FAIR WORK COMMISSION

AM2021/63

THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION
Applicant

APPLICATION UNDER SECTION 157 OF THE *FAIR WORK ACT 2009* (CTH) TO AMEND THE *AGED CARE AWARD 2010* AND *NURSES AWARD 2020*
First Matter

AM2020/99

HEALTH SERVICES UNION
Applicant

APPLICATION UNDER SECTION 157 OF THE *FAIR WORK ACT 2009* (CTH) TO AMEND THE *AGED CARE AWARD 2010*
Second Matter

AM2021/65

HEALTH SERVICES UNION
Applicant

APPLICATION UNDER SECTION 157 OF THE *FAIR WORK ACT 2009* (CTH) TO AMEND THE *SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010*
Third Matter

AUSTRALIAN NURSING AND MIDWIFERY FEDERATION SUBMISSIONS ON "*CLASSIFICATION AND ALLOWANCE ISSUES*"

1. Order 10 of Hatcher J's Orders made 02 August 2023 was that any party which had filed a draft determination was to file evidence and submissions in support of its draft determination, as well as any other evidence in chief and submissions concerning "*classification and allowance issues*," by 27 October 2023. On 16 October 2023 those orders were amended such that this material is now due today.

2. "*Classification and allowance issues*" are issues 1–16 in the "*Revised Stage 3 Issues Summary*," dated 02 August 2023 ("**Issues Document**")—relating, in broad terms, to what classifications should exist in the various awards affected by these applications, and what rates of pay should attach to each. There are many sub-issues, of course, bound up in this headline issue, only some of which are the subject of submissions.

3. To be precise, and consistently with the position articulated in its document filed 15 September 2023 and entitled, "*Australian Nursing and Midwifery Federation Position in respect of 'Classification And Allowance Issues'*" ("**Position Document**"), the ANMF has submissions to make concerning items 1–2, 6–14, and (briefly) 16.

4. The ANMF will identify below when it is addressing a particular item, but it thinks that at a higher level the items can be divided up as follows.

5. In Part A ([9]–[74] below), the ANMF addresses items 6–7, 12–14, and 16: issues of principle or more-general application.

6. In Part B ([75]–[132] below), the ANMF addresses items 1–2: the classification structures sought by the ANMF in the *Aged Care Award* and in the *Nurses Award*.

7. In Part C ([133]–[149] below), the ANMF addresses items 8–11: more–particular issues in relation to the framing of the *Aged Care Award*.

8. The evidence upon which the ANMF relies is as follows:

   (1) evidence filed in Stage 1 of this proceeding, as identified herein;

   (2) a statement of Annie Butler (Federal Secretary, ANMF) dated 01 November 2023;

   (3) a statement of Julianne Bryce (Senior Federal Professional Officer, ANMF) dated 01 November 2023.

A. Items 6–7, 12–14, and 16: issues of principle or more-general application

9. Under this heading, the ANMF addresses items that give rise to issues of principle, or are of more-general application than the specific drafting questions which are addressed in Part C. They are addressed in an order that enables later parts to build on submissions made in earlier parts, rather than necessarily in item order.

A.1 Item 14: use or application of the C10 framework and relativities

10. Item 14 is described in the Issues Document as "*Issues relating to application of the C10 framework & internal & external relativities*."

11. As articulated in the Position Document, the ANMF's position with respect to this issue is that:

> "The ANMF's position remains, as articulated in its Response to BD10 at [49]-[51], [56], [60] and [62], that the C10 Metals Framework should be applied to ENs, RNs and NPs in the *Nurses Award* in the following manner:
>
> - RN (level 1, pay point 1) should be aligned to C1(a) of the Manufacturing Award. Per Re IEU [2021] FSCFB 2051 ("Teachers decision") at [562], C10($995)*148% = $1472.60
> - The existing relativities as between ENs, RNs and NPs be maintained, with RN (level 1, pay point 1) as the benchmark.
>
> It is acknowledged that this position departs from the ANMF's original application for a 25% increase across the board.
>
> The ANMF's position addresses the significant non-alignment, at present, of RN rates with the Metals Framework and reflects "the provisional view" as expressed by the Full Bench in the Interim Decision [2022] FWCFB 200 at [955] that there is "considerable merit in such an approach".
>
> Maintenance of existing relativities between AINs/PCWs and RNs is no longer sought. The ANMF has changed its position in respect of AINs/PCWs since its response to BD10.
>
> As articulated at Item 12 [to the Position Document] above, the ANMF now proposes:
>
> - a new definition and classification structure for AINs in aged care under the *Nurses Award*; and
> - alignment of AINs in aged care under the *Nurses Award* with PCWs under the *Aged Care Award*."

A.1.1 Proper application of the C10 Metals Framework Alignment Approach

12. The decision of the Full Bench in stage 1 of these proceedings ([2022] FWCFB 200) ("***Stage 1 decision***") described the 3-step process for determining properly-fixed minima in respect of the C10 framework and relativities approach set out in the *ACT*

Child Care Decision[1] as the "***C10 Metals Framework Alignment Approach***". That three step process is as follows:

> "1. The key classification in the relevant award is to be fixed by reference to appropriate key classifications in awards which have been adjusted in accordance with the MRA process with particular reference to the current rates for the relevant classifications in the Metal Industry Award. In this regard the relationship between the key classification and the Engineering Tradesperson Level 1 (the C10 level) is the starting point.
>
> 2. Once the key classification rate has been properly fixed, the other rates in the award are set by applying the internal award relativities which have been established, agreed or maintained.
>
> 3. If the existing rates are too low they should be increased so that they are properly fixed minima."

13. Considering relativities in the context of s 157(2)(a) of the *Fair Work Act 2009* (Cth) ("**FW Act**"), the Full Bench made the following observations in the *Stage 1 decision* at [293.7] (see also at [192] and [939]):

> "Having regard to relativities within and between awards remains an appropriate and relevant exercise in performing the Commission's statutory task in s.157(2). Aligning rates of pay in one modern award with classifications in other modern awards with similar qualification requirements supports a system of fairness, certainty and stability. The C10 Metals Framework Alignment Approach and the AQF are useful tools in this regard. However, such an approach has its limitations, in particular:
>
> - alignment with external relativities is not determinative of work value
> - while qualifications provide an indicator of the level of skill involved in particular work, factors other than qualifications have a bearing on the level of skill involved in doing the work, including 'invisible skills' as discussed in Chapter 7.2.6
> - the expert evidence supports the proposition that the alignment of feminised work against masculinised benchmarks (such as in the C10 Metals Framework Alignment Approach) is a barrier to the proper assessment of work value in female-dominated industries and occupations (see Chapter 7.2.5), and
> - alignment with external relativities is not a substitute for the Commission's statutory task of determining whether a variation of the relevant modern award rates of pay is justified by 'work value reasons' (being reasons related to the nature of the work, the level of skill and responsibility involved and the conditions under which the work is done)."

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[1] *Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 – re Wages rates*, PR954938 [2005] AIRC 28 (***ACT Child Care Decision***).

14. The ANMF respectfully adopts this analysis. The C10 Metals Framework Alignment Approach ought not be applied mechanically without specific regard to the statutory criteria. Used without proper regard to the potential for gender-based undervaluation of work, the C10 Metals Framework Alignment Approach may act as a barrier to the proper assessment of work value in female-dominated industries. However, considered alongside evidence, including expert evidence of the "*invisible skills*" involved in performing work in female dominated industries, the application of the C10 Metals Framework Alignment Approach can support fairness, certainty, and stability.

15. At [952] of the *Stage 1 decision* the Full Bench also observed that:

> "… The qualifications required for a particular role will usually be relevant to the task of assessing the level of skill exercised by an employee. And, 'work value reasons' justifying the amount that employees should be paid for doing a particular kind of work are 'reasons related to', among other things: 'the level of skill … involved in doing the work' (s.157(2A)(a)). We also accept, as is evident from our discussion of 'invisible skills' in Chapter 7.3.2 that the relevant qualification is, plainly, not exhaustive of the level of skill exercised in doing a particular kind of work."

16. Again, the ANMF respectfully adopts this analysis.

17. Whilst the C10 Metals Framework Alignment Approach described in the *ACT Child Care Decision* identified the Engineering Tradesperson Level 1 (the C10 level) as the "*starting point*", it is clear that different key classifications may be adopted.

18. In the *ACT Child Care Decision* itself, the Australian Industrial Relations Commission ("**AIRC**") considered applications to vary an ACT award and a Victorian award, covering child care workers, including with respect to wage rates and classification structure. In applying the C10 Metals Framework Alignment Approach, the AIRC there identified two key classifications, determining that:

    (1) the AQF Diploma-level child care worker classifications should be linked to the C5 level in the Metal Industry Award; and

    (2) there should be a nexus between the "*CCW level 3 on commencement*" classification in the ACT Award (and the Certificate III level in the Victorian Award) and the C10 level in the Metal Industry Award.[2]

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[2] *ACT Child Care Decision* at [182] and [367].

19. In the *Teachers Decision*,[3] the Commission applied the C10 Metals Framework Alignment Approach using the classification of "*Proficient Teacher*," who has a degree and has obtained registration, aligned with Level C1(a) in the Metal Industry Award.[4]

20. In the *Pharmacy Decision*,[5] the Commission identified the non-aligned relativity between a degree qualified Pharmacist and the relevant classification under the Metals Framework. It was noted that this may potentially constitute a work value consideration.[6] Subsequently, on 9 June 2023, Hatcher P issued a recommendation in that proceeding.[7] That Recommendation included (at [11(1)]) that parties engage in reconsideration of the classification structure regarding the establishment of a benchmark classification for a four year degree qualified, fully practicing pharmacist with a properly fixed rate of pay aligned with the notional C1 classification in the Metal Framework.

A.1.2 Step 1(a)—RN level 1, pay point 1 as a key classification under the *Nurses Award*

21. There seems to be general consensus in the current proceeding that the classification of RN, level 1, pay point 1, is an appropriate key classification for the purpose of the C10 Metals Framework Alignment Approach. This consensus is apparent from the following:

    (1) *First,* it is uncontroversial that the RN classifications involve an accredited tertiary degree—which is an AQF Level 7 qualification, aligning with C1 in the Metals Framework;[8]

    (2) *Second*, the position of the ANMF since April 2022 has been that, if the C10 Metals Framework Alignment Approach is to be applied, this would involve alignment of RN Level 1, pay point 1 with C1(a);[9]

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[3] *Independent Education Union of Australia* [2021] FWCFB 2051 (***Teachers Decision***).
[4] *Teachers Decision* at [653])
[5] *Four Yearly Review of Modern Awards – Pharmacy Industry Award 2010* [2018] FWCFB 7621 (***Pharmacy Decision***).
[6] Pharmacy Decision at [194] to [198].
[7] *Recommendation - The Association of Professional Engineers, Scientists and Managers, Australia t/a Professionals Australia - Pharmacy Industry Award 2020*, Sydney, 9 June 2023.
[8] Joint Employer Closing Submissions dated 22 July 2022 at [7.5]; *Stage 1 decision* at [943] – [944].
[9] Reply Submissions of the Australian Nursing and Midwifery Federation, dated 21 April 2022 at [57] – [61]; Closing Submissions in Reply of the Australian Nursing and Midwifery Federation, dated 17 August 2022 at [142] – [148].

(3) *Third* the position of the Joint Employers is that for the "*professional*" classifications under the *Nurses Award*, the key classification is Registered Nurse level 1 (which aligns to C1 for which the reference point becomes the *Professional Employees Award 2020*).[10] The position of the Joint Employers also recognises that a benchmarking of the RN level 1, pay point 1, with level C1(a) of the Metals Framework is consistent with the guidance provided by the C10 Metals Framework Alignment Approach;[11]

(4) *Fourth,* the Full Bench in the *Stage 1 decision* at [955] recognised that the comparison between the C10 Metals Framework and the *Nurses Award* disclosed an anomaly, and that the realignment of the classification rates in the *Nurses Award* (effecting a 35 per cent increase to all classifications) would also be consistent with the approach taken in the *Teachers Decision*. The Full Bench also went on to express a "*provisional view*", that "*there is considerable merit in such an approach.*"

22. The alignment of the RN classification in the *Nurses Award* with the C1 classification in the Metals Framework also draws support from the *Annual Wage Review 2022-23 Decision*.[12] By that decision the Commission identified a work value issue with implications for the minimum wage rates of modern award-reliant females on higher award classifications, particularly those applying to persons holding undergraduate degrees. Specifically, it was noted at [134] that, under the C10 Metals Framework Alignment Approach:

> "… employees with degree qualifications were meant to be aligned with a theoretical C1 classification, with relativities to C10 in the range of 180-210 per cent. However, for most degree-qualified classifications in awards, this process was never carried through and they were never placed in the appropriate relativity to C10."

