

**What are their pathways to employment?**

There is no minimum entry educational requirement for employment, and people enter the assistant workforce from a variety of backgrounds:

- those already employed in the health and social care workforce
- Year 10–12 schooling recruitment to caring services; nationally recognised credit structure programs towards certificates of education relevant to assistants are available during schooling, or as a form of traineeship or apprenticeship (Nancarrow and Mackey 2005)
- on completion of a vocational education and training (VET) health or community care qualification
- as an entry point into the healthcare profession (with a degree-level qualification) or as a student healthcare professional
- following carer or voluntary work in aged or disabled care
- from other industries such as sales, hospitality, cleaning or clerical work (just over one-third of Personal Care Assistants) and industries in decline
- from an existing assistant position to an advanced assistant role, developed in response to changing demand and detailed under the section ‘What assistants do’.

**What are their qualifications and/or on-the-job training?**

Assistants are covered by the vocational education and training (VET) sector. Certificate II, III and IV qualifications for assistants (education resulting in a certified vocational qualification) are attained under the Australian Qualifications Framework, designated:

- HLT: in health – allied health and nursing
- CHC: in aged care and health and community services

See Appendix 10: VET courses and commonalities between AH and Nursing.

The training package (TP) comprises core and elective elements. Mapping these across the many relevant courses for assistants reveals a high level of diversity but also commonality, indicating an opportunity to streamline elements to support better mobility across sectors.

---

2 Victorian Curriculum and Assessment Authority: Victorian Certificate of Education VET Health Program
3 Students who are enrolled in degree qualifications or people already qualified at diploma or higher degrees may elect to enter the healthcare sector via the assistant role, when it is the only available entry point into their preferred profession.
The relevant educational attainments range from:

- certificate II to certificate III: assistants tend to have a foundation certificate III qualification in a specific sector – aged care, community services work; home and community care; health support services; health services assistance; or health support services. Assistants may be required to do further formal training to transfer across sectors\(^5\)

- certificate IV qualification: for enhanced practice or a specific area of work depending on employer needs. Certificate IV in AHA is the accepted qualification requirement for a role covering up to three AH disciplines (from a list of 5) but is not an automatic entry to the role (Department of Health 2008; ACT Health 2007).\(^6\) ACT, Queensland and Victoria support three levels of classification

- vertical career pathways exist from certificate III and IV on to professional diploma and bachelor programs\(^7\) (see nursing example in Western Australia: Appendix 11)

- practical on-the-job clinical care training and training covering theoretical structured course work. Models that combine formal and informal training and ongoing workplace development opportunities are seen as best practice (Rural Division Clinical Education and Training Institute 2010). Some large employing organisations (accredited as their own RTO) internally support assistants through their own formal qualification.\(^8\)

### Assistant recruitment and retention

**How many assistants are there and how many do we need?**

While shortages are predictable, future supply of a particular workforce is more difficult as it is affected by demographic trends. Vacancies can be used to assess potential workforce imbalances (see Appendix 7).

The workforce data for assistants in aged care is gathered on a regular basis (National Institute of Labour Studies 2012). Similar data for assistants in public health services is not as readily available.

Increasing reliance will be placed on the VET-qualified workers and generalist roles to meet the increasing demand projected (Appendix 344), which outstrips growth in the registered workforce, coupled with constraints on public health and community spending (CSHISC 2013).

What we do know is:

- health and community services currently employ 1.374 million health care and social assistance workers (9 per cent of the full-time workforce). This is projected to grow by at least 35 per cent over the next ten years (CSHISC 2013)

- as at November 2011 there were 82,100 Nursing Support and Personal Care workers (ANZSCO code 4233 only) in community services and health, with a predicted need for a further 13,600 workers (16.5 per cent increase) by 2016–17 (CSHISC 2013)

- by including aged and disabled carers (ANZSCO codes 4231 and 4233) this group is projected to have one of the largest increases in employment of any occupational group, with 34,500 new jobs required over the five years from November 2012 to November 2017 (DEEWR 2012). This proportion is based on the assumption that the demand for aged and disabled carers remains at current per capita levels

- total employment in residential aged care in 2012 was estimated to be 202,344 workers, including personal care attendants who rose from 56.5 per cent of the workforce in 2003 to 68.2 per cent in 2012 (Booth et al. 2005)

---

\(^5\) NB: there are currently 117 different Cert III qualifications (CHC 30112 to CHC31008) and 31 HLT different Cert III qualifications (HLT 30212 to HLT 33112) which may be selected as relevant

\(^6\) The UK skills levels for assistants are Skills for Health Bands 2 to 4 and for advanced roles (assistant practitioner) Band 5.

\(^7\) Describing a pathway to becoming an enrolled or division 2 nurse completing a HLT 43407 (Cert IV in Nursing), HLT 51607 (Dip Nursing) or HLT 61107 (Advanced Diploma of Nursing). Then professional advancement via Bachelor of Nursing (Registered Nurse qualification)

\(^8\) For example Uniting Care Ageing
in community aged care the estimated workforce is 149,801 workers (2012). Despite differences in the estimation procedures between 2007 and 2012, there was a shift from 60,587 to 76,045 community care workers (20.3 per cent increase) representing 81.4 per cent of the total community workforce

• the number of employed therapy aides increased threefold between 1996 and 2011, ie by 2,814

• estimates of the need for ‘an additional 750,000 direct care givers within just one generation’.9

The National Institute of Labour Studies (NILS) survey concluded that in aged care ‘the capacity of the nursing workforce may well be approaching over-utilisation’ but that the 12 per cent personal care attendants preferring to work a standard full-time week may provide ‘some room to acquire further capacity’ (NILS 2012).

The emphasis on primary health care and in home care (Commonwealth of Australia 2013) will increase demand for personal care workers, as will the National Disability Insurance Scheme for disability support staff (DEEWR 2012). The challenge is to use our scarce resources well and identify and streamline supply options across all sectors (CSHISC 2013).

How long do assistants stay in the assistant role?

The retention and turnover rates of assistants vary according to location, sector and discipline (United Voice 2013). Overall the aged care workforce is relatively stable, with generally long tenure (a third of residential direct care workers and a quarter of community direct care workers had been in the sector for 15 years or more). However, workers frequently move between aged care organisations (NILS 2012).

The proportion of residential aged care facilities with vacancies has been increasing since 2003 and is most pronounced for PCAs. Thirty-six per cent of facilities reported recruitment of PCAs to replace staff; because they are the largest staff group, facilities with vacancies often need multiple PCAs to fill their staffing needs (National Institute of Labour Studies 2012). On average only one-third of vacancies were filled in one week, and with about one suitable applicant per vacancy (DEEWR 2012). There were significant state differences and metropolitan employers expected to have more turnover than rural.

The most usual reasons for turnover and lower retention rates (see Appendix 8) are:

• changing employers as a consequence of needing to fulfill caring responsibilities, wanting to work closer to home and desired hours and shifts

• wanting to find more challenging work (and at the same time limited career pathways)

• poor private and non-profit sector pay and conditions despite the recent wage case10

• being undervalued by their employer where the clinician perception is that they are not only unqualified but also ‘untrained’ (Skills for Health 2011)

• a lack of organisational support

• pursuing work in the mining industry (WA) versus less attractive carer roles in aged care11

• as they tend to be older, the length of time spent in the workforce will necessarily be shorter than that for younger workers (NILS 2012; Booth et al. 2005; United Voice 2013; CSHISC 2012)

• difficulties and risks associated with providing in-home care as a lone worker (DEEWR 2012).

In health the turnover is higher, particularly in rural and regional areas. The employment time for AHA is more difficult to ascertain with certainty. Variable tenure times have been reported, from less than five years (Rural Division Clinical Education and Training Institute 2010) to between 6.6 and 12 years (NSW Health 2012). This has implications for care continuity, costs of recruitment and training requirements, and projected shortages (CSHISC 2013).

10  Fair Work Decision of 1 February 2012, for aged care community sector workers
Appendix 6: Characteristics of assistants – personal care workers (PCWs)

DEEWR report Nov 2012 – Figure 10: Demographic Profile of Personal Care Workers (%)

Appendix 7: Assistants required – skill shortages and vacancies in residential aged care

Table 2: Proportion of residential aged care facilities reporting skill shortages in 2012 (per cent), by location and occupation affected

<table>
<thead>
<tr>
<th>Whether had skill shortage</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>All</th>
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<td>25.3</td>
<td>8.1</td>
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<td>75.9</td>
<td>74.7</td>
<td>91.9</td>
<td>90.5</td>
<td>76.1</td>
</tr>
</tbody>
</table>

Yes, for

- Registered Nurses 62.2 63.8 62.3 70.3 42.9 62.5
- Enrolled Nurses 32.7 32.9 34.9 48.6 28.6 33.2
- Personal Care Attendants 49.1 42.9 53.1 78.4 76.2 48.7
- Allied Health 19.5 18.2 21.6 18.9 9.5 19.4

Note: figures are %; Multiple responses allowed, columns do not sum to 100

Table 3: Vacancy rate (per cent of all residential aged care facilities) and mean number of vacancies (in facilities with vacancies), by occupation: 2003, 2007 and 2012

<table>
<thead>
<tr>
<th>Vacancies - residential aged care</th>
<th>% of facilities with any vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>Registered Nurses</td>
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<tr>
<td>Enrolled Nurses</td>
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<tr>
<td>Person Care Attendants</td>
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</tr>
<tr>
<td>Allied Health</td>
<td>6.3</td>
</tr>
</tbody>
</table>

*mean number of (FTE) vacancies in facilities with any vacancies

Appendix 8: Assistant recruitment and retention factors in aged care

DEEWR report Nov 2012 – Figure 6: Top 5 reasons for difficulty in recruitment and retention

- Too few applicants: 86.4%
- Location: 50%
- Wages not competitive: 40.9%
- Nature of the work: 36.4%
- Working hours: 31.8%
Appendix 9: Overseas supply for ANZSCO codes 4231 and 4233

Table 3: Persons employed who were born overseas and arrived in Australia between 1996 and 2011, by country of birth and highest non-school qualification – 2011. ABS Census 2011: Nursing Support and Personal Care Workers

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Bachelor and above</th>
<th>Advanced Diploma and Diploma Level</th>
<th>Certificate Level</th>
<th>Level of education not stated/inadequately described</th>
<th>Not applicable (no non-school qualification)</th>
<th>Total</th>
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Table 4: Persons employed who were born overseas and arrived in Australia between 1996 and 2011, by country of birth and highest non-school qualification. 2011- ABS Census 2011: Aged and Disabled Carers