23. Table 18 to the *Stage 1 decision* shows *Nurses Award* wage rates where the classification of RN level 1, pay point 1 is adopted as a key classification and aligned with C1(a) of the Metals Framework.[13] That table reflects the *Teachers Decision* at

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[10] Position of the Joint Employers: Classifications and Allowance Issues, dated 15 September 2023 at [50(a)].

[11] Position of the Joint Employers: Classifications and Allowance Issues, dated 15 September 2023 at [51] and [52].

[12] [2023] FWCFB 3500 (***Annual Wage Review 2022-23 Decision***).

[13] See *Stage 1 decision* at [944].

[562], incorporating C1 rates extrapolated from those appearing in the award as originally made on 19 December 2008, as adjusted consistent with Annual Wage increases since then. The rates in that table reflect those in effect prior to 30 June 2023.

24. As identified in the *Teachers Decision* at [561], the Metal Industry classification structure reflected at [562] of that decision (and in Table 18 to the *Stage 1 decision*) differs from that originally formulated in the *Metal Industry Award 1984 – Part I* ("**Metals Award**") in two ways:

    (1) *First*, because of flat dollar increases awarded in safety net reviews by the AIRC, in wage decisions of the Australian Fair Pay Commission, and in the initial annual wage reviews of this Commission, the relativities between classifications became compressed. For that reason, the relativity as between the C10 and C1 classifications has been compressed from 180/210 per cent to 148/167 per cent.

    (2) *Second*, the full Metals Award classification structure was incorporated by the AIRC into the *Manufacturing and Associated Industries and Occupations Award 2010* ("**Manufacturing Award**") when it was made on 19 December 2008. However, the highest C1 classification was deleted on 30 December 2009 on the basis that degree-qualified professional engineers and scientists previously covered by the classification would now be covered by the *Professional Employees Award 2010* ("**PE Award**"). Further, the salary rates provided for in the PE Award were not consistent with the relativities originally provided for in the Metals Award classification, and were generally lower than the C1 rates which originally appeared in the Manufacturing Award and were themselves the result of the compression of relativities.

25. The C1 classification under the Metals Award identified the minimum training requirement for the C1 classification of "*Professional Engineer [/] Professional Scientist*" to be a "*Degree*".

26. The title "*Registered Nurse*" is a protected title under the *Health Practitioner Regulation National Law Act 2009*[14] ("**National Law**"). To become an RN, a person

[14] ANMF 2, *Health Practitioner Regulation National Law Act 2009* (Qld) sch Health Practitioner Regulation National Law.

must have successfully completed a program of study accredited by the Australian Nursing and Midwifery Accreditation Council ("**ANMAC**") and approved by the Nursing and Midwifery Board of Australia ("**NMBA**").[15]

27. ANMAC has published the Registered Nurse Accreditation Standards which are used to evaluate education programs. The Registered Nurse Accreditation Standards prescribe that the program of study must be delivered at an AQF Level 7 or above for the award of a Bachelor Degree, as a minimum.[16] Currently, this minimum standard involves a three-year Bachelor of Nursing degree which must be delivered by an education provider registered with the Tertiary Education Quality and Standards Agency as a university or higher education provider.[17] That is, the classification of RN, level 1, pay point 1, requires the minimum training requirement of a "*degree*".

28. The Registered Nurse Accreditation Standards, also stipulate, *inter alia*, that:

    (1) the accredited program of study is delivered in Australia to prepare graduates for safe and ethical practice;[18] and

    (2) the content and subject learning outcomes of an accredited program of study ensure achievement of the NMBA Registered Nurse Standards for Practice ("**RN Standards for Practice**").[19]

29. All RNs have a professional responsibility to meet the RN Standards for Practice[20] as read and applied in conjunction with the applicable NMBA companion documents (including the Code of conduct for nurses, National framework for the development of decision-making tools for nursing and midwifery practice, Supervision guidelines for nursing and midwifery, and Guidelines for mandatory notifications).[21]

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15 Statement of Julianne Bryce, dated 29 October 2021 at [21].

16 Further Statement of Julianne Bryce, dated 01 November 2023, "JB-1", ANMAC Registered Nurse Accreditation Standards, Standard 3.2 - Standard 3: Program of study.

17 Further Statement of Julianne Bryce, dated 01 November 2023, "JB-1", ANMAC Registered Nurse Accreditation Standards, p 4, Preamble.

18 Further Statement of Julianne Bryce, dated 01 November 2023, "JB 1", ANMAC Registered Nurse Accreditation Standards, p 14, Standard 1.2 - Safety of the public.

19 Further Statement of Julianne Bryce, dated 01 November 2023, "JB-1", ANMAC Registered Nurse Accreditation Standards, p 16, Standard 3.5(a) - Program of study.

20 ANMF tender bundle at ANMF 23.

21 Further Statement of Julianne Bryce dated 01 November 2023, at [12] and NMBA Registered Nurse Standards for Practice ("**RN Standards for Practice**"), ANMF tender bundle at ANMF 23, p 3.

30. In accordance with the RN Standards for Practice, an RN:

    (1) is responsible and accountable for ensuring they are safe and have the capability for practice;[22]

    (2) accurately conducts comprehensive and systematic assessments;[23]

    (3) is responsible for the planning and communication of nursing practice;[24]

    (4) provides and may delegate quality and ethical goal-directed actions;[25] and

    (5) takes responsibility for the evaluation of practice based on agreed priorities, goals, plans and outcomes and revises practice accordingly.[26]

31. Once an RN is fully qualified and has obtained registration with the NMBA they are considered fully registered. An RN level 1, pay point 1 would not be subject to required supervision, unless there is a condition or undertaking on their registration.[27] In this respect, an RN level 1, pay point 1 may be contrasted with a graduate teacher, for whom the skills and responsibilities of the profession are not yet being fully exercised, as recognised by the national registration system requirements.[28]

32. For the above reasons, applying step 1 of the C10 Metals Framework Alignment Approach would result in the Commission aligning the key classification of RN level 1, pay point 1 of the *Nurses Award* with C1(a) of the Metals Framework.

A.1.3 Step 1(b)—key classifications for PCW and AIN classifications

33. The ANMF understands the position of the HSU[29] and the Joint Employers[30] to be that the classification currently described in the *Aged Care Award* as "*Aged care employee—direct care—level 4*" would be the key classification for direct care workers

[22] RN Standards for Practice (ANMF 23), p 4, Standard 3.
[23] RN Standards for Practice (ANMF 23) p 5, Standard 4.
[24] RN Standards for Practice (ANMF 23) 5, Standard 5.
[25] RN Standards for Practice (ANMF 23) p 5, Standard 6.
[26] RN Standards for Practice (ANMF 23) p 5, Standard 7.
[27] Further Statement of Julianne Bryce dated 01 November 2023, at [15].
[28] Further Statement of Annie Butler dated 01 November 2023, at [88] and [152]; *Cf. Teachers Case* at [653].
[29] Summary of the HSU's Position in Respect of 'Allowance and Classification Issues', filed 22 September 2023, Item 14. See also HSU Excel spreadsheet explaining the calculations underpinning the proposed wage rates, filed 28 September 2023 which Identifies the classification.
[30] Position of the Joint Employers: Classifications and Allowance Issues, dated 15 September 2023 at [48(a)].

under the *Aged Care Award*, and that such a classification would be aligned to the C10 classification. The ANMF agrees that it is appropriate to proceed on that basis. On the ANMF's application, this classification in the *Aged Care Award* would be known as "*Grade 3 – Personal Care Worker (qualified)*".

34. Consistently with the Commission's approach in the *ACT Child Care Decision*, it is open (and here, appropriate) to select multiple key classifications when applying the C10 Metals Framework Alignment Approach.

35. The ANMF seeks alignment of the rates of pay as between PCW classifications under the *Aged Care Award* and AIN classifications under the *Nurses Award*. The "*Grade 3 – Aged care nursing assistant (qualified)*" classification would therefore align with the "*Grade 3 – Personal Care Worker (qualified)*" under the Aged Care Award.

36. Accordingly, the Commission would adopt the "*Grade 3 – Aged care nursing assistant (qualified)*" classification as a key classification under the *Nurses Award* and align this with C10 of the Metals Framework.

A.1.4 Step 2—application of internal relativities to key classifications

37. Step 2 to the C10 Metals Framework Alignment Approach calls for the application of internal relativities which have been established, agreed, or maintained once the key classification has been properly fixed.

38. The Award Modernisation Process leading to the making of the *Aged Care Award* is addressed in the witness statement of Leigh Svendson[31] and in Background Document 2.[32] That process involved the consideration of submissions from numerous parties as to the classification structure and internal relativities. Ultimately, the classification structure in the *Aged Care Award* was derived from awards, including:

    (1) *Health and Allied Services – Private Sector – Victoria Consolidated Award 1998*;

    (2) *Health and Allied Services – Public Sector – Victoria Consolidated Award 1998*;

[31] Witness statement of Leigh Svendson, 23 April 2022, at [172] – [224].

[32] *Background Document 2 - Award Histories*, 9 June 2022 at [7] – [26].

(3) *Notional Agreement preserving the Aged Care General Services (State Award)*; and

(4) *Notional Agreement preserving the Charitable Sector, Aged and Disability Care Services (State) Award 2003*.[33]

39. The ANMF proposes retaining internal relativities as between AINs / PCWs in the *Aged Care Award* and the *Nurses Award*, and proposes retaining internal relativities as between nursing classifications in the *Nurses Award*.

40. So, for AIN / PCW classifications:

(1) in the *Aged Care Award*, the Commission would fix the rates for the "*Aged care employee—direct care—level 4*" or "*Grade 3 – Personal Care Worker (qualified)*" classification, and then apply existing internal relativities for PCW classifications;

(2) in the *Nurses Award*, the same rates (and relativities) would apply to AIN classifications as apply to PCW classifications.

41. For Nursing Classifications in the *Nurses Award*, having fixed RN level 1, pay point 1 to C1(a) of the Metals Framework, the Commission would retain existing relativities as between that classification and classifications for ENs (including student ENs), RNs, and NPs. This approach is appropriate where:

(1) EN rates have historically been set as a percentage of the RN rate;[34]

(2) Internal relativities as between ENs (including student ENs), RNs and NPs have been established, agreed or maintained over a period of time though various proceedings;[35]

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33 Witness statement of Leigh Svendson, 23 April 2022, at [4].

34 See, *EN National Rates Case* AIRC Dec 680/92 Print K3662, Australian Industrial Relations Commission 10 July 1992, at p 15 - 16 (Statement of Kristen Wischer, 14 September 2021, Attachment No: AH 14).

35 See, *e.g.*, *Federal A257 Nurses Anomalies Case*, Decision 224/97 M Print G7200 [1987] AIRC 135 (Statement of Kristen Wischer, 14 September 2021, Attachment No: AH 7); See also the table 'Award rates of pay-key classification entry level' attached to the Australian Nursing Federation October 2008 Award Modernisation Submissions (Statement of Kristen Wischer, 14 September 2021, Attachment No: AH 26(C)).

(3) ENs, RNs and NPs are each regulated health practitioners, responsible and accountable to the NMBA in accordance with the National Law. Employees in those classifications must have completed programs of study accredited by the Australian Nursing and Midwifery Accreditation Council in accordance with standards approved by the NMBA. Each will also have a professional responsibility to meet the NMBA Standards for practice and a contemporary knowledge and skill base to deliver safe nursing care;[36] and

(4) The work value of a Student ENs is to be assessed relative to an EN, not some other form of carer.

A.1.5 Step 3—increasing rates so that they are properly fixed

42. The application of steps 1 and 2 of the C10 Metals Framework Alignment Approach to direct care classifications under the *Aged Care Award* would lead to rates that are too low and are not properly fixed. The *Stage 1 decision* recognised that this process led to a wage outcome that was at least 15 per cent below what was plainly justified by work value reasons.[37] The same may be said of the application of steps 1 and 2 of the C10 Metals Framework Alignment Approach to AIN classifications under the *Nurses Award*.

43. In that respect, Step 3 has significant work to do here to ensure that the rates are properly fixed minima especially having regard to:

(1) "*invisible skills*," as discussed in Chapter 7.2.6 of the *Stage 1 decision*;

(2) the fact that the alignment of feminised work against masculinised benchmarks (such as in the C10 Metals Framework Alignment Approach) is a barrier to the proper assessment of work value in female-dominated industries and occupations (as discussed in Chapter 7.2.5 of the *Stage 1 decision*); and

(3) the matters identified in the ANMF's Submissions on Wage Adjustment Issues of 15 September 2023.

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36 Further Statement of Julianne Bryce, dated 01 November 2023 at [4] – [11].

37 *Stage 1 decision* at [957], [961], [966], [967] and [1085].

44. Consistently with the ANMF's draft determinations for the Aged Care Award and Nurses Award, the proper application of step 3 of the C10 Metals Framework Alignment Approach would result in:

    (1) a further 10 per cent increase beyond the "*interim increase*" for all "*aged care employees-direct care*" classifications in the *Aged Care Award*;

    (2) increases for all "*aged care nursing assistant*" classifications under the *Nurses Award* fixed by reference to the aligned "*aged care employees-direct care*" classifications in the *Aged Care Award*;

    (3) the adoption of minimum rates for the RN, level 1, pay point 1 classification, fixed by reference to C1(a) of the Metal Framework and retained internal relativities for all EN (including student EN), RN and NP classifications.

A.1.6 Procedural fairness and the broader implications of adopting RN level 1, pay point 1 as a key classification

45. The Commission at [956] of the *Stage 1 decision* observed that the realignment of the rates for nurses in the aged care sector (adopting RN level 1, pay point 1 as a key classification) would have implications for nurses employed in other sectors and for the employers in those sectors. The Commission went on to state that it had not taken this particular issue any further, given (amongst other things) the fact that other parties likely to have an interest in the matter are entitled to be heard.

46. For three reasons, there is no procedural fairness impediment to adopting the approach for which the ANMF contends.

47. *First*, it is safe for the Commission to proceed on the basis that all interested parties who <u>wish</u> to be heard are already before the Commission. In this connection, the ANMF (and the HSU) have sought increases in award minima of (at least) 25 per cent for several years. If employers in other, non-aged-care, sectors wished to be heard in relation to that level of increase, they could have sought to be heard. The prospect of there being a non-aged-care employer who has been uninterested in being heard in relation to 25 per cent increases, but who <u>would</u> wish to be heard in relation to 35 per cent increases, is remote and need not trouble the Commission.

48. *Second*, in any case, the possibility of a 35 per cent wage rise for aged care nurses has been a live issue since July 2022, when it was raised by the Joint Employers in their

closing submissions (see *Stage 1 decision* at [942]). And, the ANMF has positively sought such a wage rise since March 2023.[38] On 15 September 2023, the ANMF filed a draft determination contemplating such a wage rise. All of these documents have been published to the Commission's webpage. Again, there has been ample time for non-aged-care employers to posit a right to be heard, if any wished to do so.

49. *Third*, the Commission's decisions in these matters will directly affect (only) employers and employees in the aged-care sector. Every other effect on every other person is indirect. A change in rates payable to aged-care nurses would not affect the rights or obligations of (say) employers of nurses in other sectors, or, indeed, nurses in other sectors. Before there could be any such an effect on employers in other sectors (*e.g.*, by different variations to the *Nurses Award*), those other employers would of course have the option of being heard, in response to a different application.

50. It is possible that, as a practical matter, an increase in rates of aged-care nurses increases pressure on the employers of non-aged care nurses to increase their rates. But that connection is too remote to qualify as an "*interest*" (it is clearly not a "*right*") for the purpose of an obligation to afford procedural fairness. An increase in wages anywhere in the economy can have an effect on rates in analogue or related industries. For example, an increase in award minima in (say) food services will affect the relative attractiveness of such employment in comparison with (say) retail work. But it is not the case any retail employer would be entitled to be heard by the Commission in relation to an application to vary rates of pay in relation to food services work.

51. Here, of course, the connection is closer—aged-care nurses, and non-aged-care nurses—but it remains that the only "*interest*" that a non-aged-care employer could have in the rates of pay of aged-care nurses is derivative and secondary. Accepting that "*interests*" in the phrase "*right and interests*" are broader than "*rights*,"[39] still it is necessary that some form of recognised "*interest*" be affected—noting the list of examples of such interests given in *Kioa v West* (1985) 159 CLR 550 and quoted in the majority in *S10* at 658 [66].

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[38] See, *Australian Nursing and Midwifery Federation Response to Background Document 10—Stage 3 Outstanding Issues*, dated 07 March 2023, at [52]–[57].

[39] See, *e.g.*, *Plaintiff S10/2011 v Minister for Immigration and Citizenship* (2012) 246 CLR 636 at 658–659 [66]–[70] (Gummow, Hayne, Crennan and Bell JJ).

52. In short, the position is that:

    (1) non-aged care employers have been on notice of significant wage increases being sought (though not specifically the figure of 35 per cent) for years;

    (2) such employers have also been on notice of specifically the figure of 35 per cent as a possibility since July 2022 (when it was first raised), or March 2023 (when it was first sought by the ANMF), or September 2023 (when a draft determination was filed), and none have made application to be heard;

    (3) in any case, it is doubtful that the rights or interests of such employers would be affected by any decision varying the rates of pay for aged-care workers.

53. In this light, there is—as the ANMF commenced by saying—no procedural fairness impediment to the Commission considering and determining the issue of whether RN level 1 pay point 1 should be aligned with level C1(a), having the effect of (around) a 35 per cent increase in wages.

54. The Joint Employers suggest that Commission does not have before it any evidence that speaks to the implications of such a change for nurses and employers covered by the *Nurses Award* that do not work in aged care.[40] For the reasons identified above, such implications could only be indirect and should not prevent the making of the determination sought by the ANMF. It is not a jurisdictional requirement that the Commission have evidence of that kind before varying a modern award.

55. The Joint Employers also contend that to make such an adjustment (*i.e.*, to adopt RN level 1, pay point 1 as a key classification and grant a commensurate increase to award minimum wages) only for "*aged care*" nurses would introduce significant inequity into the *Nurses Award*. It is suggested that this would substitute one anomaly for another.[41]

56. It would be preferable if the minimum rates for all classifications under the *Nurses Award* were fixed at the same time. But, if the Commission were satisfied that work value reasons, and application of proper wage-fixation principles, justified an increase in award minima for a particular group of employees, it could not be a proper exercise of discretion to <u>refuse</u> to grant that increase because other employees could be identified

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40 Position of the Joint Employers: Classifications and Allowance Issues, dated 15 September 2023 at [54].
41 Position of the Joint Employers: Classifications and Allowance Issues, dated 15 September 2023 at [53].

for whom an increase may be (or is) also appropriate. It is not possible to properly fix all wages, in all classification, in all industries, at once.

57. The ANMF brought this application as a direct response to a recommendation in the Aged Care Quality and Safety Royal Commission Final Report. Throughout this proceeding the ANMF has consistently stated an intention to bring a further application to increase the minimum rates for classifications under the *Nurses Award* beyond the scope of the current application.[42] It outlined its reasons for not having yet done so in its letter dated 06 July 2023 to the President of the Commission (copy **annexed** to this submission). Any "*anomaly*" will be short-term only, and will either be addressed by the Commission's ongoing projects (referred to in [4] of the ANMF's July 2023 letter), or by the ANMF's subsequent application.

58. The Commission would therefore properly fix minimum rates under the *Nurses Award* for EN, RN and NP classifications on the basis of adopting RN level 1, pay point 1 as a key classification, and progressing through the other steps as outlined above.

A.2 Item 6: time- or competency-based progression?

59. The ANMF abides by:

(1) the position expressed in its submissions dated 07 March 2023 in relation to Background Document 10 (see at [10]–[14]); and

(2) the position expressed in its closing submission in reply dated 17 August 2022 at [171]–[180].

60. The ANMF's draft determination for the *Aged Care Award* does not contemplate time-based progression, so no issue presents.[43] For the *Nurses Award*, the progression is <u>partly</u> time based, but partly not (see cl 15.3(b)). The progression structure has evolved as a product of decades of industrial arbitration.[44] It remains that no party—including the Joint Employers, despite their apparent objection to time-based

[42] Form F46 – Application to vary a modern award, 18 May 2021, Annexure 2 at [8], Reply Submissions of the ANMF, dated 21 April 2022 at [71]; and ANMF Closing Submissions in Reply, dated 17 August 2022 at [169].

[43] Save for the progression out of an entry-level Grade after a period of time—on the ANMF's case, six months—which the HSU and Joint Employers propose as well and which the ANMF therefore does not understand to be controversial.

[44] See ANMF submissions dated 07 March 2023 at [10(2)], statements of Kristen Wischer dated 14 September 2021 and Leigh Svendson dated 23 April 2022, and Background Document 2 - Award Histories.

progression—has proposed a draft determination for the *Nurses Award* that entirely eliminates such progression.

61. In the circumstances, the Commission would retain (in the *Nurses Award*) the current approach to progression (partly time-based, partly not—see cl 15.3 of the ANMF's Draft Determination filed 15 September 2023).

A.3 Item 7: separate classification structure in the *Aged Care Award* for PCWs

62. The ANMF's position has been, and remains, that there should be a separate classification structure in the *Aged Care Award* for PCWs.[45]

63. As the ANMF has repeatedly said, if there are different wage rates between direct care workers and other workers, then separate classification streams is an "*obvious drafting technique*." And even if the wage rates are the same, the work is qualitatively different.

64. This point seems, in effect, now to have been acknowledged by the HSU (which as far as the ANMF can discern was the most-vocal opponent to separate classification streams). In the HSU's draft determination filed 28 September 2023 (and in the Residential Aged Care classifications):

    (1) some levels (Level 1) are applicable only to what they call the "*General, Administrative and Food Services stream*", and not to the "*Personal Care Work stream*";

    (2) nearly all other levels, under the heading of "*Description of work*," provide descriptions of very different work depending on whether the work is "*Personal Care Work*" or "*General, Administrative, or Food Services Work*" (*e.g.*, Level 2). Some levels are broken down still further (*e.g.*, Levels 3, 4, 5, 6);

    (3) only Level 7 (Supervisor) appears to be applicable to all "*streams*."

65. Taking, for example, Level 3, a distinction is drawn between personal care work and other kinds of work in the areas of "*description of work*," "*qualifications and experience*," "*accountability and extent of authority*," "*specialist knowledge and*

[45] See ANMF submissions dated 21 October 2021 at [209], submissions dated 22 July 2022 at [873] and submissions dated 07 March 2023 at [18]–[20]

skills," and "*work environment*." The only heading that is agnostic as to stream is "*judgment and decision-making*."

66. None of this is a criticism of the HSU. It is, rather, an observation that it is not possible to draft a useful and meaningful classification structure that does not distinguish between what are very different kinds of work. And once one goes that far, whether the distinction is drawn by having separate headings in most classifications in a single classification structure, or is drawn by simply having multiple classification structures, is a matter of form rather than substance. The latter approach, the ANMF submits, is more user friendly and accords with the regulatory arrangements discussed at [86]–[104] below and in the Further Statement of Annie Butler at [9] – [47].

A.4 Items 12–13: differences between AINs and PCWs, reflection / consolidation

67. In the below:

    (1) where the word "*alignment*" is used, that means that aged-care AIN classifications in the *Nurses Award* are made to be identical (or substantially so) to PCW classifications in the *Aged Care Award*;

    (2) where the word "*consolidation*" is used, that means that aged-care AIN classifications in the *Nurses Award* are deleted or excised, such that all persons who had been aged-care AINs pursuant to the *Nurses Award* would become classified as PCWs under the *Aged Care Award*.

68. As the Commission noted at item 13 of the Issues Document, the parties' positions in relation to whether there should be consolidation of aged-care AINs into the *Aged Care Award* were:

    (1) the ANMF strongly opposed it;

    (2) the Commonwealth opposed it;

    (3) the Joint Employers "*did not necessarily oppose*" it, but noted that there were challenges and that evidence in support of such a change would need to be compelling;

    (4) the HSU "*did not oppose*" it.

69. So, the position as described by the Commission in its Issues Document was that no party actually sought consolidation of aged-care AINs from the *Nurses Award* into the *Aged Care Award*, and two of the active parties opposed it.

70. In its Position Document dated 15 September 2023, UWU indicated that it was neutral on the question (see item 12). The Joint Employers' position was unchanged.[46] The HSU, in its Position Document, said nothing about consolidating AINs into the *Aged Care Award* (items 12–13). No party filed any draft determination excising aged care AINs from the *Nurses Award*.

71. In a word, the current position is that, whereas the ANMF and the Commonwealth oppose consolidation of aged care AINs into the *Aged Care Award*, no party seeks such consolidation, and no party has filed a Draft Determination which would have the effect of such consolidation. While the Commission is, of course, entitled to make award changes of its own motion, the ANMF does not understand the present position to be that it has indicated an intention to do so. Rather, the ANMF understands the position to be that the Commission raised for the parties' consideration whether any party wished to seek consolidation—and no party does.