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Bachelor and above</th>
<th>Advanced Diploma and Diploma Level</th>
<th>Certificate Level</th>
<th>Level of education not stated/ inadequately described</th>
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Table 5: Total persons employed, by highest non-school qualification and born overseas – ABS Census 2011

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Total persons employed

<table>
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<th>Aged and Disabled Carers</th>
<th>Nursing Support and Personal Care Workers</th>
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</thead>
<tbody>
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<td>Female</td>
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Source: 2011 Census of Population and Housing
Table 6: Visa grants to Nursing Support and Personal Care Workers (ANZSCO 4233) - Primary Applicants

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</table>

Source: Department of Immigration and Citizenship
## Appendix 10: Applicable VET training packages for ANZSCO codes 4231 and 4233

<table>
<thead>
<tr>
<th>Common Training Packages used for Assistants in Nursing</th>
<th>Common Training Packages used for Assistants in Allied Health</th>
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<tbody>
<tr>
<td>CHC30102 - Certificate III in Aged Care Work</td>
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<tr>
<td>CHC30199 - Certificate III in Community Services (Aged Care Work)</td>
<td>CHC30199 - Certificate III in Community Services (Aged Care Work)</td>
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<td>CHC30202 - Certificate III in Home and Community Care</td>
<td>CHC30202 - Certificate III in Home and Community Care</td>
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<tr>
<td>CHC30208 - Certificate III in Aged Care</td>
<td>CHC30208 - Certificate III in Aged Care</td>
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<tr>
<td>CHC30308 - Certificate III in Home and Community Care</td>
<td>CHC30308 - Certificate III in Home and Community Care</td>
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<td>HLT30802 - Certificate III in Health Support Services (Client/Patient Support Services)</td>
<td>HLT30802 - Certificate III in Health Support Services (Client/Patient Support Services)</td>
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<tr>
<td>HLT31002 - Certificate III in Health Support Services</td>
<td>HLT31002 - Certificate III in Health Support Services</td>
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<td>HLT31402 - Certificate III in Health Service Assistance (Hospital and Community Health Pharmacy Assistance)</td>
<td>HLT31402 - Certificate III in Health Service Assistance (Hospital and Community Health Pharmacy Assistance)</td>
</tr>
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<td>HLT31407 - Certificate III in Hospital/Health Services Pharmacy Support</td>
<td>HLT31407 - Certificate III in Hospital/Health Services Pharmacy Support</td>
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<td>HLT31602 - Certificate III in Health Service Assistance (Client/Patient Services)</td>
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<td>HLT31702 - Certificate III in Health Service Assistance (Allied Health Assistance)</td>
<td>HLT31702 - Certificate III in Health Service Assistance (Allied Health Assistance)</td>
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<td>HLT32407 - Certificate III in Allied Health Assistance</td>
<td>HLT32407 - Certificate III in Allied Health Assistance</td>
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<td>HLT32507 - Certificate III in Health Services Assistance</td>
<td>HLT32507 - Certificate III in Health Services Assistance</td>
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<td>HLT32807 - Certificate III in Health Support Services</td>
<td>HLT32807 - Certificate III in Health Support Services</td>
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<td>Additional and Different Training Packages in AHA</td>
<td>Additional and Different Training Packages in AHA</td>
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<td>HLT42507 - Certificate IV in Allied Health Assistance*</td>
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<td>CHC40108 - Cert IV Aged Care</td>
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<td>CHC40102 - Cert IV Aged Care Work</td>
<td>CHC40102 - Cert IV Aged Care Work</td>
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<tr>
<td>CHC40308 - Cert IV Disability</td>
<td>CHC40308 - Cert IV Disability</td>
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<tr>
<td>CHC40302 - Cert IV Disability Work</td>
<td>CHC40302 - Cert IV Disability Work</td>
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<tr>
<td>HLT 43312 Cert IV in Medical Practice Assisting</td>
<td>HLT 43312 Cert IV in Medical Practice Assisting</td>
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Example of core and elective units for an assistant training package

Health Training Package: Qualification Framework
HLT32507 Certificate III in Health Services Assistance

15 units of competency are required for award of this qualification, including six core units and 9 electives outlined in the Health Training Package.

Core units:
- BSBFLM303C Contribute to effective workplace relationships
- BSBMED201A Use basic medical terminology
- HLTAP301B Recognise healthy body systems in a healthcare context
- HLTHIR301B Communicate and work effectively in health
- HLTIN301C Comply with infection control policies and procedures
- HLTOHS200B Participate in OHS processes

Electives:
- HLTCSD305C Assist with client movement
- HLTCSD306C Respond effectively to difficult or challenging behaviour
- HLTCSD208C Transport clients
- HLTAIN302B Provide support in an acute care environment
- HLTCSD201C Maintain high standard of client service
- HLTCSD304C Support the care of clients
- HLTCSD203B Prepare and maintain beds
- HLTHIR 403B Work effectively with culturally diverse clients and co-workers
- HLTTSMS203B Organise personal work priorities and development

Skills set for Assisting in Nursing Work in Acute Care recommended by NSW Health:
- The above HLT electives in bold, plus
- HLT AIN301A assist nursing team in acute care environment
- HLT AIN302A provide support in an acute care environment

NB: * Certificate IV in AHA additionally includes

- HLTAH401C Deliver and monitor a client-specific exercise program
- HLTAH408C Assist with the development and maintenance of client functional status
- HLTAH410C Support development of speech & communication skills (Note prerequisite: HLTAH301C)
- HLTCR401C Work effectively in community rehabilitation
- HLTCR403B Support community access and participation
- HLTHIR403C Work effectively with culturally diverse clients and co-workers
- CHCCM401D Undertake case management
- TAEDEL401A Plan, organise and deliver group-based learning
- SISCCRO303A Plan and conduct a recreation program for older persons
- BSBWOR401A Establish effective workplace relationships
- BSBWOR502B Ensure team effectiveness
- CHC 40108 Certificate IV Aged Care PCWs; Support workers; Assistant Coordinators; AHA; Rehabilitation Assistant
- CHC40308 Certificate IV Disability Senior PCAs and Support officers
Appendix 11: Pathways to a nursing or midwifery career in WA

Entry options

Year 10
- Certificate II
- Other RPL

Year 11
- Certificate III
- STAT
- Other RPL

Year 12 (pass English and Maths)
- Certificate IV
- STAT
- Other RPL

Year 12 (WACE)
- Enrolled Nurse qualification
- STAT
- Other RPL

Other degree
- Graduate entry Masters in Nursing

Qualification

Certificate III – Assistant in Nursing

Certificate IV –
eg: Aboriginal Health Worker, Health Science Foundations, Preparation entry to Nursing

Enrolled nurse – Diploma of Nursing (Enrolled Division 2 Nursing)

Registered Midwife – Bachelor of Science (Midwifery) ATAR 80
- Dual degree available (ATAR 65)

Registered Nurse – Bachelor of Science (Nursing) ATAR 55-70

Employment opportunities

Assistant in nursing

Aboriginal Health Worker

Enrolled nurse

Registered midwife

Registered nurse

Graduate entry Masters in Nursing

Acronyms

RPL Recognition of Prior Learning

STAT Special Tertiary Admission Test

WACE Western Australian Certificate of Education

NB: Updated pathway on 2014 with ATAR changes (not yet available on WA website)

Further education opportunities

Advanced Diploma in Nursing

Postgrad cert

Grad Diploma

Doctoral Degree

Masters Degree

Grad Dip or Masters of Midwifery

Postgrad cert

Grad Diploma

Doctoral Degree

Masters Degree

Nurse Practitioner

Other degree
Appendix 12: Post-school qualifications in residential aged care and community care workers

Post-school qualifications completed by the residential direct care workforce, by occupation: 2012 (per cent) (Table 3.12 - NILS Survey 2012)

(Source: NILS Aged Care Survey 2012)

<table>
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<tr>
<th>Qualification</th>
<th>Care Manager</th>
<th>Care Leaders</th>
<th>RN</th>
<th>EN</th>
<th>PCA</th>
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## Qualification Distribution

The table below shows the distribution of residential facilities by proportion of Personal Care Attendants (PCAs) with certificate-level qualifications: 2007 and 2012 (per cent) (Table 3.13, NILS Survey).

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<th>Qualification</th>
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<th>Care Leaders</th>
<th>RN</th>
<th>EN</th>
<th>PCA</th>
<th>AH</th>
<th>All DCW*</th>
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### Distribution of PCAs with Certificate Qualifications

The table below illustrates the proportion of PCAs with either a Certificate III or IV in Aged Care for the years 2007 and 2012.

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Post-school qualifications completed by the community direct care workforce, by occupation: 2012 (per cent) (Table 5.12, NILS Survey 2012)

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<tr>
<th>Qualification</th>
<th>Care Manager</th>
<th>Care Leaders</th>
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Distribution of community outlets by proportion of Community Care Workers (CCWs) with relevant certificate-level qualifications: 2007 and 2012 (per cent) (Table 5.13: NILS Survey)

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Total (a) includes students where age and sex unknown
Voc Stats 14 June 2013
## Assistants in Allied Health – Qualifications Completed for Selected Industry Skills Council Training Packages (NCEVER)

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1. Provision of care
   1.1 Performing healthcare activities
      1.1.1 Plan and prepare
      1.1.2 Perform and deliver
      1.1.3 Monitor and evaluate
      1.1.4 Modify or replan
   1.2 Supporting processes and standards
      1.2.1 Evidence-based practice
      1.2.2 Quality care provision and risk management
      1.2.3 Information management

2. Collaborative practice
   2.1 Collaborating with clients
      2.1.1 Relationship building
      2.1.2 Shared decision-making
      2.1.3 Shared responsibility
   2.2 Collaborating interprofessionally
      2.2.1 Vision and objectives
      2.2.2 Role clarity
      2.2.3 Workplace communication
      2.2.4 Collaboration within and across teams
      2.2.5 Collaborative decision-making
      2.2.6 Conflict management
      2.2.7 Team reflexivity
      2.2.8 Individual contribution
   2.3 Collaborating across time and place
      2.3.1 Clinical handover, follow-up and referral
      2.3.2 Integrated care

3. Health values
   3.1 Respect
   3.2 Equity
   3.3 Diversity
   3.4 Prevention and wellness
   3.5 Whole person focus
   3.6 Responsible use of resources
   3.7 Innovation and change

4. Professional, ethical and legal approach
   4.1 Professional behaviours
      4.1.1 Ethical and legal practice
      4.1.2 Self-regulation and self-management
      4.1.3 Accountability
      4.1.4 Conscientiousness
      4.1.5 Integrity
      4.1.6 Self-care

5. Life-long learning
   5.1 Development of self
      5.1.1 Life-long learning and professional development
      5.1.2 Self-reflection
   5.2 Development of others
      5.2.1 Professional support relationships
      5.2.2 Feedback and peer assessment
Appendix 14: ABS role definitions for workers classified under ANZSCO codes 4231 and 4233

Nursing support and personal care workers (4233) may:
- assist patients with their personal care needs such as showering, dressing and eating
- assist patients with their mobility and communication needs
- participate in planning the care of individuals
- follow therapy plans with interventions to assist those with dementia and behavioural problems
- observe and report changes in patients’ condition, and report complaints about care
- assist with rehabilitation exercises, basic treatment and delivering medications
- provide direct support and assistance to therapists.\(^\text{12}\)

Nursing support workers (423312) (or assistants in nursing) may perform the following tasks:
- adhere to specialised care or treatment for elderly, mental health patients and patients with disabilities
- assist nurses in treatments and rehabilitation movements
- collaborate with nurses to understand individual patient circumstances and plan for recovery
- notify nurses and doctors of patient’s development and reaction to treatments and medications.\(^\text{13}\)

Personal care assistants (423313) may perform the following tasks:
- advise patients and their families concerning healthcare needs, diet restrictions, and cleanliness
- aid patients to live efficiently in their own homes or in residential care facilities\(^\text{14}\)
- care for patients and families during times of incapacitation, convalescence or family disruption by providing personal care and companionship
- change bed linens, prepare food, clean homes, and transfer clients who are unable to do so themselves
- help patients dress, eat, move around their homes/healthcare facilities.

Therapy aides (423314) who are predominantly in either hospitals or aged care residential services and in the private sector, may perform the following tasks:
- provide general care and comfort to patients and ongoing therapy as directed
- guide and assist patients in the performance of craft, recreational and leisure activities
- assist in the training of disabled persons in self-care and daily living activities
- assist patients in the performance of routine physiotherapy or hydrotherapy exercises on an individual or group basis
- report on action taken, clients’ progress and any unusual circumstances.\(^\text{15}\)

Aged and Disabled Carers (4231) (or home support workers/ personal care workers) may:

- accompany aged and disabled persons during daily activities
- assist clients with their mobility
- prepare food for clients; shop and run errands\(^{16}\)
- arrange social activities; provide companionship, friendship and emotional support
- perform housekeeping tasks such as vacuuming and cleaning
- assist in personal hygiene and dressing.

Appendix 15: Care contribution models

Model 1: The personal care worker (PCW or PCA)

PCWs provide personal care, general household assistance, emotional support and companionship for aged persons and those with a disability (DEEWR 2012); this includes assisting with hygiene and/or bathing and toileting, helping with dressing, supporting wellbeing, companionship and emotional support, and general cleaning and changing bedding.

Employees working in clients’ home tended to have more tasks than employees working in residential care facilities, with duties including shopping, meal preparation, general cleaning and transportation to appointments. PCWs in residential care facilities are more likely to contribute to dementia care programs and medical observations (DEEWR 2012). They mostly work under a purely task delegation model, rather than being integral to the whole team and effective team problem-solving processes.

Task variation in residential care and in clients’ own homes (% of employers, multiple responses allowed) (Figure 1: DEEWR 2012)
Corpus Christi (Catholic Homes), a not-for-profit organisation, introduced ‘RAISE the BAR’ (Relationships, Advanced Practice, Innovation, Skill Sets and Expectations) into its operations to improve client outcomes. It also aimed to build its staff capability to do the best job possible, have greater job satisfaction and engage the organisation’s interface services in a much stronger partnership of care for clients and their families.

Why did the Melbourne-based organisation implement this fundamental change project? Nursing skills had been gradually eroded because it was an expectation that any acute illness was managed in hospital. The nurses felt increasingly less confident about their scope of practice. The personal care assistants (PCAs) and volunteers felt unvalued, uninvolved and that their reports were missed or not listened to. The staff also realised that together with their locum doctors they had trouble identifying the potentially fatal sepsis inflammation early enough. (Sepsis is the major cause of deterioration and reason for frequent client transfers to emergency departments.)

The focus of the project was on all of the organisation’s 29 RNs, 35 ENs, 156 PCAs and 86 volunteers, to provide clear direction and pathways so as to remove the ‘it’s not my job’ attitude from their systems of working.

Stop and Watch, a validated early warning tool, was introduced to record any change in residents such as mood, pain, and mobility. This record was then used to reflect on employees’ clinical practice/care skills; Emergency Decision Guidelines and an End of Life Pathway supported the next steps. This was underpinned by better organisational policies and procedures and nursing leadership. Training was a big part of getting this off the ground and everyone, including the cooks and activity workers, participated in understanding how to use the Stop and Watch tool and identify symptoms associated with a resident deteriorating or dying. Corpus Christi now has an imprest stock replenishment system on site for medicines, and better equipment for measuring vital signs.

So what does this mean for the PCAs? The nurse manager says that Stop and Watch means the PCAs now know that their reports on a client’s health status are listened to and followed up. PCAs have embraced the culture change about learning and not blaming. Most of their assistants are from a non-English speaking background, often have a professional qualification, and are also studying. They ‘just picked it up and ran with it’ because it makes sense (clinical care manager). The End of Life Pathway has given them permission to be integrally involved and they have clear directions and a set pathway. They now ‘brim with pride’ in their care and partnership with the client and family.

And the outcomes so far? Corpus Christi says it’s about functioning as a real team.

Lisa (clinical care manager) says, ‘we have no more debates with the ambulance service because we give an accurate clinical picture. We have broken the barrier of what the hospital thinks of our capacity. For example we have had clients returned from the ED with a wet plaster because they know we can manage it. GPs love having the full clinical information at their fingertips and can now manage treatment of infections and palliative care in situ. Night nurses are now doing catheterisation with the full support of the in-reach team from Monash Medical Centre. We are rapidly picking up on such things as cardiac arrhythmias and our falls have reduced’.

She adds, ‘this is the most rewarding thing I’ve done’.
Model 2: A single-discipline allied health assistant

Single-discipline AH assistants are supervised by a single professional. A day in the life of this type of assistant may involve the following tasks and activities in physiotherapy:

**Direct patient care**

- Prepare clients for treatment; assist with routine evaluations by the physiotherapist and collect observational data as required; report any changes in patient/client behaviour or performance; assist with the organisation of groups; prepare and conduct or co-facilitate group activities at bedside/home or in the hydro pool according to a prescribed treatment plan; document in patient/client medical records. Apply and remove casts, braces and splints under direction; reinforce education from the physiotherapist by helping the patient repeat the exercises.

**Clinical care support**

- Assist with patient/client intake - collect referrals and enter data; prepare treatment space or hydro pool for next client; prepare or make aids under the supervision of AHP; update and maintain resources; assist with cleaning therapy aids; administer equipment loan pool; monitor and day-to-day maintenance of hydro pool; deliver equipment and adjust in-home according to specifications from physiotherapist.

**Administrative support**

- Book appointments; collect and enter data for monitoring; assist with ordering/purchasing of supplies; word processing, telephone duties, photocopying, and assist in the sourcing and ordering of equipment.

In NSW their introduction is supported by NSW Ministry of Health employment and delegation/supervision frameworks (NSW Health 2010).

Model 3: Assistants in nursing (AiN) and personal care in private health – acute care

The position statement for assistants in nursing and personal care attendants in the private hospitals group, Ramsay Health Care, describes assistants as: ‘Assist(ing) the Registered Nurses and Enrolled Nurses in the delivery of safe and effective nursing care for patients within the limitations specified by their educational and qualification standards, hospital practices and guidelines’ (Ramsay Health Care 2012).

It is the Ramsay preference for health service assistants (who may be AiNs or PCWs) or Bachelor of Nursing undergraduate students to complete the Certificate III in Health Services Assistance (HLT 32507). Many health services assistants are recruited from aged care and upskilled to perform AiN/PCA duties.

Ramsay Health Care’s Scope of Practice for Health Care Assistants (AiNs/PCAs) in its Australian facilities identifies:

- the competencies required and duties, and states that ‘Some sites may wish to exclude some of these duties, while some may require expansion to meet hospital needs’.
- tools for performance and competence assessment
- key points to foster understanding
- eight steps for decision making when providing care to patients within a team
Competencies are: communication; patient safety; documentation; environmental maintenance; observations: vital signs (blood pressure/temperature/pulse/respirations/oxygen saturation, and blood glucose levels); activities of daily living; assisting with elimination; urinalysis; meal assistance; personal hygiene (bed bath or assisted shower); personal hygiene (mouth care, shaving, hair and nails); positioning and ambulating the patient; mobility; pain management (non-pharmacological interventions); and general duties.

**Model 4: Advanced or expanded scope allied health assistant**

The key differences with an advanced scope assistant (Queensland Health 2013) are:

- the educational attainment is generally agreed to be Cert IV in AH Assistance (HLT 42507) (ACT Health 2007)
- the scope of practice and competencies to undertake are:
  1. managing own caseload of low-risk clients and/or providing for patients with complex conditions (within a defined range)
     - individual treatment, for example progressing exercises with clients, developing a treatment program based on diagnosis and goals set by AHP, and modifying within set parameters
     - group work, for example designing the group based on objectives set by AHP
     - specialised screening based on additional training
     - defined treatments for people with complex conditions
  2. management skills, for example supervising more junior AHAs
  3. quality improvement, for example initiating a quality improvement activity
  4. knowledge, for example undertaking further training relating to a specific disease affecting the core client group
  5. communicating with other agencies (International Centre for Allied Health Evidence 2013; ACT Health 2013)
- the confidence, experience, and ability to reflect and ‘think outside of the box’ (Nancarrow and Mackey 2005; International Centre for Allied Health Evidence 2013).

Example: the ACT Health Community Services Discharge Coordinator – Allied Health Assistant.

The aim was to overcome the limitations of discharge planners and discharge liaison nurses working from the acute wards, improve the experiences of older people in their managed return home, and ensure existing services are profession- or task-based (for example wound care) rather than focused on client needs as a whole. The role was based in the community, with Aged Care and Rehabilitation Services providing governance and support. It worked under a delegated/assigned workload.
Case study: ACT Health discharge coordination

When the allied health assistant (AHA) first visited at home it was found that both Genevieve (client) and Sally (daughter) were quite confused by the amount of information they had been given. Sally displayed some anxiety and an inability to retain information. Her coping strategy seemed to be to reject all services. Genevieve was not able to initiate activities herself and relied completely on Sally.