72. In these circumstances, the ANMF does not understand consolidation to be an option that has either been sought, or is under consideration. Should any party adduce evidence or make submissions in support of consolidation (despite not having filed a determination seeking the same), the ANMF reserves its rights including in relation to the filing of reply evidence and submissions.

73. In respect of issue 12, the ANMF's position is that the work value of AINs employed in aged care under the *Nurses Award* and PCWs under the *Aged Care Award* is the same.

74. AINs in aged care and PCWs perform markedly similar work and there is no material difference in their skills or qualifications.

[46] Submissions of Joint Employers dated 15 September 2023, at [43]-[47].

B. Items 1–2: the ANMF's proposed classification structures for the *Aged Care Award* and the *Nurses Award*

75. The ANMF does not support the HSU's proposed changes to the Aged Care Award classification structure as set out at [28] and Attachment A of BD10. The ANMF's position in this respect is summarised in the Position Document.

76. On 28 September 2023 the HSU filed a Draft determination seeking proposed amendments to the Aged Care Award 2010 ("**HSU Aged Care Draft Determination**"). The classification structure identified in the HSU Aged Care Draft Determination differ substantially from the changes to the Aged Care Award classification structure sought by the HSU as set out at [28] and Attachment A of BD10. The ANMF does not support the HSU's proposed changes to the classification structure as set out in the HSU Aged Care Draft Determination.

77. The ANMF has its own proposal for changes to the Aged Care Award classification structure reflected in the draft determination filed. The ANMF also proposes changes to the classification structure of AIN aged care employees under the *Nurses Award* as identified in the draft determination filed. These proposals are the result of a consultation process guided by Annie Butler, Federal Secretary of the ANMF, with stakeholders and ANMF employees, including:

    (1) Associate Professor Anne Junor, Associate Professor Meg Smith and Honorary Professor Ian Hampson;

    (2) ANMF Professional Officers;

    (3) ANMF Industrial Officers; and

    (4) Registered nurses working in the aged care sector in senior, managerial roles, being equivalent to the role of Director of Nursing.[47]

78. For the reasons identified below, the ANMF's proposed changes to the Aged Care Award classification:

    (1) Are to be preferred to the classification structure currently contained in the Aged Care Award;

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[47] Further Statement of Annie Butler dated 01 November 2023, at [89].

(2) Are to be preferred to the classification structure identified in the HSU Aged Care Draft Determination;

(3) Are necessary to achieve the modern awards objective.

79. Likewise, the ANMF's proposed changes to the *Nurses Award* classification are necessary to achieve the modern awards objective.

80. The ANMF proposes variations to the "*Aged care employee – direct care*" classifications at Schedule B.2 to the *Aged Care Award* and a variation to the *Nurses Award* by including a new classification structure for "*Aged care nursing assistants*". Those variations are appropriate and necessary to reflect the practical reality and the policy and applicable regulatory framework of the work performed.

81. The findings of the Commission in the *Stage 1 decision* drew no distinction between AINs (under the *Nurses Award*) and PCWs (under the *Aged Care Award*).[48] Those findings support the proposition that AINs and PCWs in aged care perform markedly similar work with no material difference in their skills or qualifications. The findings also support a conclusion that the work value of AINs employed in aged care under the *Nurses Award* and that of PCWs under the *Aged Care Award* is the same.

82. The Report to the Full Bench by Commissioner O'Neill dated 20 June 2022 ("**Lay Evidence Report**") drew no distinction between the work performed by AINs (under the *Nurses Award*) and PCWs (under the *Aged Care Award*). It found at [104] that the typical duties of a personal carer in residential care facilities can include:

(1) observing, monitoring and documenting residents' care and behaviour;

(2) monitoring residents for skin wounds, lesions and bruises and reporting these to the RN/EN where necessary;

(3) continence management;

(4) medication rounds;

(5) performing blood pressure checks, blood sugar levels, weighing residents,

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48 See for example Stage 1 decision at [890] to [917] "*The evidentiary findings*".

(6) monitoring bowel movements and urination and collecting a urine or stool sample if necessary and reporting to the RN where necessary;

(7) turning residents to avoid pressure sores;

(8) assisting residents with toileting, showering and dressing;

(9) assisting residents to the dining area for meals, including serving meals and beverages, and feeding residents;

(10) monitoring fluid intake;

(11) undertaking fluid rounds;

(12) undertaking cleaning duties;

(13) keeping residents occupied with activities and entertainment;

(14) managing behaviours (for example when residents become violent or distressed);

(15) resettling residents when they wake during the night, or are distressed, crying or in need of support;

(16) observing emotional and mental health;

(17) responding to enquiries about residents from families;

(18) completing administrative tasks.

83. The Lay Evidence Report at [130] also identified typical duties of the personal carer in community care. The evidence there considered included evidence from persons engaged to perform "*domestic*", "*personal care*" or "*social support*" duties or a mix of these duties in a shift. Accordingly, the findings extended beyond the duties of persons employed as AINs. Nonetheless, the typical duties identified in the Lay Evidence Report included a majority of tasks that amounted to the provision of "*nursing care*" or aspects of "*nursing practice*" as discussed below.

84. At [358]–[359], the Lay Evidence Report recognised Care Plans to be formal documents that record how each resident is to be looked after, and their care needs. It found that, in residential care facilities, when a resident is first admitted, an RN will

usually prepare a Care Plan in consultation with the resident and their family and, further, that personal carers, together with RNs and ENs, implement different aspects of the Care Plan.[49] The Lay Evidence Report also identified at [369] that in community care, the Care Plan is also generally prepared by a RN.

85. There is a large volume of evidence before the Commission regarding the role of nursing teams, comprising RNs, ENs and AINs / PCWs, working together in aged care. Care Plans provide the foundation for the work and cooperative activity of the nursing team.[50]

86. The regulatory framework in which direct aged care work is performed in residential facilities has been recently varied by the introduction of:

    (1) the requirement for providers to ensure that at least one RN is on site, and on duty, at all times[51] (**RN 24/7**); and

    (2) mandated minimum care minutes.[52]

87. The mandated minimum care minutes involve a statutory requirement to provide minimum care minutes per resident. That minimum is variable, with 200 minutes per day per resident being the current sector average. This will increase to 215 minutes per day per resident from 1 October 2024. The requirement is adjustable for each service, based on the resident case mix, meaning high needs residents may receive more than 200 minutes of care per day, and lower needs residents, fewer care minutes.[53]

88. Mandated minimum care minutes are based on the delivery of "*direct care*". "*Direct care*" is defined by section 4 of the *Quality of Care Principles* to mean the care provided to an individual care recipient that is of a kind described in various items of Schedule 1

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49 As to the evidence regarding care plans, see also the ANMF Closing Submissions, 22 July 2022, Part E.4.5 "*Care plans – Lay Evidence Report Part D.4.5*" at [374] – [378].

50 See, ANMF Closing Submissions, 22 July 2022, Part D.8 "*Nursing Teams*" at [132] – [144] and the Further Statement of Annie Butler dated 01 November 2023, at [33] and [76]–[82].

51 See the *Aged Care Amendment (Implementing Care Reform) Act 2022* which amended s 54-1 of the *Aged Care Act 1997* to insert "The provider must, on and after 1 July 2023, ensure at least one registered nurse (within the meaning of the *Health Insurance Act 1973*) is on site, and on duty, at all times at the residential facility.

52 See the *Aged Care Legislation Amendment (Care Minutes Responsibilities) Principles 2023* which amended s 9 of the *Quality of Care Principles 2014* to now prescribes the amount of direct care per care recipient per day in respect of a residential care service.

53 Further Statement of Annie Butler dated 01 November 2023, at [19].

of the *Quality of Care Principles* (other than the planning or delivery of activities to a group of care recipients).[54] That definition encompasses daily living activities assistance (Schedule 1, item 2.1), emotional support (Schedule 1, item 2.3) and treatments and procedures that are carried out according to the instructions of a health professional or a person responsible for assessing a care recipient's personal care needs (Schedule 1, item, item 2.4),

89. The RN 24/7 requirement came into effect on 1 July 2023 by reason of an amendment to the *Aged Care Act 1997* (Cth). Whilst exemptions are available in some circumstances, current statistics indicate that:

    (1) 86.26 per cent of facilities met the requirement of providing 24/7 registered nurse coverage;

    (2) 7.51 per cent were within 2 hours of 24/7 coverage;

    (3) 4.07 per cent were more than 2 hours from 24/7 coverage; and

    (4) 2.16 per cent did not report.[55]

90. The Commonwealth Department of Health and Aged Care has published a "*Care minutes and 24/7 registered nurse responsibility guide*"[56] ("**Responsibility guide**"). The Responsibility guide addresses care minutes by care workers in Section 2. It there provides that care minutes can only be delivered by RNs, ENs and personal care workers and assistants in nursing (PCWs/AINs). By way of example, it identifies that PCW/AINs assist with daily living routines and perform tasks as delegated by nurses.[57]

91. Specifically addressing PCWs and AINs at section 2.3, the Responsibility guide identifies that "*PCWs and AINs work under the supervision and guidance of a nurse (RN/EN)*".[58] It further recognises that core practice generally requires an EN to work under the direct or indirect supervision of an RN at all times.[59]

92. Section 3 of the Responsibility guide, "*Direct Care activities*" identifies that:

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54 Quality of Care Principles s 4 definition of "direct care".

55 https://www.health.gov.au/resources/publications/registered-nurse-coverage-in-residential-aged-care-dashboard?language=en

56 Further Statement of Annie Butler dated 01 November 2023, Annexure AB 9.

57 Responsibility guide, p 17.

58 Responsibility guide, p 18.

59 Responsibility guide, p 18.

> "Only direct 'clinical care' and 'personal care' activities provided by specified workers (RNs, Ens or PCWs/AINs) can be counted for the purposes of meeting the care minutes responsibility."

93. The personal care performed by AINs and PCWs as identified in the Lay evidence Report, and the work defined to be "*direct care*" for mandated minimum care minutes, falls within the definition of "*nursing care*" contained in Schedule A to the *Nurses Award*. By that definition, "*nursing care*" relevantly means:

> "• giving assistance to a person who, because of disability, is unable to maintain their bodily needs without frequent assistance;
>
> • carrying out tasks which are directly related to the maintenance of a person's bodily needs where that person because of disability is unable to carry out those tasks for themselves; and/or
>
> • assisting a registered nurse to carry out the work described in clause [Registered nurses]."

94. As has been identified in the evidence of Annie Butler, ANMF Federal Secretary[60] and as will be further addressed in her evidence to the Commission in this stage of the proceeding,[61] personal care is the foundational component of all nursing practice. Courts and industrial tribunals have also consistently recognised the type of care work performed by AINs and PCWs in aged care to be "*nursing care*" or "*nursing services*" within the "*nursing industry*".[62]

95. The performance of this "*nursing care*" by AINs and PCWs cannot be divorced from the professional obligations of RNs.

96. As regulated health practitioners, RNs are responsible and accountable to the NMBA in accordance with the National Registration and Accreditation Scheme for health practitioners and the National Law. RNs must meet the NMBA Registered Nurse Standards for Practice ("**RN Standards for Practice**") in order to maintain their registration under the National Law.[63] The RN Standards for Practice are to be read and applied in conjunction with other NMBA national professional practice framework

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60 Amended Statement of Annie Butler, 2 May 2022 at [155] to [160].

61 Further Statement of Annie Butler dated 01 November 2023, at [71]–[75].

62 *Australian Nursing Federation v Alcheringa Hostel Incorporated* (2004) FCA 375 (6 April 2004) Ryan J at [76] to [81]; *Australian Nursing Federation - re alteration to eligibility rules* - T4652 [2000] AIRC 715, Williams SDP at [37]; *Australian Nursing Federation - re Alteration to eligibility rules* - PR952637 [2004] AIRC 1040, Williams SDP at [22] – [34]; and *Uniting Church in Australia T/A Blue Care and Wesley Mission Brisbane v Queensland Nurses Union of Employees* [2014] FWCFB 1447.

63 Amended Statement of Annie Butler dated 2 May 2022, at [157]; Further Statement of Annie Butler dated 01 November 2023, at [83].

documents, including the NMBA Decision-Making Framework for Nursing and Midwifery.[64]

97. In accordance with the RN Standards for Practice:[65]

> "RNs determine, coordinate and provide safe, quality nursing. This practice includes comprehensive assessment, development of a plan, implementation and evaluation of outcomes. As part of practice, RNs are responsible and accountable for supervision and the delegation of nursing activity to enrolled nurses (ENs) and others."

98. Standard 5 of the RN Standards for Practice identify the requirement for an RN to develop a plan for nursing practice. Standard 6 identifies that RNs provide and may delegate, quality and ethical goal-directed actions. Standard 6.3 relevantly provides that the RN "*appropriately delegates aspects of practice to enrolled nurses and others, according to … others' clinical or non-clinical roles*".

99. Importantly, the RN Standards for Practice define "*delegation*" as the relationship that exists when the RN delegates aspects of their nursing practice to another person, including a non-nurse. The definition goes on to provide that:

> "The RN who is delegating retains accountability for monitoring of the communication of the delegations to the relevant persons and for practice outcomes."

100. The RN Standards for Practice definition of "*accountability*" includes that:

> "Accountability cannot be delegated. The RN who delegates activities to be undertaken by another person remains accountable for their decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated (Nursing and Midwifery Board of Australia 2013)."

101. As noted above, the RN Standards for Practice are to be read and applied in conjunction with the Decision-making framework. The Decision-making framework provides a guide to practice decisions on scope of practice, delegation and supervision of RNs. The Decision-making framework specifically provides a "*Guide to delegation decision*". It provides that a delegation relationship will exist when the RN (the

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[64] Further Statement of Julianne Bryce dated 01 November 2023, Annexure JB 4 ("**Decision-making framework"**).

[65] ANMF tender bundle at ANMF 23 at p 2 "Orientating statements".

delegator) delegates aspects of nursing practice in any practice setting to another person (the delegatee). Further:

> "The delegator retains accountability for the decision to delegate, monitoring performance and evaluating outcomes. The delegatee is unable to sub-delegate without referring back to the delegator."[66]

102. The effect of the RN Standards of Practice and the Decision-making framework are that an RN working in aged care will remain accountable for ensuring the appropriate delegation of nursing care to RNs, ENs, AINs and PCWs.[67] However, those standards do not prescribe that the RN will or must always exercise <u>direct</u> control over delegated care. This is consistent with the evidence in this proceeding about the relationship between the RN and AIN or PCW and the functioning of care plans and nursing teams.

103. At present, neither the classification structure for AINs under the *Nurses Award*, nor the classification structure for "*Aged care employee—direct care*" under the *Aged Care Award* reflect these responsibilities, or the practical reality of the delivery of care to aged persons. The amendments to these classification structures sought by the ANMF, developed through the consultation process conducted by Annie Butler, would align both classification structures with the applicable regulatory and policy requirements.

104. These amendments would also align the classification structures with the practical reality of the delivery of aged care and modern nursing. They would be consistent with the distinctions drawn in the Lay Evidence Report and in the Interim Decision (see, *e.g.*, at [965]–[966]) between direct care workers and other aged care workers. In these respects, the revised classification structures are designed to promote the flexible modern work practices and the efficient and productive performance of work.

B.1 New "*Aged care nursing assistants*" definition in *Nurses Award*

105. The ANMF proposes the insertion of a new definition of '*Aged care nursing assistant*" in the *Nurses Award* in the following terms:

> "Aged care nursing assistant means an aged care employee, other than an RN, EN, student EN or Nurse practitioner, who is subject to the supervision, delegation and direction of an RN and whose employment is to assist in the provision of nursing care to aged persons."

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[66] ANMF 78 at p 9.

[67] Further Statement of Annie Butler dated 01 November 2023, at [78(c)].

106. This definition would apply to "*aged care employees*" currently classified as a "*Nursing assistant*" . The basis for the adoption of this new definition is addressed in the Further Witness Statement of Annie Butler at [93] to [119] and discussed further below.

B.1.1 Aged care nursing assistant - "*direct control*" v "*supervision, delegation and direction*"

107. The new definition of an of "*Aged care nursing assistant*" in lieu of a "*Nursing assistant*" who is an "*aged care employee*" would remove the reference to the employee being "*under the direct control and supervision of a RN*". The existing requirement in the aged care setting for an AIN to work under the "*direct control*" of a RN is not supported by the RN Standards for Practice, the Decision-making framework or other aspects of the codes and guidelines, which together comprise the professional practice framework for nurses. Similarly, the mandated minimum care minutes do not require or envisage an RN having direct control over the delivery of "*direct care*".

108. Further, as will be the evidence of Annie Butler, ANMF Federal Secretary, the term "*control*" is antiquated and now carries negative connotations, which are no longer appropriate as a descriptor in a contemporary document, particularly in the context of nursing, where nursing care is delivered through the combined efforts of the nursing team.[68]

109. The evidence in this proceeding is that in aged care, "*nursing care*" is provided by AINs as part of a nursing team and pursuant to a Care Plan, prepared by an RN. The RN's role is to provide supervision in the implementation and carrying out of what is required in the Care Plan. The RN must ensure that the Care Plan is implemented by staff with the appropriate skills, knowledge and training and must supervise that implementation.[69] Such supervision may be direct or indirect.[70] In practice, an RN will not always exercise immediate control over the performance of that work, whether in the residential or home care setting. However, consistent with the RN Standards for Practice and the Decision-making guidelines, a RN will remain of accountable for supervision and the delegation of the "*nursing care*" delegated to AINs and others. The RN Standards for Practice and Decision-making guidelines also make clear that an RN

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68 Further Statement of Annie Butler dated 01 November 2023, at [105].

69 Further Statement of Annie Butler dated 01 November 2023, at [108].

70 Further Statement of Annie Butler dated 01 November 2023, at [108].

will remain accountable for monitoring the level of performance by the person carrying out the delegated activity as well as monitoring and evaluating practice outcomes.

110. The reference to AINs being subject to the delegation of an RN gives effect to the provisions of the Decision-making guidelines in the proposed definition of '*Aged care nursing assistant*".[71]

111. The inclusion of the word "*direction*" in the proposed definition of "*Aged care nursing assistant*" reflects the more "*hands on*" instruction or requests by an RN to perform certain work.[72]

112. The capacity for supervision, delegation and direction by an RN is enhanced by the increased availability of RN present on site at residential aged care facilities as a result of the introduction of RN 24/7 requirement. The presence of an RN on site means that the capacity for supervision is always available.

113. For these reasons, the Commission would vary the existing definition of "*Nursing assistant*" for aged care to remove the reference to <u>direct</u> control and instead insert reference to an aged care nursing assistant being "*subject to the supervision, delegation and direction of an RN*".

B.1.2 Aged care nursing assistant—removal of "*<u>solely</u> to assist*"

114. The current definition describes the role of the AIN as being one "*whose employment is solely to assist an RN or Enrolled Nurse (EN) in the provision of nursing care to persons.*" The ANMF proposes the deletion of the reference to an aged care nursing assistant's employment being <u>solely</u> to assist an RN or EN. This recognises the fact that whilst an aged care AIN will be subject to the supervision, delegation and direction of an RN when delivering nursing care, she or he may also be subject to the supervision, delegation and direction of other staff.

115. The evidence of Annie Butler will be to the effect that the work of assisting in the delivery of nursing care in aged care is to be viewed holistically where its purpose is

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[71] Further Statement of Annie Butler dated 01 November 2023, at [110].
[72] Further Statement of Annie Butler dated 01 November 2023, at [114].

primarily to assist the older person.[73] In practice the AIN may assist a wider range of people in delivery of nursing care to aged persons than the current definition allows.

116. This is especially relevant with respect to the proposed new classifications of Grade 4 and Grade 4A Aged care nursing assistants who "*may assist with the supervision of others*" and the proposed new classification of Grade 5 Aged care nursing assistant supervisors. All Aged care nursing assistants would work subject to the supervision, delegation and direction of an RN when delivering nursing care. However, some Aged care nursing assistants may also have some degree of supervision from Grade 4, Grade 4A or Grade 5 Aged care nursing assistants.

B.1.3 Aged care nursing assistant – replacement of reference to "*registered with the Nursing and Midwifery Board of Australia or its successor*"

117. The ANMF's proposed new definition of "*Aged care nursing assistant*" would replace the carve out for employees "*registered with the Nursing and Midwifery Board of Australia or its successor*" with a specific reference to excluded employees, being employees who are an "*RN, EN, student EN or Nurse Practitioner*". This is appropriate in circumstances where a national registration scheme for personal care workers is proposed such that AINs/PCWs may subsequently become registered with the NMBA.[74]

B.1.4 The Aged care nursing assistant classification under the *Nurses Award*

118. As a basic proposition, where no distinction exists between the work value of aged care AINs working under *Nurses Award* and PCWs under the *Aged Care Award*, there should be equality of the applicable minimum award rates of pay. Accordingly, the ANMF proposes classification structures for AINs and PCWs that are aligned and largely mirror one another. The basis for the new classification structure for AINs is further addressed in the Further Witness Statement of Annie Butler at [122] to [150] and discussed below.

[73] Further Statement of Annie Butler dated 01 November 2023, at [117].
[74] Further Statement of Annie Butler 01 November 2023, at [48]–[70].

119. In summary, the proposed new classification structure is necessary for the following reasons:

(1) The current structure is too limited and does not provide adequate recognition of the skill, training and experience that an AIN in aged care brings to the role and which continues to develop.

(2) Recognition of advancement in skill, responsibility and complexity of the work, is necessary to attract and retain care workers in aged care.

(3) Safe and quality nursing care cannot be delivered without skilled AINs. Both residents and people receiving aged care services at home will benefit from a more developed classification structure that allows AINs to progress, commensurate with the acquisition of greater skills, training and experience in aged care.

(4) Greater opportunity to progress is already in place in the *Aged Care Award*. AINs should not be disadvantaged because of the title under which they are employed.

(5) AINs under the *Nurses Award* and PCWs under the *Aged Care Award* perform markedly similar work and there is no material difference in their skills or qualifications, or in their work value.

(6) The new classification structure will be clearer and easier to understand for employers and employees.

(7) The revised classification structure is intended to avoid industrial arrangements that fail to adequately recognise the character of feminised work.

120. The existing classification structure for AINs under the *Nurses Award* comprises four points. The first three points are based on years of experience in the role, being 1st year, 2nd year and 3rd year and thereafter. No qualification is required at these points and progression is based on a year of service at each point. The highest existing classification of AIN is that of "*Experienced (the holder of a relevant certificate III qualification)*". The existing classification structure does not provide for any further progression for an AIN aged care employee under the *Nurses Award*, regardless of experience, training or further qualification.

121. Presently, the *Nurses Award* does not provide descriptors for the existing levels within the AIN classification, beyond the current definition of Nursing Assistant at Schedule A.1 and the work described under the definition of Nursing Care at Schedule A.2. It is accepted that, in large part, the existing classification structure under the *Aged Care Award* more clearly identifies the skills, qualifications and experience required at each level of "*Aged care employee-direct care*" than does the *Nurses Award* for AINs in aged care. The *Aged Care Award* also provides for classifications above that applicable to the holder of a relevant Certificate III qualification. Accordingly, the "*Aged care employee-direct care*" classification structure under the *Aged Care Award* provides the appropriate starting point for the classification structure for "*Aged care nursing assistants*" under the *Nurses Award*.

122. The ANMF proposes a classification structure for "*Aged care nursing assistants*" under the *Nurses Award* which reflects the five grades of personal care worker previously recognised in the *Aged Care Award*, plus the inclusion of a new Grade 4A classification.[75]

123. Consistently with the classification structure for "*Aged care employee-direct care*" under the *Aged Care Award*, it is appropriate for an entry level "*Aged care nursing assistant*" at Grade 1 to progress to Grade 2 after six months of service, rather than the current full year of service. An entry-level AIN will have gained sufficient experience over the course of 6 months of service to warrant progressing to Grade 2.[76] It is appropriate that this experience be recognised for an aged care AIN under the *Nurses Award*, as it would be for a PCW under the *Aged Care Award*.

124. The current classification "*Experienced (the holder of a relevant certificate III qualification)*" fails to recognise the work value of an AIN who possesses knowledge and skills equivalent to a Cert III qualification. It does not require a connection between the skills and knowledge gained from that qualification and the performance of their work. The ANMF proposal for the "*Grade 3-Aged care nursing assistant (qualified)*" classification would rectify these deficiencies.

125. Work is being performed by AINs and PCWs that involves the exercise of skills and a level of responsibility exceeding that of an employee who may otherwise hold a

[75] As to Grade 4A, see the discussion of issue 10 at Part C.2 below.
[76] Further Statement of Annie Butler 01 November 2023, at [132].

relevant Cert III qualification (or possesses equivalent knowledge and skills). For example, work of AINs and PCW may involve:

(1) assisting with the administration of medication;[77]

(2) possessing and exercising specialist knowledge and care, including in relation to dementia care and palliative care;[78] and

(3) assisting with the supervision of other workers.[79]

126. It is appropriate that the value of this work be recognised by the applicable award classification structure and minimum rates. By failing to do so, the current classification structure for AINs in aged care is too limited. The current classification structure for AINs in aged care under the *Nurses Award* also fails to provide an opportunity for career progression to AINs who wish to remain working as AINs in aged care (rather than pursuing a nursing qualification). It is appropriate than an AIN enjoy the same recognition for the advancement in skill, responsibility and complexity of their work as would a PCW engaged under the *Aged Care Award*. Accordingly, the Commission would insert the new classifications of Grade 4 – Senior aged care nursing assistant, Grade 4A – Specialist aged care nursing assistant and Grade 5 – Aged care nursing assistant supervisor. Specific submissions regarding those classification are addressed at Parts C.1–C.3 below.