The AHA initially worked with both of them to develop trust by helping set up simple memory and organisational strategies. She organised for Sally to have a folder into which she could arrange all the paperwork relating to her mother’s health and social needs. A calendar was used to help both women remember particular appointments. On the daughter’s request, the AHA communicated with the care agency to clarify start dates, access and the carer’s exact role. She also worked with Sally to develop her confidence in contacting services herself, for example by sitting with Sally while she contacted the linen service.

The AHA followed up on the occupational therapist’s recommendations by ensuring the suggested equipment and home modifications occurred. This included arranging a visit to the local Independent Living Centre to work towards re-establishing a personal alarm. She also practiced with Genevieve the mobility and transfer techniques advised by the physiotherapist. This required some repetition to help Genevieve remember.

When the time came for Sally to return to work, she articulated to the AHA her concerns about her mother being at home by herself all day. Genevieve did not initiate activities and would either sit all day or go back to bed. The AHA worked on two options with the family:

- asking local volunteer organisations to start regular visits to Genevieve to engage her in reminiscence-type activities. These proved popular with Genevieve
- arranging for Genevieve to begin trial days at an aged day centre. Whole days at the centre initially proved too much for Genevieve, so the AHA arranged an alternative centre which was able to provide a graded program starting with half days.

At the time of discharge, Genevieve was showing some signs of deterioration in her cognitive abilities. Sally and her sister (who lives interstate) were exploring residential options. In the meantime the services set up by the AHA – for appropriate care, equipment and engagement in meaningful social and leisure activities – helped improve Genevieve’s safety while her daughter was at work.

The AHA was supervised by the occupational therapist in this instance and was also able to work in a flexibly combined role with the multidisciplinary team. Her scope of practice/delegation arrangement allowed her to bring time-critical information back to clinicians for further decision making. It also allowed her (within the limits of her trained scope of practice and the agreed protocols) to put solutions into place as issues occurred, and be part of the problem-solving team. The AHA worked with the client and the family to identify their issues and goals and then acted as a link between the client’s needs and the health practitioner’s expertise. She commenced referrals and linkages to services, based on the client’s and family’s issues and the goals identified by them.
Model 5a: The blended or combined role

Assistants will often perform a mix of tasks which do not necessarily belong to one discipline or another, but cover good holistic and integrated care. Roles and the mix of tasks that assistants perform vary according to the setting and service type (Nancarrow and Mackey 2005).

An example is the Ovens and King Community Health Service (OKCHS) in Victoria (initially supported under a Victorian Workforce Innovation Grant). The occupational therapist (OT) and continence nurse advisory services experienced the heaviest demand of all disciplines in the Central Hume region. Clients waited for a service in excess of six months, if low priority, and two to three months for high priority.

An OT and continence promotion assistant role was developed to assist with the service challenges. They were trained in the Stanford Lorig model of better health self-management, strengths-based training, and Certificate II Continence Promotion and Care (course code 21922VIC) as recruited. (Assistants recruited were at certificate III level and upgraded to certificate IV level via the Australian Institute of Flexible Learning, achieved through recognition of prior learning).

Assistants were effectively used in managing clients who:
• were identified as a low clinical priority and usually failed to receive a timely service, but had a high capacity to return to independence and would therefore need less service over time
• needed more individual care:
  » to optimise their motivation and confidence
  » for example follow-up AH assessment including home-based client education, ordering and resourcing of equipment, and home modifications
  » for example shared-care plans with other community-based service providers (eg home care), working in conjunction with the Early Intervention in Chronic Disease Management coordinator.

During the trial the use of an assistant delivered an 11 per cent saving in comparative total service provision costs and six new service types resulting in a 60.5 per cent increase in service provision to individuals. This resulted in a more effective service with a:
• 29.8 per cent decrease in total wait time
• 31.4 per cent decrease in total number of clients waiting for service
• 78 per cent increase in contact time for clients referred to continence promotion programs.

Client satisfaction was related to reduced waiting times: 86 per cent did not require continence nurse assessment or intervention following the program; there was some increase in quality of life and less continence-related spending; fluid and dietary recommendations had been implemented; and clients were able to more actively engage in physical and social activities.
Model 5b: Multidisciplinary role – rehabilitation assistant

The assistant is not new to rehabilitation and intermediate care. Working with therapists, nurses and social workers they are supported by basic training that covers all three areas. This provides a highly flexible workforce within the multidisciplinary team, which creates team efficiencies. The positive aspects of the multidisciplinary assistant are:

- the provision of an intrinsically flexible (Moran 2011) and efficient workforce, covering more than one discipline, fits well with the focus of rehabilitation, holistic care and complex care needs (Stanmore, Ormrod and Waterman 2006)
- the intrinsic value in working across boundaries and alongside professionals to deliver integrated care for client needs. Assistants are trained to be conscious of: the implications and consequences of treatment; patient safety; and working in an enabling manner. The greater levels of rehabilitation given by the assistants increased client independence, confidence and ability. Rehabilitation assistants ‘displayed the ability to operate at a level beyond simply following instructions and seemed to have a good overview of the rehabilitation process (Lizarando et al. 2010)
- ward-based professionals felt that the patient ‘being mobile quicker … was down to the rehab assistants’, and noted ‘the continuity of care previously missing, promoted interdisciplinary communication and saved professionals time’ (Stanmore, Ormrod and Waterman 2006).

Advanced community rehabilitation assistant (ACRAs) roles have been successfully combined with telehealth technology in rural service delivery models (Kumar et al. 2008). Validated processes are used to determine the specific tasks to be undertaken by the AAHA (advanced allied health assistant), as well as to identify the competencies and training required to perform the role effectively and safely.17

Example 1: The Kingaroy Allied Health Team at South Burnett, Queensland, broadly uses the AAHA as the first point of face-to-face contact for patients and telehealth technology, to assist:

- in standardised clinical assessments, including screening and outcome assessments under the remote guidance of an allied health professional
- treatment for patients as prescribed by the allied health professional via remote supervision
- group facilitation and making changes to treatment under defined protocols
- in clinical observations of patients, and feedback to supervisor and care team
- preparation of individual or generic treatment resources as directed by the professional
- maintenance of the treatment environment including equipment inventory, cleaning and maintenance, and room preparation
- the provision of basic education to patients or groups of patients as directed by allied health.

Example 2: The Goulburn Valley Health ‘Rehabilitation in the Home’ (RITH) program utilises allied health assistants (AHAs) to work with clients in their homes, under the remote supervision of an allied health professional. Assistants complete orientation to subacute programs as well as skills-based training to build their capability to deliver the program. The AHA and allied health professional make four to five home visits a week to deliver home-based therapies to RITH patients. The RITH program has increased the capacity and efficiency of service delivery and improved orthopaedic patient flow through the care process. This program is sustainable as the workforce maintains its skill set competencies to ensure a safe and effective service.18

17 Queensland Health has used a validated process – the Calderdale Framework.
18 See HWA Inventory of Innovation http://www.hwainventory.net.au
Model 6: Assistant in nursing in public acute care

NSW Health’s ‘Assistants in Nursing working in the acute care environment’ program supports both the employment and clinical allocation of assistants in nursing acute settings who have a Certificate III in Health Services Assistance HLT32507 (NSW Health 2010).

A typical day assisting the nursing team on the ward might include supporting patients in personal hygiene, mouth and dental care; helping patients move in bed; transfer (and operating lifting and transferring equipment) and walking; maintaining equipment and aids; TPR, BP and blood glucose measurements and reporting/documenting in client records; simple wound cleansing and collecting/testing urine samples; building relationships with patients and families (eg listening and responding effectively to their needs); contributing to the management of difficult and challenging behaviours; remaining alert to potential risks; following OH&S practices. The attitudes to clients, care models and effective communication are paramount. The assistants work according to care plans, under the supervision of a nurse, but retain responsibility for their own actions.

In Victoria, health assistants (nursing) or HA(N) worked in three wards at the Austin Hospital and four at Bendigo Health (including the emergency department) as a part of a pilot program in 2009. In 2013 this has been broadened to more roles at the Austin and a further three regional hospitals, based on findings which showed the following benefits:

• reducing the number of agency and specialising hours
• relieving nurses to focus on more clinically oriented work; and increasing one-to-one contact with patients, thus improving the overall quality of patient care
• responsiveness at times of high nursing vacancies (Department of Health 2011).

The program demonstrates the importance of structured implementation – eg clarifying role definition and supervision structures; educating staff in their roles; providing a structured support mechanism for the HA(N); establishing leadership and forums to promote communication.

As in NSW the assistants focus on daily living activities and supporting direct patient care, hygiene, toileting, manual handling, feeding, bed making, documentation and restocking the ward (Department of Health 2011). While the indicators of rate of falls or pressure ulcers per 1,000 bed days did not alter significantly (Department of Health 2011), with the inclusion of health assistants 84 per cent of nurses felt they were able to focus on a higher level of clinical care: ‘I no longer have that sense of anxiety and frustration at not being able to provide the proper care and attention that I want my patients to have. The HA(N)s are absolutely superb.’ Also noted: ‘obvious difference in the nursing staff displaying increased morale and decreased stress levels’.

Health assistants do ‘rounding’ on the wards, making time for each patient so that their complete care is attended to, eg the patients can tell them whether they want to go to the toilet, have anything else attended to, or have other concerns. The assistants make sure the areas around patients’ beds are de-cluttered (they are the champions of falls risk management), footwear is safe, the over-way table can be accessed, the call bell is within easy reach, and that patients’ hair is brushed, ‘lippy on’ and teeth properly cleaned. On the oncology ward health assistants are working with nurses and dietitians and are rostered to be available at all three mealtimes, to make sure that the meal is on time, its packaging can be opened, the meal is warm, and the patients are fed. The nurses feel more comfortable that basic care is under control. A relative summed it up thus: ‘Why didn’t you do this years ago?’.
Model 7: Discipline-specific traineeship

Podiatry assistance in clinical podiatry care was relatively new in Australia when it was introduced in ACT Health community services (Moran et al. 2012). Assistants in podiatry services traditionally have worked either as chair-side assistants or in administration support roles. This podiatry assistant role was different in that it required the assistant to complete a certificate IV qualification, and provide clients with basic foot care under the indirect supervision of the podiatrist (usually from an off-site location). This project used a traineeship model to gain the Certificate IV Allied Health Assistant (Podiatry) qualification. The traineeship (Moran et al. 2012) allowed gradual exposure to the profession in tandem with formal study. It was designed to address rural workforce shortages and service gaps.

The role was supported by a documented scope of practice, with level of risk determined by referral and by a screening process carried out by the podiatrist.

Prior to the appointment of the assistants, enrolled nurses (ENs) from community care were providing basic foot care (in addition to their regular tasks), in an effort to meet a gap in podiatry services. The introduction of the assistants enabled Div 2 Enrolled Nurses to return to more complex tasks; this increased nursing capacity and increased accessibility to foot care. Waiting times for care were reduced through an increase in basic foot low-risk care services (Moran et al. 2012).

The assistants’ skills acquisition was directly shaped by the needs of the podiatry practitioner; the core work was seen to be foot hygiene. Assistants took about 18 months to achieve full scope of practice. A dedicated podiatry assistant (trained to certificate IV) was also employed to give basic foot treatment – nails, corns and calluses – and give footwear advice. The role will hopefully develop further into health promotion, nail surgery and making orthotic modifications under guidance from the podiatrist.

Model 8: Medical practice assistant (MPA)

MPAs are members of a multiskilled team within a general medical practice. They are trained in clinical and administrative tasks to support the GP, practice nurse and manager. The training is likely to be certificate IV MPA HLT43312.

Generally MPAs schedule appointments, create practice accounts, maintain patient records, and access and manage patient recalls and reminders; they facilitate communication through managing telephone calls effectively and through patient ‘meet and greets’; they also assist the effective use of practice information by extracting data for analysis and action.

Where authorised and supervised they may: apply first aid to patients; apply bandages/splints and slings; assist with the application of back slabs and suturing/staple removal; handle laboratory specimens and perform ECGs/spirometry/peak flow/HbA1C measurement and vital signs. Additional tasks requiring further training, competency assessment and supervision are: performing venipuncture, vitamin B12 injections, ear irrigation, and coordinating telehealth support under practice and policy protocols. Most commonly their duties are related to assisting with chronic disease management.

See Appendix 16 for a Queensland practice case study: Brisbane North Medicare Local.

In New Zealand 19 primary care practice assistant positions are being trialled; the positions incorporate formal and practice-based training. One of the trainees ‘could immediately see the benefit of having a better understanding of basic patient enquiries … [they could also] appreciate things such as the significance of blood pressure readings, being able to assist a patient who presented acutely unwell at the front desk, and in general [had] a better knowledge of the next steps of a patient’s visit to the practice.’ One morning a week the trainee pre-consults for doctors and gathers relevant information missing from a patient’s file – eg vital statistics and signs. Benefits include time saved by clinicians (meaning additional services can be provided), pleasing levels of acceptance by patients, and the role’s sustainability.

Model 9: An assistant in rural and remote health - Murrumbidgee

At Deniliquin Community Health Centre, therapy aide roles were expanded to become allied health assistants. The AHAs took over the routine administrative tasks and implemented care plans—which previously only the professionals were permitted to do—giving the professionals more time to deploy their expertise. The wait time for a dietetic appointment dropped from two months to under two weeks. An audit of the dietetic service at another regional community health centre showed improved weight loss and greater progress against key nutrition care plan goals. Continuity of care improved because AHAs have the capacity and opportunity to give follow-up care and support. The assistants also bring local knowledge to their job. This helps patients feel comfortable because they’re dealing with a person who works and lives in the area:

‘Positive feedback from … the professionals – even from some that may have been a bit uncertain to start with – they’re definitely seeing the benefits … it saves them [professionals] time but it also means that they’re more targeted … it’s freed them up to run more programs, see more clients, reduce their waiting lists. It’s a much more satisfying way for them to work.’

‘AHA[s] … had worked in a position for a really long time and now they’ve got recognition for that.’ AHAs also appreciated the opportunity to supplement their practical skills with formal training so as to gain theoretical knowledge of client care:

‘I got the theory side which then you match the two together and you really understand … why things are done that way.’

The certification of the assistants’ roles gave the employees more esteem and led them to personally invest more in their jobs:

‘I felt that gave me a bit of recognition … I think it actually gave me a bit more responsibility …’

‘Before I would go on a home visit but I would probably go with either the physio or the OT or something … but then you had the piece of paper to say that you can go by yourself so then I was able to go and deliver the equipment by myself and set it up because I’d been trained in how.’ (Australian Workforce Productivity Agency 2012)

Model 10: Clinical support officers (NSW Health)

Five hundred clinical support officers have been recruited since 2012, as part of the NSW Government’s response to the Special Commission of Inquiry into Acute Care Service in NSW Public Hospitals (Garling Report). The aim is to increase nursing workforce efficiencies in NSW by reducing the amount of time that senior nursing staff spend undertaking administrative tasks.

These ward-based officers assist local nurses with administration and paperwork relating to recruitment, rostering, stock and supply orders and reports, so that the nurses can spend more time caring for patients. This means senior nurses can focus on coordinating services and care around the needs of each patient (see HWA Inventory of Innovation).

The story of one clinical support officer at Wollongong Hospital (21-year-old Amy) is reported at http://www.illawarramercury.com.au/story/624476/clinical-support-officers-ease-strain-on-hospitals/:

‘She has worked in administration for nearly seven years and in the health service for the past few years. The formal job description for the clinical support officers is massive, with dozens of separate tasks. They are meant to support nurses, midwives, medical and allied health staff in such things as data entry for rosters, ensuring births are registered, preparing financial reports, recruitment, leave, payroll and ordering medical stocks. Previously many of these duties were undertaken by the nurse unit manager.'
“I find that my managers now have more time to spend with patients,” said Amy.

Amy helps four nurse unit managers in intensive care and the high-dependency units. “They’re all very happy to see me,” she said. “They’re happy that they’re able to liaise with their nurses more and find out what’s going on [on the ward].”

“I saw my manager’s office - when I first [arrived] there was quite a pile of paperwork and now that’s my office.”

The director of nursing at Wollongong Hospital said the new jobs would make a “huge difference” to life in the wards for patients and staff.

“It’s of great benefit and certainly a position that is very much appreciated by the three clinical groups …”. 

Previously, she said, nurse managers spent up to 40 per cent of their time on clerical work, making it difficult to spend time managing patient care and supervising staff. “It will free clinical time up for nursing, allied health, and the medical officers … It puts these people back on the floor for patient care. … There will be improved supervision and availability … to talk to the patients and their families, and communication is a key thing.”

**Model 11: The community worker**

**Example 1: The Maximising Our Remote Professional Health (MORPH) workforce project (HWA Aged Care Workforce Reform and SA Country Health).**

This project aimed to improve the efficiency and effectiveness of the fly in/fly out (FIFO) visiting allied health professionals (AHPs), registered and enrolled nurses, and medical specialists in two remote community services (Coober Pedy and Ceduna):

- by increasing capacity through expanding the health service assistant (HSA) competencies
- by driving professional staff to operate at their full scope of practice
- with a flow-on effect of delivering increased access to Older Persons’ Health Services in remote communities.

The assistant (Julie) completed a Certificate III in Aged Care 20 months ago and was employed by the MORPH project. The aim was to redesign the workforce team to deliver enhanced care so as to prevent functional decline. Julie is fairly typical of the demographic of this worker – female, second career, 49 years old and a longstanding member of the local community – ‘You know them personally and as you see them in the street notice things that have changed and … it alerts you to make this a priority visit’.

The protocols she uses are:

- the PREVENT tool (getting older doesn’t mean you have to fall apart, you can PREVENT it); this is an evidence-based checklist designed to alert professionals to risks of functional decline, and
- the Home and Community Care (HACC) functional screen.

This is combined with close and regular supervision. Julie’s supervisor is her ‘pillar’, the supervisor uses reflection on Julie’s observations and practice (within her scope), plus the guidelines.

A typical task for Julie was the review she undertook for the coordinator, who had been unable to get to a client. Julie was able to identify early signs of a urinary tract infection, cognitive decline, poor management of the client’s diabetes and fear of being put in a residential aged care home. Julie proceeded with a series of actions and referrals to help this client and reassure the client’s daughter.
'This has taught me to listen for these alarm bells. … The outcomes made me feel there is a reason for this job and it made me feel really good about what I could do by getting in before a catastrophe happened.’

(Interview: October 2013)

Example 2: Community care worker – SA Local Health Network

The home support worker’s (HSW) training and protocols enable her to be a part of the problem-solving team within the scope of her delegation arrangements. This ensures that the professional/clinician receives timely information, careful reporting, and support and back-up. In this way they can be confident about:

- the information
- when to intervene

and that:

- the right actions were taken.

Don and Helen are a couple in their 80s, living independently, though they need some help with heavy housework and showering. Don has heart problems and is the main carer for his wife who has disabling arthritis and diabetes. The HSW visits three times per week to help with showering Helen, weekly housework, plus social support. While showering Helen, Mary hears that Don had a funny episode early that morning as he was getting breakfast. For about 10 minutes he spoke in a confused manner and could not move his right arm, after which he improved and returned to normal. Helen is obviously concerned and indicates Don did not want her to call an ambulance. When she’s finished helping Helen, the HSW has a chat to Don.

Based on her training and the agreed protocols of questioning, observation and reporting, the HSW feels that: Don’s conversation is more restricted than normal; his speech is not as clear as usual and he seems a little confused; he is drooling slightly from one side of his mouth, is not sitting straight, and has not drunk his cup of tea. The HSW is able to make a basic assessment of what has changed (although not an interpretation of that change), eg speech and swallowing disturbance, and changes to cognition, balance and range of movement. Based on the protocols, the HSW considers whether this is an emergency and if an ambulance needs to be called. She also takes into account what Don wants and if Helen is able to cope if Don has to stay in hospital.

The protocols will determine whether the HSW first calls the supervisor or calls the ambulance. The HSW will also assess how to reassure Helen and Don that they will be cared for, and will set up support for Helen; this includes phoning the supervisor for emergency respite for Helen, and determining how to document and report this incident.

The HSW can ask Don the following questions while she is there and report to her supervisor:

- How are you feeling? When did you start feeling unwell? (NB Why do we need to know the time it occurred?)
- How is your arm movement - has something happened, for example a fall? Has this happened before?
- Have you got any pain, for example headache? Have you taken any medication?
- I’ve noticed you haven’t drunk your tea - is there a problem?
- You seem to be having trouble talking to me, why do you think that is?
- Helen is very worried about you but tells me that you don’t want to get help – why not?
Appendix 16: Case study 1– MPA scoping study

**Practice A, Qld**

Helen is an MPA graduate from Metro Brisbane North Medicare Local's Medical Practice Assisting course. There are two MPAs employed part-time (20-25 hours a week) at Practice A in Brisbane, Qld. The practice also employs 3-4 GPs, 1 RN, 1 EN, 2 part-time MPAs, as well as reception staff. The practice has a generously sized treatment room available for MPAs and nursing staff, and patients are triaged at reception.