127. In addition to providing additional opportunities for career progression and proper recognition for work value, the proposed new *Nurses Award* classification structure will also be clearer and easier to understand for employers and employees.

B.1.5 The Aged care employee-direct care classification under the *Aged Care Award*

128. The ANMF proposes the retention of the core of the existing classification structure for PCWs under the *Aged Care Award*. The ANMF proposes to align the classification structures for PCWs under the *Aged Care Award* with that for AINs in aged care under

[77] Lay Evidence Report at D.5.3.5, [442] – [466]. See also ANMF Closing Submissions, 22 July 2022, at [463] – [477].

[78] Lay Evidence Report at D.6, [467] – [499]. See also ANMF Closing Submissions, 22 July 2022, at [478] – [510].

[79] Amended Witness Statement of Annie Butler dated 2 May 2022 at [174].

the *Nurses Award* addressed above.[80] It is appropriate for that alignment to occur so as to avoid any incentive to employ under one structure rather than the other.

129. The ANMF proposal to amend the *Aged Care Award* classification would omit reference to "*Aged care employee—direct care—level 1*". The entry level for PCWs under the Aged Care Award has been at level 2 (Grade 1 – Personal Care Worker). There is no basis to introduce a new classification grade that may have the effect of downgrading a PCW on commencement.

130. The ANMF proposal for the *Aged Care Award* classification structure would also adopt the "*grade*" based terminology for the different classifications of "*Aged care employees-direct care*". Subject to the introduction of the new grade 4A classification discussed below at Part C.2 that approach is consistent with the classification structure applicable to PCWs under the *Aged Care Award* until 30 June 2023.

131. Under the current Aged Care Classification structure, a PCW at level 2 (proposed Grade 1) is described as "*being capable of prioritising work within established routines, methods and procedures*." The ANMF proposal is to remove that descriptor because at entry level, an unqualified and inexperienced PCW is likely to require direction in the prioritising of work. The ability to prioritise work can only be gained after some experience in the role.

132. In accordance with the ANMF proposal, each grade of "*Aged care worker-direct care*" would now also now be "*subject to the supervision, delegation and direction of a Registered nurse (RN)*". Further, references to "*Aged care employees-direct care*" working "*under limited supervision, either individually or in a team*" would be omitted from the classification descriptors at grades 1, 2 and 3. These amendments appropriately reflect the fact that, as addressed above:

(1) PCWs (like AINs) are part of the aged care nursing team and deliver direct care in accordance with a Care Plan; and

(2) the work of a PCW involving the delivery of "*nursing care*" to aged persons will be the subject of supervision, delegation and direction of a RN in accordance with the applicable regulatory framework.

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80 Save that lifestyle officers are included under the *Aged Care Award*, but not under the *Nurses Award*.

C. Items 8–11: specific classification issues

C.1 Item 8: "*Senior*" PCWs and medication competency

133. The HSU (at Level 5) and the ANMF (at Grade 4) both support the inclusion of a "*Senior*" Personal Care classification. The important difference between them is that the HSU's proposal includes the following in relation to medication:

> "2. May include the administration of medication (where appropriate training has been completed and competency verified)."

whereas the ANMF's proposal includes this (emphasis added):

> "may be required to assist aged persons with self-administration of medication and hold a relevant unit(s) of competency."

134. The Joint Employers' proposal is that administration (rather than assistance in the self-administration) of medication should attract an allowance (see proposed cl 15.8).

135. It is convenient to deal with this second question first. As the Lay Evidence Report shows (in particular in Part D.5.3.5), involvement in the administration of medication is widespread, commonplace, and a typical, frequent, and regular part of the duties of persons who are involved in residential aged care. In these circumstances, it introduces unnecessary complication to the application of the *Aged Care Award* to make the payment of an additional weekly amount depend on assessment of whether, in a given week, the employee has been "*approved by their employer*" to administer medication under supervision. It is preferable simply to deal with the issue of involvement in medication administration at the level of classification.

136. Now, the issue of whether the classification should refer to "*administration*," or "*assist[ance] ... with self-administration*," bearing in mind that this is a PCW / AIN classification.

137. There can be no doubt, based on the evidence summarised in the Lay Evidence Report (see again Part D.5.3.5 in particular) that some AINs / PCWs do, as a matter of fact, administer certain medications in residential aged care. The principal difficulty, however, in including that in a classification description is that, whereas in certain jurisdictions that is lawful, in others it would not appear to be.

138. As an example of the former, in the Australian Capital Territory, the *Medicines, Poisons and Therapeutic Goods Regulation 2008* (ACT) at reg 361 provide for "*a person*"

(defined thereafter as "*the assistant*") to administer medicine to another person, in the circumstances set out in that regulation. As an example of the latter, in Western Australia, s 25(1)(a) of the *Medicines and Poisons Act 2014* (WA) provides for prescription in the regulations of classes of health professional that is authorised to administer, possess, prescribe, supply, or use a medicine. Part 7 Div 7 of the *Medicines and Poisons Regulations 2016* (WA) prescribes NPs, RNs, ENs, and midwives. And, in some jurisdictions, the position is governed by statute and regulations intermingled with professional codes of conduct—see, *e.g.*, s 36F of the *Drugs, Poisons and Controlled Substances Act 1981* (Vic).

139. Inserting into a National award a description of work that would appear to be unlawful in at least some law areas would be an inappropriate exercise of modern award powers. The most-benign effect would be to shut AINs / PCWs out of the relevant classification (Level 5 / Grade 4) in areas where they could not lawfully perform the relevant work. The less-benign effect might be to create the impression that the Commission had formed the view that the work described was lawful in each law area (even if the Commission had not formed that view).

140. It is preferable, by far, that the award reflect a common denominator. There does not appear to be an impediment in any law area to assisting with self-administration. That, therefore, is an appropriate descriptor.

C.2 Items 9–10: "*Experienced*" and "*Specialist*" PCWs

141. The Joint Employers press for a level between the Cert III level (Grade 3 in their draft determination), and the Cert IV level (Grade 5 in their draft determination). This intermediate level (Grade 4) is an employee who meets the requirements of Grade 3, "*and in addition has 3-years post-qualification experience exercising the competencies of a Grade 3 employee*."

142. The ANMF does not support an intermediate position based on the effluxion of 3 years' time. Rather, in its submission, the preferable course is to include intermediate positions at Grade 4 (as set out above) and on the basis set out in the last bullet point of Grade 4A in its draft determination: "*may require relevant skills, training or experience in Dementia Care or Palliative Care*." This is preferable to the Joint Employers' approach, which:

(1) does not contain any classification or allowance for palliative care; and

(2) contains an allowance (rather than a classification) in relation to dementia care.

143. The Lay Evidence Report identified in Parts D.6.1 and D.6.2 that dementia and palliative care are commonplace in residential aged care. As noted at [468] of the Lay Evidence Report, "*[m]any [staff] gave evidence that they received specialised training on how to deal with residents living with dementia*," and there was plentiful evidence of dementia and its related behaviours affecting the work of staff in residential aged care. Likewise, at [488], the Lay Evidence Report records that "*[m]any witnesses gave evidence on … an increasing need for aged care workers to provide palliative care*." There was evidence of a need for formal and informal skills and experience (see at [491], [494], [495], [497] in particular).

144. The Commission is therefore safely able to find that:

(1) the need for dementia care and palliative care is common and increasing;

(2) training in these areas is valuable and increases the work value of those who have undertaken it;

(3) it is preferable, given that prevalence of dementia in particular, that an additional amount payable be referable to training;

(4) it is undesirable that, as the Joint Employers propose, that additional amount be referable to appointment to work in a "*specialised dementia unit*," given that the need for skill and training in dealing with residents with dementia is not limited to such specific units;

(5) it is also undesirable, as the Joint Employers contemplate, that the higher level of skill and training involved in providing palliative care not be specifically the subject of compensation for the higher work value.

145. These matters all lead to the conclusion that insertion of a classification for Cert III holders, who may have relevant skills, training or experience in Dementia Care or Palliative Care, is preferable to the Joint Employers' approach.

146. The difference between the HSU approach and the ANMF approach is that:

(1) whilst the HSU and ANMF introduce this specialisation (in dementia, palliative care, or—in the HSU's proposal—a "*household model of care*") at the same level (HSU Level 6, "*Specialist*"; ANMF Grade 4A);

(2) the HSU's model has the Cert IV qualification at the same level, whereas the ANMF has the Cert IV qualification at Grade 5 (what would be HSU Level 7).

147. As is captured at [111]–[117] of Background Document 10, the ANMF submitted (and submits) that the HSU's proposal may result in the downgrading of Cert IV holders who presently are at Grade 5 (Level 7) but on the HSU's proposal may be re-aligned down to Level 6. It is undesirable to introduce the risk of workers being downgraded, or in any event lowering the pay point for Cert IV holders into the future. A similar risk arises from the HSU's proposed reference to "*leading or supervising of others*" at Level 6. Currently, supervisory responsibilities are recognised at Grade 5 (Level 7) while those at Grade 4 (Level 5) may "*assist*" with supervision. There is no evidence that would satisfy the Commission that such an alteration to pay points for supervisors or Cert IV holders is warranted.

C.3 Item 11: Cert IV PCW classification

148. Currently, there are references to Cert IV in levels 6 and 7 of the *Aged Care Award* (though there is no "*indicative task*" corresponding with a grade of PCW at level 6). The competing proposals would have these effects:

(1) on the ANMF's approach, the Cert IV reference for PCWs would be retained in level 7 (Grade 5);

(2) on the HSU's approach, the Cert IV reference would be retained at level 6, and would become applicable to a grade of PCWs who may then become classified at that level;

(3) on the Joint Employers' approach, the Cert IV reference would be moved to wage level 5 (which, as far as the ANMF can discern, is the equivalent of HSU Level 7, except at a much-lower pay point).

149. The ANMF's and Joint Employers' determinations both contemplate Cert IV at the highest level (level 7 / Grade 5). The ANMF opposes, however, the Joint Employers'

proposal for a far-lower pay point (than the unions propose) for employees classified at that level.

D. Conclusion

150. For the foregoing reasons, the Commission would make determinations in the form proposed by the ANMF in its draft determinations for the *Aged Care Award* and the *Nurses Award*, each filed 15 September 2023.

J C McKenna
J E Hartley
V M G Jones

Counsel for the ANMF

01 November 2023

………………………
Gordon Legal
Solicitors for the ANMF

Gordon Legal
IT'S PERSONAL

6 July 2023

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Dear Associate

Application to vary the *Nurses Award 2020 [MA000034]*, pursuant to section 158 of the *Fair Work Act 2009* (Cth)

1. We act for the Australian Nursing and Midwifery Federation ("**ANMF**").
2. The ANMF is a party to the current Work Value – Aged Care proceedings,[1] which (as the Commission knows) pertain to nurses, AINs / PCWs, and other workers in an aged care setting ("**Aged Care proceedings**").
3. The ANMF has several times foreshadowed in the Aged Care proceedings its intention to make a further application in respect of all remaining nurses and AINs covered by the *Nurses Award 2020 [MA000034]—i.e.*, outside of aged care. This application would, as has been the ANMF's case in the Aged Care proceeding, seek relief based both on historical undervaluation and on changes in work value ("**Broader proceeding**").
4. Because the ANMF has several times foreshadowed that Broader proceeding, our client considered it appropriate to update the Commission, in light of the Commission's recent statements and initiatives which we see as having a bearing on the timing and content of that Broader proceeding, being these:
   - 4.1. Former President Ross's statement of 4 November 2022 on Occupational segregation and gender undervaluation, as informed by the earlier undergraduate review.[2]
   - 4.2. President Hatcher's statement of 3 February 2023 on Pay equity and the Care and Community Sector – Expert panels, with particular focus on the Commission's research program as outlined at [17]–[19].
   - 4.3. The *Annual Wage Review 2022-23* [2023] FWCFB 3500 at [111]–[139], with particular focus on:
     - 4.3.1. at [120], the Full Bench's indication, having regard to recent amendments to the *Fair Work Act 2009*, that "*issues of unequal remuneration for work of equal or comparable value or gender undervaluation can no longer be dealt with on an application-by-application basis outside the framework of the Review process.*"

[1] Proceedings AM2021/63, AM2020/99, and AM2021/65.
[2] [2019] FWC 5934.