The MPA performs a range of assistive clinical support tasks, with a particular focus on 75+ health assessments at the practice rather than in the home. The MPA is also starting to undertake some GPMP (GP Management Plan) work. The MPA meets with the patient and proceeds to complete the health assessment template in the clinical software system, saving the doctor time. The doctor then reviews the data in the template and decides on the care required.

Having received the required training, the MPA also performs vitamin B12 injections, pathology and vaccine ordering, some ear syringing, setting up recalls on practice software in liaison with GPs, and also assists the plastic surgeon who visits the practice regularly in areas such as post-operative dressings. Venepuncture is not performed by the MPA as there is an onsite pathology company.

Ultimately the MPA is under the supervision of the practice’s GPs, but works very closely with the nursing staff, receiving ongoing education from them. The EN in the practice is predominantly involved in care plans and health assessments in patients’ homes, as well as some childhood and travel vaccinations.

Helen also works closely with the practice manager, who is a trained RN. It appears that this practice has a very strong team focus with much information- and skill-sharing. This occurs both informally, on the job, as well as through in-house continuous practice development (CPD), which includes focused meetings. This is possibly also why the MPA role seems to work very well in this practice.

When we spoke briefly to the practice’s principal GP, he described the in-house CPD-type sessions as being part of their regular meetings. In one CPD meeting he described the signs of stroke. Not long after this, an MPA was on reception and noticed a patient showing some of these signs and was immediately able to implement the strategies to help this patient. Had the MPA not received this type of information, they might not have picked up on this as quickly and efficiently, and the outcome could have been very different.

Helen has worked in general practices for quite some time and this experience shows. She is particularly interested in and willing to learn about the assistive clinical support aspects of the MPA role and to further develop these. Helen also hopes to continue her studies and become an EN in the near future. (Helen, 2012)
### Appendix 17: Assistant workforce – Australian state and territory overview

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Training</th>
<th>Guidelines/frameworks/resources</th>
<th>Research/evaluation</th>
<th>Pilot/Ongoing/Models</th>
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<tr>
<td>ACT</td>
<td>Development and delivery of Cert III and IV in Allied Health Assistance – training face-to-face OT/PT/SP/NUT</td>
<td>Licence Deed between ACT Government Health and Victorian Health Department enabling use and modification of Victorian Supervision and Delegation Framework for AHA.</td>
<td>Literature review 2007: Feasibility of supporting the introduction of the Certificate IV in Allied Health Assistant</td>
<td>Advanced AHA pilot project (2013)</td>
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<td>Development and delivery of traineeship model, blending formal study Cert IV in AH Assistance and on-the-job training: OT/PT/SP/NUT/Pod</td>
<td>Standards of Practice for ACT allied health professionals 2004 (to be reviewed).</td>
<td>Canberra Institute of Technology 2006 – PT/OT/SP</td>
<td>AHA traineeship model 2010-12</td>
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<td>ACT Health 2004: examine the need for an allied health assistant (AHA) training program in the ACT; determine the training requirements for an AHA; and explore the feasibility of expanding the number of AHAs employed in the ACT</td>
<td>New Health Care Assistant (HCA) classification embedded in Enterprise Agreement 2010 onwards</td>
<td>Podiatry and the Certificate IV in Allied Health Assistant: Nutrition in the ACT. ACT Health.</td>
<td>Conducted pilots in six clinical areas at the Canberra Hospital for a period of three months, introducing 10 assistants to reduce non-nursing duties undertaken by RNs and ENs.</td>
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<td>Certificate III (aged care or disability) or currently undertaking a Nursing Degree/Diploma; or are interested in gaining the experience of utilising skills in a hospital system</td>
<td>ACT Health 2004: examine the need for an allied health assistant (AHA) training program in the ACT; determine the training requirements for an AHA; and explore the feasibility of expanding the number of AHAs employed in the ACT. Download Allied Health Assistants Discussion Paper 2004</td>
<td>Evaluation of the impact of upskilling ACT Health Technical Officers</td>
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<td>Assistants in nursing in acute care.</td>
<td>Health Directorate - Assistant Projects - ACT Health - ACT Government.</td>
<td>HWA Caring for Older People Project 2010-11 Testing AHA D/C Coordination role</td>
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<td>Assistants in Nursing project Evaluation Phase Final Report May 2010</td>
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| NSW          |          | NSW Ministry of Health: Ways of Working project June 2011  
 Includes:  
 • improved support for staff new to an area of practice  
 • improved capacity to effectively utilise all skills within the nursing team  
 • A key recommendation (45) of the Garling Report: principles of best practice for supervision of junior clinicians should be developed - this has relevance for assistants | www.health.nsw.gov.au/workforce/alliedhealth/Documents/NSW-Health-2012-AHA-Survey-Results.pdf |  |
| NT           | • Limited local training options  
 • Focus on Indigenous Training Pathways  
 Certificate III pathway or undergraduate student nurse | General terms used in NT are:  
 • Personal care worker  
 • Patient support assistant  
 • Therapy assistant  
 • Newborn hearing screener  
 • Nutrition worker |  |  
 |              |          | Northern Territory Aboriginal Health & Community Services Workforce Planning & Development Strategy 2012  
 Aboriginal Health and Community Services Workforce Strategy |  | PCA/PSA review underway in relation to role and function at two major hospitals  
 Consideration of implementation of ‘Pupil Nurse’ roles to be undertaken in 2014  
 Review of allied health assistant roles and function to be completed in early 2013. |
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<tr>
<td>Qld</td>
<td>Developing delegation training for AHPs and AHAs.</td>
<td>AHA Governance framework and guidelines</td>
<td>Allied Health Assistant Project Phase II Completion Report.</td>
<td>Pilots – AHA role - trainee, assistant and advanced</td>
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<td>• Sample Job Description</td>
<td>Nancarrow, Roots, Moran, Grace and Lyons (2012, Southern Cross Univ): a systematic review of the literature in relation to Qld; health practitioner models of care which includes assistants funded by Health Workforce Australia</td>
<td>8 pilots of AHAs including one advanced AHA</td>
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<td>• Sample Task List</td>
<td>Preliminary evaluation of the clinical education and training for AHA in Queensland Health project (Siggins Miller with ClinEdQ, Qld Health 2011.)</td>
<td>HWA Caring for Older People Project 2010-11 – OT assistant and learnings for a general assistant</td>
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Covers assistants in nursing  
Queensland Nursing Council, 1998  
QNC Decision-making framework: define scope of practice and facilitate delegation of care  
Allied Health Workforce Reform Project Final Report February 2008 – March 2010 SA Health & Community Services Skills Board Inc. (45 AHA cert IV trained )  
Lizarondo et al. – A systematic review of the literature: AHA and what they do (2010). Commissioned by the Allied Health Workforce Reform Project - managed by SA Health and Community Skills Board | AHA project aim: to define AHA roles  
• Integrate AHAs into existing AHA structures in a consistent way  
• Promote linkages between vocational training and AHA cert III and IV.  
• Promote ongoing learning and demonstrate career pathways for people working or aspiring to become AHAs.  
SA Health AHA Model(2012) specifies current model and 2 models under consideration – assistant types – multidisciplinary assistants, discipline-specific, therapy –administration  
HWA ACWR – Country Health SA FIFO project |
| SA           | Aged care sector trained 45 AHA Cert IV using the NSW Ryde Rehab model that Steele-Smith developed  
AIN: 2nd and 3rd year student, in an undergraduate program in nursing or midwifery | Guidelines for developing AHA roles.  
General website SA Health:  
Under the SA Public Sector Enterprise Agreement 2010, assistants in nursing (acute) can be enrolled as a 2nd and 3rd year student, in an undergraduate program in nursing or midwifery; supervised by RN/M and may be overseen by an EN;  
Assistants in nursing (AINs) were introduced into the Nurses’ South Australian Public Sector Enterprise Agreement 2001. The AINs’ scope of practice, remuneration and classification points have been embedded in the Nurse’s Enterprise Agreement since 2001. Currently under negotiation for the 2013 Enterprise Agreement. NB AINs in aged care who have undertaken cert III or IV studies, are not included in the above Enterprise Agreement | | |

102  
HWA | Assistants and support workers: workforce flexibility to boost productivity
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<th>Jurisdiction</th>
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<tr>
<td>TAS</td>
<td>Training for AHP working with Assistants Training existing AHAs Tasmanian Health Organisation South – now an RTO and considering training programs to be undertaken/supported including assistants For assistants in nursing trial: Certificate III in Health Service Assistance HLTEN32507 (Acute Care) or Current undergraduate Bachelor of Nursing student (2nd year or 3rd year) who has completed at least one clinical placement in second year, or An enrolled nursing student who has completed first clinical placement</td>
<td>Allied Health Assistant Supervision and Delegation Framework. Sept 2012: Department of Health &amp; Human Services, Office Assistants in Nursing (AIN) Statement of duties and workplace guidelines Jan 2013. <a href="http://www.themercury.com.au/article/2011/01/18/200771_print.html">http://www.themercury.com.au/article/2011/01/18/200771_print.html</a> AIN included in nurses and midwives career structure as Grade 1 classification</td>
<td>Assistant in Nursing Consultation Project and Mapping 2010 (unpublished but contributed to National AH reform agenda) Trial Evaluation Report Assistant in Nursing working in the acute care environment Oct 2012 (presented at Inaugural AIN Conference, Sydney 30-31 August 2012) Evaluation and report of trial extension and overall introduction of AINs into Acute Care completed and presented to Tasmanian Health Organisation –South and the ANMF February 2014. Awaiting response. The Introduction of AINs into Tasmania: A Comparison of Two Cohorts - RHH</td>
<td>Assistant in Nursing - 2013 Trial (April) Extension Update (July 2013). AINs complement existing roles at the Royal Hobart Hospital Extended AIN Trial with expanded scope of practice finishes 31 December 2013</td>
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<td>Jurisdiction</td>
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| Victoria     | Training resource and case study for Cert IV in Allied Health Assistance (AHA). | Uptake of the AHA role, supervision and related training (Department of Health Victoria 2011)  
  - Guidelines to scope and introduce new allied health assistant roles  
  - Supervision and delegation framework for allied health assistants and overview  
  - Supervision and delegation for allied health assistants case studies  
  - Growing your allied health assistant workforce planning tool *note this is a validated alternative to Calderdale Framework  
  - Melbourne Health Cert IV in AHA workplace training resource and case study  
  - Barwon Health Cert IV in AHA training framework  
  Guidelines to scope and introduce new allied health assistant roles docs.health.vic.gov.au › Document library Cached May 1, 2012  
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<td></td>
<td>• Allied health assistant training series - order form for DVDs</td>
<td>• Allied health assistant recruitment, orientation and induction</td>
<td>Rural WA therapy assistant project (PDF)</td>
<td>Rural WA therapy assistant project (PDF)</td>
<td>Rural WA therapy assistant project (PDF)</td>
<td>Rural WA therapy assistant project (PDF)</td>
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<td>• Allied health assistants training mini-module (PDF)</td>
<td>• Allied health assistant orientation and induction workbook</td>
<td>WA Country Health Service DSC therapy assistant initiative training report</td>
<td>WA Country Health Service DSC therapy assistant initiative training report</td>
<td>WA Country Health Service DSC therapy assistant initiative training report</td>
<td>WA Country Health Service DSC therapy assistant initiative training report</td>
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<td>VALUATION - June 2005</td>
<td>• Allied health assistant learning, development and support</td>
<td>WA Health</td>
<td>WA Health</td>
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<td>• Allied health assistant role audit tool</td>
<td>Discussion paper: allied health assistants (PDF 600KB) 2008</td>
<td>Discussion paper: allied health assistants (PDF 600KB) 2008</td>
<td>Discussion paper: allied health assistants (PDF 600KB) 2008</td>
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<td>• Rural and remote allied health competencies: allied health assistants</td>
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**Nursing**  
Acute Traineeship model  
RPL - AIN into EN 147 EFT in trained in 2011  
Assistants in nursing traineeship.  
Ongoing at 2013  
Certificate III in Health Services Assistant (Acute Care) Duties and Competencies Guidelines  
2013 Nurses Guide for the Assistant in Nursing (Acute Care) Traineeship providing hospital nurses information on human resource management and operational advice for the 2013 Assistant in Nursing (Acute Care) Traineeship
Appendix 18: International Reviews relevant to assistants and Support workforce


Seven key recommendations relevant to assistants and support workforce:

1. Common training standards – all healthcare assistants should complete a certificate in ‘fundamental’ care before they can look after patients unsupervised.

2. Career progression – talented care workers will be able to progress into nursing and social care through the creation of a ‘Higher Certificate of Fundamental Care’. This will ensure they have a route to progress in their careers and an opportunity to use their vocational experience of working as healthcare assistants to enter the nursing profession.

3. New job title – HCAs who completed the certificate should be allowed to use the term ‘nursing assistant’ in a bid to reduce the number of current job titles held by support workers.

4. Caring experience – the Nursing and Midwifery Council should make caring experience a prerequisite to starting a nursing degree and review the contribution of vocational experience towards degrees.

5. Recruitment – directors of nursing should take back responsibility for the HCA workforce from human resources departments. Employers should also be supported, at the recruitment stage, to test potential staff’s values, attitudes and aptitude for caring.

6. Quality assurance – Health Education England, with Skills for Health and Skills for Care, should develop proposals for a rigorous system of quality assurance for training and qualifications, which links to funding outcomes, so that money is not wasted on ineffective courses.

7. Poor performance – the legal processes for challenging poor performance should be reviewed so that employers can be more effective in identifying and removing any unsatisfactory staff.

3. The UK Royal College of Nursing has published its response to the Francis (Mid Staffs) Report. Full report: http://royalnursing.3cdn.net/597cdae26a008208a6_bim6bquwh.pdf

Key points:
- a call for mandatory safe staffing levels, based on local judgement and enshrined in law
- support for the role of the ‘named nurse’ as a mechanism to organise work around the needs of the patient rather than a series of tasks
- a focus on the importance of strong nurse leadership and support for increased educational opportunities for senior staff, with supervisory ward sisters free to lead and mentor nurses
- a recognition that more must be done to improve the culture in the NHS and tackle the ‘care fatigue’ experienced by some longer-serving health care staff
- a push for mandatory training and registration of health care assistants
- support for the move towards values-based nurse recruitment
• defence of the practical preparation of nursing students and rejection of the need for three months pre-degree care experience

• calls for nationally recognised career pathways for those wishing to develop their skills in older people’s nursing, and for everyone in nursing to understand how to deliver excellent care in this area.

UK Government (Department of Health) announcements in response to the Francis and Cavendish Reports

1. Mandatory 3-week course on Fundamentals of Care for all assistants, October 2013

2. Registration of assistants will not be pursued (November 2013) http://www.bbc.co.uk/news/health-24994016

Key points:

Government has rejected proposal for national registration of assistants. However, a care certificate will be used to ensure healthcare assistants and social care workers have the right skills and training. The National Minimum Training Standards for assistants were published earlier in 2013. Health Education England has been asked to lead work with the Skills Councils, other delivery partners and health and care providers to develop a ‘Care Certificate’ for healthcare support workers.
## Appendix 19: Framework to guide decisions – Support nationally, act locally

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<th>Element</th>
<th>Components</th>
<th>Checklist</th>
<th>Resources</th>
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<tr>
<td>Element 1 Drivers</td>
<td>Determination of requirements Context, drivers and setting</td>
<td>Evidence of: - Workforce shortages – supply – maximising hidden skills - Cost containment; funding model - Demand – client complexity and better healthcare/service provision - Introducing new model of care and service reform, eg cross-sectoral or cross-discipline - Risk management and/or quality of care* * May be only one driver – need to be explicit</td>
<td>- Local and national data/benchmarks - Financial modelling - Service complexity/client acuity modelling (ACFI or CCDM – NZ) - Evidence-based elements of MoC - Complaints</td>
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| Element 3 Skills | Skills mix | What workforce capacity is required to deliver a wide range of services in right place, first time, with best person? Concepts of staff mix and skills mix to align with context and driver needs, covering:  
  • Number of staff – FTEs and proportion of FT/PT quantum of work possible per person and patient/client acuity *  
  • Mix of discipline backgrounds  
  • Mix of qualifications (highly qualified to total pool)  
  • Variable pathways and usage of ENs  
  • Balance of expertise and experience (senior/junior and professional/assistant)  
  • Mix of disciplines, single and combined, for well-rounded care.  
* NB: No specific thresholds available  
The actual roles and skills required are more important for both cost and quality than the grades and qualifications or job titles. Any change in costs needs to be balanced with the efficiencies created in other parts of the team e.g. giving up roles/activities or improved quality.  
NB must be supported by organisational preparedness – see element 6 | Literature sources  
Primary resource: Dubois and Singh 2009 and see Appendix 20  
Secondary resources: Department of Health 2010; 2011; Buchan and Dal Poz 2002  
WACHS Internet Site: Allied health Competency frameworks www.wacountry.health.wa.gov.au/alliedhealthcompetencies  
HWA NCHRC for capabilities  
Competencies: eg APA Position of physiotherapy assistants and their duties (2005)  
LOG – track over time skills mix/changes and the impact of variance management  
NZ Care Capacity and Demand Management Model http://www.thefreelibrary.com/Safe+staffing--balancing+demand+with+resources.-a0276720740 |
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<td>Element 3 Skills management</td>
<td>Matching the redesign of workforce to the service contributions required: the value and contributions of different skills mix and ways of working (not just task delegation) across all staff are used to best effect – so as to manage overuse, underuse, and inappropriate use of workforce.</td>
<td>Service contributions (Analysis: Section 3) Duty statements identifying • Tasks • Level of complexity in scope • Level of independence they can operate under • Key accountabilities and delegation/supervision/confirmation of competency processes • Training and skill requirements (NSW Health 2012; ACT Health 2013; Queensland Health 2013) • Core competencies across all training courses and applicable to all roles – ie proficiency in English, basic care skills, problem solving and risk factor detection, negotiation</td>
<td>Examples: NSW Health Allied Health Assistant Framework June 2013 and NSW Assistants in Nursing in acute care implementation package (August 2010) - Health Service Implementation Package Vic Health (see Appendix 17) Guidelines to scope and introduce new allied health assistant roles Growing your allied health assistant workforce planning tool * NB validated alternative to Calderdale Framework (assessed in Nancarrow et al. 2012) Quality – ACHS; Aged Care Standards</td>
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<tr>
<td>Element 3 Skills management</td>
<td>Increasing the depth of a job/role of a worker (role enhancement) • expanding the breadth of a job and exchanging one type of worker for another (partial substitution and role enlargement) • making better use of the clinician’s premium skills (supplementation/complementation or role delegation and/or flexible use) • creating a new role and new type of worker, or focusing on generalist roles (innovation) Service enhancement or enlargement or decrease = • gaps, access, responsiveness: through complementation or supplementation/role delegation • undertaking routine tasks as workforce of choice (using skill flexibility &amp; shift from task orientation to integrated care and possibly assigned discrete workload) • deployment of staff to match location of need in primary health care/early intervention: through assigned workload/complementation/partial substitution</td>
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<tr>
<td>Element 3 Skills management</td>
<td>Workforce or role enhancement and enlargement – using skill and role flexibility delivers team efficiencies and effectiveness; freeing up clinicians; expanded roles and/or advanced scopes</td>
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| Element 4 Evidence Part 1 | Transformational case studies | • ‘How’ to implement is as important as ‘what works’  
• Narratives cover  
  » clients and carers  
  » service  
  » workforce |
| | | Resources |
| | | Care contribution models: see Appendix 15  
Vic Govt case studies re implementation:  
HWA Inventory of Innovation http://www.hwainventory.net.au  
NB matching case study to size and resources of the change site; and use public, private and NGO models (as EBA crosses all nursing)  
Complaints mechanisms: identifies indicators for change |
| Element 5 Evidence Part 2 | Team productivity measures | Team productivity and other metrics to:  
• assess the whole-of-workforce baseline and ongoing productivity and client outcomes  
• cost effectiveness of different types of skills mixes and their impact on the healthcare system as a whole  
• benchmark  
Using  
• Before and after studies  
• Multi- & inter-disciplinary team productivity measures  
• Team/client-sensitive indicators (falls, skin, medication errors, infection rates etc.)  
• Staff satisfaction |
| | | Resources |
Advisory Board: staff engagement survey |
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| Element 6 Implementation management | Organisational preparedness for the practice environment Supporting skills mix change (element 3) | Commitment to cultural and organisational change to make redesign work sustainably. Top down authorisation/policies and practice structures or guidelines to support assistant input and give clinicians confidence. Options include:  
• Expected culture/priorities/interdisciplinary teamwork  
• When and how to use assistants  
• Change management capacity and leadership  
• Training for HP and assistant in delegation, supervision; confirmation of competence; and skills for teaching skills  
• Agreed and documented scopes: delegated - tasks and/or assigned workloads  
• Agreed and documented shared duties (role overlap)  
• Agreed and documented reporting mechanisms  
• Protocols for care decision making: eg early warning tools and when to refer on, seek advice, initiate care, and workloads to expect (what, how to be conducted, who, when and where)  
• Protocols for access to clinical supervision: including when working alone, or supervised by a similar role, or supervision not immediately available; working with multiple disciplines: lead supervisor roles  
• Checks of skill attainment in formal qualifications  
• Position descriptions  
• Reflection on practice  
• Support/pathways to achieve certificate-level qualification  
• Continuous practice development | Board commitment to strategy/governance  
Interdisciplinary Management Tool – workbook, 2012  
Sheffield Hallam University  
http://www.researchgate.net/publication/234093973_The_Interdisciplinary_Management_Tool  
National Health Common Capability Resource and complementary resources provisional edition Mar 2103  
Delegation and Supervision Frameworks and Implementation evaluation (see Appendix 17 for scan of jurisdictional resources)  
Protocols  
For example:  
• Catholic Homes, Victoria – Emergency Decision Guidelines; End of Life Pathway  
• SA Country Heath - P.R.E.V.E.N.T.  
• South Brisbane GP Division RACF/ED protocols |
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</table>
| Element 6 Implementation management | Change leadership and capacity | • Organisational culture and values  
• Organisational communication strategies  
• Distributive leadership: across organisation  
• Client and service outcome-focused: clear communication with consumers about role and their supports/supervision  
• Engagement: Communities of practice and collaboration  
• Preparedness for dynamic development based on next-best practice  
• Systems thinking | Health Leads Australia  
Victorian DH: See Appendix 17: better skills best practice |
Appendix 20: A framework for optimising human resources in healthcare