Rather, "*[s]uch issues, insofar as they may be identified, should now be dealt with in the Review process or in other Commission-initiated proceedings between Reviews*"; and

4.3.2. at [137]–[139], the timing of stages 1 and 2 of the research project and the proceedings to follow.

4.4. The recommendation of President Hatcher in respect of the application to vary the *Pharmacy Industry Award 2020 [MA000012]* made 9 June 2023:

> "[11] However, my *recommendation* is that the parties engage in a more holistic reconsideration of the classification structure in the Award involving the coordinated resolution of three intersecting issues:
>
> (1) The establishment of a benchmark classification for a four-year degree qualified fully practising pharmacist with a properly-fixed rate of pay aligned with the notional C1 classification in the Metal Industry Award classification scale. The Full Bench decision in *Application by Independent Education Union of Australia* [2021] FWCFB 2051 (referred to in the *2022-23 Annual Wage Review* [2023] FWCFB 3500 at [134]) provides the methodology for this exercise.
>
> (2) The recognition of any work value changes likely to arise as a result of pharmacists being authorised to prescribe certain medicines.
>
> (3) The establishment of an appropriate relativity between the Pharmacist or benchmark classification and the Pharmacy Intern classifications."

5. Our understanding, based in particular on the quote from [958]–[960] of the *Aged Care decision*[3] at [132] of the *Annual Wage Review* before the reference to the "*wider issue*"—gender undervaluation <u>and</u> unequal remuneration for work of equal or comparable value—is that the Commission's research project will be directed to both gendered undervaluation and work value in relation to the awards under consideration (including the *Nurses Award*). If that were so, there would be considerable overlap between the Commission's research project and the ANMF's Broader proceeding.

6. The ANMF wishes to ensure that its Broader proceeding does not cut across or disrupt the Commission's project. Because it perceives considerable overlap between the scope of its Broader proceeding and the Commission's project (as the ANMF understands the scope thereof), and because it is mindful of the Full Bench's preference that such issues "*no longer be dealt with on an application-by-application basis*," the ANMF's present intention (subject to the Commission's preference) is to delay the commencement of its Broader proceeding until the Commission's research project is further advanced. This will permit minimisation of disruption, and will allow the product of the Commission's activities to inform the ANMF's Broader proceeding (in terms of both scope and content).

7. Of course, the timing of any application is a matter for our client. Nevertheless, given the Commission's helpful foreshadowing of work that it is doing, and the evident intersection between that work and our client's foreshadowed Broader proceeding, we considered a letter of this kind to be appropriate. We would be pleased to provide any further clarification or information as might benefit the Commission.

Yours faithfully

Nicholas White
Principal Lawyer
Accredited Specialist (Workplace Relations)
GORDON LEGAL

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[3] *Aged Care Award 2010; Nurses Award 2020; Social, Community, Home Care and Disability Services Industry Award 2010* [2022] FWCFB 200, 319 IR 127.

IN THE FAIR WORK COMMISSION

Matter No.: AM2020/99, AM2021/63 & AM2021/65

Re Applications by: Australian Nursing and Midwifery Federation and others

FURTHER STATEMENT OF ANNIE BUTLER

I, Annie Butler, Federal Secretary of the Australian Nursing and Midwifery Federation, of Level 1, 365 Queen St, Melbourne in the State of Victoria say:

1. I have made an earlier statement in these proceedings dated 29 October 2021 (my **previous statement**). This statement is to be read together with my previous statement, adopting the definitions used therein.

2. There are several issues addressed in my previous statement in respect of which it is relevant to provide updated information.

3. In particular, I was responsible for guiding consultations about the development of the ANMF's proposed revised classification structures, as contained in the draft determinations filed by the ANMF on 15 September 2023 (**ANMF revised classification structures**).

4. I facilitated and participated in consideration of the revised classification structures by the ANMF. These processes are referred to in more detail below in this statement. The outcome involved a balancing of a variety of views and perspectives. I was satisfied, on the basis of the consultations, that the ANMF revised classification structures reflect an appropriate career and progression pathway for assistants in nursing (**AINs**) and personal care workers (**PCWs**). The ANMF revised classification structures also more appropriately reflect the reality of contemporary practice in aged care facilities and in community care as well as the regulatory and policy framework for the delivery of nursing care in aged care. Ultimately, I was the advocate for acceptance, by the ANMF, of the ANMF revised classification structures.

Aged Care Reform since October 2021

5. There are a number of reforms that have been implemented, or which are in the process of being implemented, that are relevant to consideration of the ANMF revised classification structure. They arise from recommendations 86, 77 and 78 of the Royal Commission into Aged

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Care Quality and Safety and concern the introduction of mandated minimum care minutes, the requirement to have a registered nurse on site at a residential care facility 24 hours a day, 7 days a week, and steps towards registration of care workers.

6. Recommendation 86 of The Final Report of the Royal Commission into Aged Care Quality and Safety (**ANMF 29**) made a range of recommendations under the heading "Minimum staff time standard for residential care."

7. Recommendation 86 is set out below:

> ***"Recommendation 86: Minimum staff time standard for residential care***
>
> *1. The Australian Government should require approved providers of residential aged care facilities to meet a minimum staff time quality and safety standard. This requirement should take the form of a quality and safety standard for residential aged care. The minimum staff time standard should allow approved providers to select the appropriate skills mix for delivering high quality care in accordance with their model of care.*
>
> *2. From 1 July 2022, the minimum staff time standard should require approved providers to engage registered nurses, enrolled nurses, and personal care workers for at least 200 minutes per resident per day for the average resident, with at least 40 minutes of that staff time provided by a registered nurse.*
>
> *3. In addition, from 1 July 2022, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility for the morning and afternoon shifts (16 hours per day).*
>
> *4. From 1 July 2024, the minimum staff time standard should increase to require approved providers to engage registered nurses, enrolled nurses, and personal care workers for the average resident for at least 215 minutes per resident per day for the average resident, with at least 44 minutes of that staff time provided by a registered nurse.*
>
> *5. In addition, from 1 July 2024, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility at all times.*
>
> *6. The minimum staff time standard should be linked to the casemix-adjusted activity based funding model for residential aged care facilities. This means that approved providers with a higher than average proportion of high needs residents would be required to engage additional staff, and vice versa.*
>
> *7. Approved providers should be able to apply to the System Governor for an exemption from the quality and safety standard relating to staff skills mix, but not the standard relating to numbers of staff. Any exemption should be granted for a limited time, and details of the exemption should be published on My Aged Care. The grounds for granting an exemption should include:*
>
> *a. specific purpose residential aged care facilities, such as specialist homeless facilities, where the profile of the residents is such that it may be appropriate to substitute a registered nurse with another qualified health professional*

> b. *residential aged care facilities that are co-located with a health service, such as Multi-Purpose Services, where registered and enrolled nurses are present at the co-located health service*
>
> c. *regional, rural and remote residential aged care facilities, where the approved provider can demonstrate it has been unable to recruit sufficient numbers of staff with the requisite skills, and*
>
> d. *residential aged care facilities where an alternative skills mix is being trialled and it would be appropriate to substitute a registered nurse with another qualified health professional. There should be a requirement for any such trial to be comprehensively evaluated and publicly reported.*
>
> 8. *The Australian Commission on Safety and Quality in Health and Aged Care should review and update this standard as appropriate. At a minimum, this should occur in line with significant revisions of the casemix classification for residential aged care facilities, or at least every five years."*

8. The Federal Government accepted the recommendations contained in Recommendation 86 and two key reforms have been adopted. The first is the requirement for mandated minimum care minutes (86. [2]-[4]) and the second is for at least one registered nurse to be on site per residential care facility at all times (86.[5]).

Mandated minimum care minutes

Calculation of care minutes

9. The *Aged Care Legislation Amendment (Care Minutes Responsibilities) Principles 2023* amended the *Quality of Care Principles 2014* (**Quality of Care Principles**).

10. Section 9 of the Quality of Care Principles now prescribes the amount of direct care per care recipient per day in respect of a residential care service.

11. The Quality of Care Principles set out the required combined staff average amount of direct care and the required registered nurse average amount of direct care.

12. Section 9(3) of the Quality of Care Principles contains a table that sets out the amounts for both the combined staff daily amount and the registered nurse daily amount for the day for the care recipient.

13. The amount is established by reference to the AN-ACC classification for the care recipient. The AN-ACC classification scale is a case mixed based tool for determining the minimum level of care required by the care recipient, which is then used to determine the level of funding the approved provider will receive to deliver that care.

14. For the purposes of establishing how many care minutes must be provided, the AN-ACC classification is used to determine the total number of care minutes needed. For example, a

care recipient classified at Class 1 (of 13) has the highest care needs and must receive 317 minutes of care a day, 57 minutes of which must be delivered by a registered nurse. In contrast, a care recipient classified in Class 6 requires 152 combined staff minutes a day, 34 minutes of which must be delivered by a registered nurse.

15. Section 10 of Quality of Care Principles provides that an approved provider must ensure that the average amount of direct care provided by direct care staff members and registered nurses is at least the required average amount of direct care per day, per resident, calculated over the relevant quarter of the financial year.

16. The requirement became mandatory from 1 October 2023.

17. Each residential care facility has a care time target for care delivered based on the case mix of AN-ACC classifications of its residents, as referred to in paragraph 14.

18. Across the aged care sector, on average people who live in aged care facilities will receive 200 minutes of care each day, including at least 40 minutes from a registered nurse. The 200 minute average is the current average. This will increase to 215 minutes of care, including 44 minutes from a registered nurse, from 1 October 2024. This will be done by an adjustment to the care minutes set out in section 9(3) of the Quality of Care Principles and through the AN-ACC allocation.

19. The provision of minimum care minutes is variable, as the figure of 200 minutes is the sector average target. The target is adjustable for each service, based on the resident case mix, meaning high needs residents may receive more than 200 minutes of care per day, and lower needs residents, fewer care minutes. Care minutes targets are averaged across all residents in a service.

Care minutes

20. Not all work performed in a residential care facility can be counted towards acquittal of the care minutes responsibility.

21. As part of the Commonwealth's response to the Aged Care Royal Commission, Recommendation 86, amendments to the Quality of Care Principles provide for the type of care to count toward the care minutes referred to above and by whom such care is to be provided.

22. "Direct care staff member" is referred to in section 4 of the Quality of Care Principles to mean a staff member of an approved provider who is a registered nurse, enrolled nurse, nursing assistant or personal care worker.

23. As discussed above, there is a minimum total number of care minutes that must be delivered by direct care staff members and of that, a minimum amount that must be delivered by a registered nurse.

24. “Direct care” is defined to mean care provided to an individual care recipient that is of a kind described in particular items of Schedule 1 of the Quality of Care Principles (other than the planning or delivery of activities to a group of care recipients).

25. The specified direct care items are described in Schedule 1 by reference to a "Service" and, in more detail in "Content".

26. The Services specified as involving direct care in Schedule 1 are as follows:

    (a) Care recipient social activities;

    (b) Daily living activities assistance;

    (c) Emotional support;

    (d) Treatment and procedures;

    (e) Recreational therapy;

    (f) Assistance in obtaining health practitioner services;

    (g) Assistance in obtaining access to specialised therapy services;

    (h) Support for care recipients with cognitive impairment; and

    (i) Nursing services.

27. These services are provided by members of the nursing team (namely “direct care staff members” as defined in the Quality of Care Principles) in accordance with the care plan.

28. Section 10 of the Quality of Care Principles requires providers to ensure that the required minimum average amount of “direct care” is provided by “direct care staff members”.

29. The Quality of Care Principles provide for a care and services plan to be documented for each care recipient (Schedule 2, clause 2(d) of the Quality of Care Principles; Schedule 2 contains the Aged Care Quality Standards).

30. In my previous statement at paragraphs [155] to [183] I referred to nursing, to the skills, capabilities, roles and responsibilities of direct care workers and to the function of nursing teams. I also referred to the role of care plans.

31. The Commonwealth Department of Health and Aged Care in September 2023 published a guide "Care Minutes and 24/7 Registered Nurse Responsibility Guide”. This guide is described as intended:

> *"To provide information to approved providers on their current care minute targets, and legislative responsibility in relation to care minutes and the incoming 24/7 registered nurse responsibility. The guide explains the categories of workers that can deliver care minutes, the activities that can qualify as care minutes, care minute targets for services and how these are calculated, for 24/7 registered nurse responsibility and reporting obligations."*

32. The Guide is annexed as **Annexure AB 9**.

33. The Guide refers to the delivery of funding to providers for care minutes through the AN-ACC model. This model includes funding to cover the provision of direct care to residents through direct care staff members.