**Institutional context:** legislation, regulation, professional systems, social and economic issues, culture, educational systems, incentives

**Organisational context:** formal structures and processes, informal structures and processes, technologies, human and material resources

**Human resources management strategies:** planning and staffing, education and training, working conditions, performance management

**Staff mix:**
- Staff numbers
- Mixing qualifications
- Junior and senior staff
- Multidisciplinary mix

**Skill management**

**Skill development:**
- Role enhancement
- Role enlargement

**Skill flexibility:**
- Role substitution
- Role delegation

Source: Dubois et al. 2009. From staff mix and beyond: towards a systematic approach to health workforce management. Human Resources for Health 7:87
Appendix 21: Guiding principles – assistant and support workforce (Example only)

A set of agreed principles guides how we design the workforce, based on the model of care and client needs. The model and principles reflect the combined needs of clients, workers, organisational priorities, service evidence and workforce governance and training. The principles also guide future development of the assistant and support workforce as needs or evidence change.

Principle 1: Health and wellness

The model of care uses the wellness approach. This is a shift from a system which is ‘reactive to illness’ to one ‘promoting wellness’ through early recognition and action to prevent avoidable deterioration (primary health care). This preserves our curative system for those who need that level and intensity of input. This requires:

• the individual client has real choices including support to take positive risks (and may include client-directed care)
• workforce attitudes and behaviours include listening to, learning from and acting on communications from the individual client and their carers
• partnership and communication, which includes acknowledging each individual is an expert on their own life, and that recovery involves working in partnership with individuals and their carers
• acknowledgement of the full range of bio-physical and social determinants of health and wellness for holistic care.

Principle 2: Person-centred

A person-centred approach is about working with families and carers as active partners in care. It recognises and respects the role of carers in prevention, early intervention, treatment, reinforcement and recovery, all of which can contribute to better practice and improved outcomes for consumers.

A person-centred approach determines the workforce design and its use.

• this contrasts with traditional roles constrained by professional ownership over technical aspects of care
• is responsive to individual differences, cultural diversity, and personal preference.

Central to the approach is:

• training in self efficacy and self management for clients, carers, volunteers
• training in ‘coaching for change’ for the paid workforce.

Principle 3: Integrated, interdisciplinary care

The model of care requires the workforce to integrate its decisions, communications, values and processes across professional, organisational and sectoral boundaries, to get away from silos of care which do not match the patient journey. This is achieved by:

• using effective interdisciplinary teamwork and learning
• adopting a ‘there is no wrong door to the right service or care’ philosophy
• delivering care closer to home, and first time, and adopting a range of care coordination and case management options.
Principle 4: Workplace culture and systems

The workplace culture has a strong focus on valuing safety and quality, and is driven by client needs, organisational priorities and scopes of practice.

All workers are valued for their unique and combined contributions and are suitably trained and competent, with access to continuing development so they can optimally make those contributions.

Principle 5: Underpinned by sustainable long-term solutions

Sustainability is underpinned by organisational reform for long-term solutions and leadership. Strategic partnerships - working across organisations and sectors - are valued for their capacity to drive systems thinking and change capacity.

Principle 6: Complementary

Existing frameworks and practice standards work alongside this approach, modelling behaviours required of all health workforce roles. The assistant and support workforce is designed to be integral to and complement existing workforce reform approaches, to deliver service reform.

Principle 7: Scalable

These approaches are applicable at all levels of the health system, not just the individual level. They support different work groups, agencies and organisations working towards improved coordination and delivery of care at the individual, community and system levels.

Principle 7: Flexible

The ability to meet growing and changing demands can only be achieved by being flexible in how we use the skills of all the health and community sector workforce that delivers services. An increased supply of professional staff by itself is insufficient to address workforce and client needs.

Flexibility enables the workforce to:

- undertake multiple tasks, work in community and/or institution-based settings, and in multidisciplinary teams or alone
- use shared capability to challenge any unnecessary restrictions on practice resulting from traditional role boundaries and silos of action, and help people to work to their full capacity
- have the freedom to deliver the right care to everyone and ensure quality and safety.
**Principle 8: Inclusive**

Anyone performing or supporting healthcare activities as part of their work role should be supported to continually develop in line with health and model of care needs. This is relevant to assistants:

- with or without formal qualifications
- providing a full range of early intervention, referral, treatment, care or support services in both acute health services and community, public, private and non-government services
- with a range of capability levels from traineeships to advanced practice
- who are culturally and linguistically aware and competent to reflect population diversity.

The role of families, carers, peer support workers and communities is acknowledged as critical in achieving good care.

**Principle 9: Forward-thinking**

The model of care and principles determine the future capacity and capability required of the workforce. A future-focused approach is important for ensuring that the health workforce is flexible, adaptable, and able to respond to new developments in healthcare.
Glossary

**Workforce productivity**: is the relationship of resources used (inputs) to create outputs. Changes in skills mix have an impact on this productivity relationship.

**Assistant**: an assistant works to and under the delegation and supervision of a health practitioner; takes on less complex treatment or care tasks; and/or performs administrative or other tasks that would otherwise reduce the time available for more complex direct care by more highly trained practitioners (Health Workforce Australia 2013, p. 4; see also Dussault and Franceschini 2006, and Wilson et al. 2009).

**Support workers**: denotes a broad range of health or care roles that work within defined service plans and report to a supervisor. They provide person-centred support and/or consumer-directed care to people in community and residential settings. Work may be carried out under regular direct or indirect supervision, or by working autonomously (self-directed recovery-oriented support). They may be used interchangeably with assistants in some contexts.

**Personal care workers**: are those other than registered (RN) or enrolled nurses (EN) and hospital orderlies who provide personal care, general household assistance, emotional support and companionship for aged persons and those with disability.

**Peer workers**: are employed in roles that require them to identify as being, or having been, a mental health consumer or carer. The lived experience of mental illness is an essential criterion of job descriptions, although job titles and related tasks vary (Mental Health Coordinating Council 2011).

**Carers**: provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail-aged.

Terminologies cited by the Australian Nursing and Midwifery Federation (2009):

- Aged person carer
- Allied health assistants and aides
- Anaesthetic technicians
- Assistants in nursing
- Assistive or support personnel
- Care assistants
- Direct carers, workers or assistants
- Healthcare workers or assistants
- Healthcare support workers
- Home health aides
- Long-term care workers
- Medical technicians
- Nursing assistants
- Nursing – aides, orderlies or attendants
- Paraprofessional long-term care workers
- Paraprofessionals
- Paramedical health worker
- Patient care technician
- Personal carers, workers, attendants or assistants
- Psychiatric aides
- Residential care workers or assistants
- Scientific support staff
- Scout and scrub – assistants or technicians
- Surgical dressers; surgical assistants
- Therapy assistants
- Multidisciplinary assistants
- OT technical assessors
- Therapy assistants/supports
- Technicians and support worker

Other terminologies used in allied health assistant systematic reviews: (See Moran et al. 2011; Kumar et al. 2008; HWA 2012c)
References


ACT Health 2013, Advanced allied health assistant project final report, ACT Government, Canberra.


Australian Nursing and Midwifery Federation 2009, Balancing risk and safety for our community: unlicensed workers in the health and aged care system, ANF, Canberra.

Australian Workforce Productivity Agency 2012, Better use of skills, better outcomes: Australian case studies – Murrumbidgee, AWPA, Canberra.


Centre for Workforce Intelligence 2013, Making the most of allied health professionals, CfWI, London, [www.cfwi.org.uk].


Department of Health 2008, Discussion paper: allied health assistants – assistants in allied health and health science workforce project, stage 2, Government of Western Australia, Perth.


Department of Health 2014, Health assistants (nursing) implementation guide, Government of Victoria, Melbourne

DHB Shared Services undated, Care capacity demand management, Safe Staffing Healthy Workplaces Unit <http://www.dhbsharedservices.health.nz/Site/Future_Workforce/SSHWU/Overview/default.aspx>.


Grattan Institute 2013, Budget pressures on Australian governments, Grattan Institute, Melbourne.


Health Workforce Australia 2012c, Queensland Health Practitioners Models of Care project: evaluation, learning, and upscaling of results for a national audience – phase 1, a systematic review of the literature, prepared by Southern Cross University for HWA, Adelaide.


Lowe J, Grimmer-Somers K, Kumar S, Young A 2008, Allied health scope of practice development in the wider allied health service delivery context: the allied health assistant (AHA), Centre for Allied Health Evidence (CAHE) University of South Australia, Government of South Australia, Adelaide.


National Allied Health Advisors Committee 2012, The assistant and support workforce, submission to HWA.

National Allied Health Assistant Working Group 2012, National supervision and delegation framework for allied health assistants, submission to HWA.


Spillsbury 2012, ‘Exploring assistant practitioners’ perceptions of their role in acute hospital wards’, RCN International Nursing Research Conference London, April 2012, research commissioned by NIHR SDO.


Wilson NW, Cooper ID, de Vries E, Reid S, Fish T, Marais BJ. 2009, ‘A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas’, Rural and Remote Health 9: 1060.