34. The regulatory and funding framework arising from the response to Recommendation 86 has a focus on the delivery of direct care by the nursing team as discussed in my previous statement.

24/7 Registered Nurse Responsibility (RN 24/7)

35. From 1 July 2023 approved providers of residential aged care facilities are required to have at least one registered nurse on-site and on duty at all times. This requirement was introduced in the *Aged Care Amendment (Implementing Care Reform) Act 2022*, which amended s 54-1 of the *Aged Care Act 1997* to require the following:

> *"The provider must, on and after 1 July 2023, ensure at least one registered nurse (within the meaning of the Health Insurance Act 1973) is on site, and on duty, at all times at the residential facility."*

36. The amendment makes provision for the Quality of Care Principles to provide for circumstances when an exemption may be granted to the requirement to have a registered nurse on duty at all times.

37. The Quality of Care Principles were amended, with effect from 1 July 2023, by the *Aged Care Legislation Amendment (Registered Nurses) Principles 2023.* This amendment provides that an exemption to the requirement to have a registered nurse on duty at all times can be granted in limited circumstances at the discretion of the Secretary.

38. Part 4C, Division 2 of the Quality of Care Principles provides for limited circumstances in which a provider can apply to the Secretary of the Department of Health and Aged Care, for an exemption from having a registered nurse on duty, on site 24/7.

39. The criteria for seeking an exemption requires that the facility is located in an area that is defined according to the Modified Monash Model as either a small rural town, (MM5) a remote community (MM 6) or a very remote community (MM7) and has no more than 30 operational places on the day of the Secretary's decision. In addition, the Secretary must

be satisfied the provider has taken all reasonable steps to ensure the clinical needs of residents will be met during the period of exemption.

40. An exemption is therefore only available in very limited circumstances. Where these circumstances exist, the provider must also be able to demonstrate how care needs are being met. This might for example involve having a registered nurse available online or by telephone across a number of connected facilities.

41. The current grounds for an exemption will expire on 30 June 2024. Any future exemption grounds are not yet finalised. The ANMF's position is that in future there should be no grounds for obtaining an exemption.

42. The Department of Health and Aged Care publishes a list of approved providers with an exemption from the 24/7 RN responsibility.[1] As at 4 October 2023, there were 41 providers with an exemption.

43. Data published by the Department of Health and Aged Care shows that in September 2023, 86.26% of facilities met the requirement of providing 24/7 RN coverage, 7.51% fell within 2 hours of 24/7 coverage, 4.07% more than 2 hours from 24/7 coverage and 2.16% did not report.[2]

The impact of care minutes and RN 24/7

44. The combined effect of the reforms referred to at paragraphs 9-43 is to embed and enshrine nursing care as the core to the delivery of aged care in residential care. This legislative reform has occurred as a direct result of the Commonwealth adopting and implementing Recommendation 86.

45. The introduction of mandated minimum care minutes gives effect to the centrality and importance of direct care in ensuring safe and quality care for older persons in residential care. The activities that count towards meeting care minute responsibilities are performed by nurses and care workers and involve the delivery of nursing care.

46. The legislatively-mandated presence of a registered nurse on-site, 24 hours a day, 7 days a week is also of great significance. It means that, in addition to enhancing the provision of quality care, in the vast majority of facilities, direct care is delivered by the nursing team (see

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[1] https://www.health.gov.au/resources/publications/approved-providers-with-an-exemption-from-the-247-registered-nurse-responsibility

[2] https://www.health.gov.au/resources/publications/registered-nurse-coverage-in-residential-aged-care-dashboard?language=en

my previous statement at [175] – [183]) under the supervision, delegation and direction of an on-site registered nurse.

47. The impact of mandated care minutes and RN 24/7 legislation was discussed in my consultations with stakeholders and ANMF employees addressed below. I had regard to these reforms throughout the process for developing the ANMF revised classification structures.

Other regulatory developments

Registration for AINs and PCWs

48. The ANMF has long advocated for AINs and PCWs to be subject to registration and for that registration to be with the Nursing and Midwifery Board of Australia (**NMBA**).

49. Following the recommendations of the Royal Commission some progress has been made towards establishing a registration scheme for AINs and PCWs.

50. Recommendation 77 of the Final Report of the Royal Commission into Aged Care Quality and Safety (**ANMF 29**) made a range of recommendations under the heading "National registration scheme."

51. The recommendation is regarding a national registration scheme for personal care workers and this extends to assistants in nursing.

52. Recommendation 77 is set out below:

> ***"Recommendation 77: National registration scheme***
>
> *1. By 1 July 2022, the Australian Government should establish a national registration scheme for the personal care workforce with the following key features:*
>
> *a. a mandatory minimum qualification of a Certificate III*
>
> *b. ongoing training requirements*
>
> *c. minimum levels of English language proficiency*
>
> *d. criminal history screening requirements*
>
> *e. a code of conduct and power for a registering body to investigate complaints into breaches of the Code of Conduct and take appropriate disciplinary action.*
>
> *2. For existing personal care workers who do not meet the minimum qualification requirements, there should be transitional arrangements that allow them to apply for registration based on their experience and prior learning.*
>
> *3. By 1 July 2021, the Australian Health Practitioner Regulation Agency should start a process to examine the feasibility of a registration scheme under the National Registration and Accreditation Scheme for the occupation of 'personal care worker (health)' or 'assistant in nursing', to*

> *inform the National Cabinet Health Council deliberations in Recommendation 77.4. [**Commissioner Briggs**]*

> *4. By 1 July 2023, the Australian Government should request that the National Cabinet Health Council determine whether to regulate the occupation of 'personal care worker (health)' or 'assistant in nursing' under the National Registration and Accreditation Scheme, established and governed under the Health Practitioner Regulation National Law."*

53. The two Commissioners, Lynelle Briggs, AO and Tony Pagone KC, differed in their conclusion as to the appropriate mechanism for personal care worker registration. Despite this, Commissioners Briggs and Pagone were clear in their findings related to Recommendation 77 that they:

> *"both consider that regulation of personal care workers by registration, with a mandatory minimum qualification requirement, ongoing training requirements, a code of conduct, and a complaint process will help to professionalise and improve the quality of the personal care worker workforce"* (Final Report Volume 3A page 392 (**ANMF 31**))

54. The Federal Government accepted the recommendations contained in Recommendation 77, with the exception of 77 1-a, which is still subject to a final Government decision.

55. An 'Aged care reform roadmap – 2022 to 2025' (the **reform roadmap**) has been published on the Commonwealth Department of Health and Aged Care (the **Department**) website. It provides the Government's Royal Commission Recommendation commitments and timeframes for implementation of each. Attached to this statement and marked **Annexure AB 10** is a copy of the reform roadmap.

Code of Conduct and Banning Orders

56. The Code of Conduct and registering body for related complaints and investigations (Recommendation 77. 1-e) has been implemented. On 2 August 2022, the Government successfully passed the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (the **Royal Commission Response Act**).

57. Schedule 3 of the Royal Commission Response Act, 'Code of Conduct and Banning Orders', made amendments to the *Aged Care Act 1997* and *Aged Care Quality and Safety Commission Act 2018*.

58. These amendments provided the legislative basis to introduce a Code of Conduct applicable to approved providers, their governing persons and all aged care workers, and to issue Banning Orders where serious breaches of the Code were found to have occurred and to record such orders on a publicly searchable register.

59. The amendments gave the Aged Care Quality and Safety Commission (the **Regulator**) functions and powers under the Code to enable the Regulator to carry out Code-related

investigations, apply Banning Orders where they deem it appropriate, and maintain the Banning Order register.

60. The Code of Conduct and Banning Orders commenced on 1 December 2022.

Criminal history screening requirements

61. The implementation of the criminal history screening requirement (Recommendation 77. 1-d) is underway and scheduled to commence 1 July 2024.

62. The 'national worker screening for aged care', as it is called in the reform roadmap, has been referenced in two rounds of public consultation (September 2022 and April 2023) as part of the new regulatory model for aged care.

63. The new regulatory model, underpinning a new aged care act, will both take effect from 1 July 2024.

64. In the Federal Budget delivered on 8 May 2023, under the Budget Measure 'Aged Care Regulatory Reform', the Government allocated '$59.5 million over 5 years from 2022–23 to fund the ICT infrastructure to establish a national worker screening and registration scheme from 1 July 2024'.

65. The Department is currently undertaking consultations with the relevant jurisdictional authorities, as each state and territory must enact legislation to operationalise the screening system.

English language and ongoing training requirements for Personal Care Workers

66. The reform roadmap earmarks 1 July 2025 for the Government to introduce 'English language and ongoing training requirements for Personal Care Workers'.

67. The Department has not yet held formal consultations on these additional elements of a registration scheme, but has indicated consultations on worker registration will occur.

68. A mandatory minimum qualification of a Certificate III was not only an element of Recommendation 77, but also subject to its own Recommendation 78 by the Commissioners. The ANMF likewise regards it as important to a full registration scheme.

69. Recommendation 78 is set out below:

> ***"Recommendation 78: Mandatory minimum qualification for personal care workers***
>
> *1. A Certificate III should be the mandatory minimum qualification required for personal care workers performing paid work in aged care.*
>
> *2. If a Personal Care Worker National Board is established, it should establish an accreditation authority to:*

> *a.* *develop and review accreditation standards for the mandatory minimum qualification*
>
> *b.* *assess programs of study and education providers against the standards, and*
>
> *c.* *provide advice to the National Board on accreditation functions.*
>
> *3.* *The National Board should approve the accredited program of study, and review the need for personal care workers in home care to have specialised skills or competencies.* ***[Commissioner Briggs]****"*

70. The ANMF continues to press for the registration of AINs and PCWs through the NMBA. Should this occur, AINs would fall outside the existing definition of Nursing Assistant. The proposed definition in the ANMF revised classification structures will 'future proof' any need for a further variation to the definition, for aged care employees at least, in the event that a registration scheme is introduced, whether under the auspices of the NMBA or a different body.

Care work as nursing care

71. Personal care is, by its nature, nursing care. The two are not distinguishable. In all aspects of care, AINs / PCWs bring a level of skill and training to the activities involved with caring for a person. So for example, showering a resident or client provides the opportunity to assess how a person is moving, feeling and responding at that time. It is also the opportunity to see if any conditions, such as wounds have improved or deteriorated, or pain levels have fluctuated.

72. The level of assessment occurs on a continuum with the AIN or PCW making observations and assessments as to what to report to the enrolled nurse or registered nurse on duty. Equally, an enrolled nurse makes observations and assessments and reports to the registered nurse.

73. The registered nurse may make further assessments based on what is reported, or observed. The registered nurse has the qualifications to then make adjustments to care plans, make further inquiries if needed, and to provide direction to other registered nurses, enrolled nurses, AINs or PCWs as to how to respond to any new or altered care needs. This is done within the legislative and policy frameworks referred to below in relation to delegation of decisions and standards of practice.

74. When seen together, this illustrates how a nursing team operates to deliver nursing care. I refer to my previous statement at [155]–[160] which provides a definition of nursing care and explains that nursing is holistic and encompasses personal care as the foundational component of all nursing practice.

75. I refer also to [175]–[183] of my previous statement which explains the operation of the nursing team. As set out at [177] of my previous statement, each member of the care team

has responsibility for delivery of care that contributes to the total package of care for the resident that encompasses clinical, social, emotional and wellbeing needs of the resident.

Decision-making framework for nursing and midwifery

76. The NMBA has published a "Decision-making framework for nursing and midwifery" (Annexure JB 4 to the Further Statement of Julianne Bryce) (**Decision-making framework**). The Decision-making framework was discussed in consultations with stakeholders and ANMF employees, and I considered it in the process of developing the ANMF revised classification structures. The Decision-making-framework provides a guide to practice decisions on scope of practice, delegation and supervision for nurse practitioners, registered nurses, enrolled nurses and midwives. Of specific relevance here is the guidance it provides for registered nurses with respect to delegation decisions.

77. The Decision-making framework identifies delegation decisions as including those decisions made by a registered nurse to delegate aspects of nursing care to another health professional or health workers. The Decision-making guidelines provide a "guide to delegation decision", addressing the situation where a registered nurse (the delegator) delegates aspects of nursing practice to another person, including unlicensed health workers such as AINs or PCWs. In those circumstances, the Decision-making guidelines provide that the registered nurse delegator retains accountability for the decision to delegate, monitoring performance and evaluating outcomes. The delegatee (such as an AIN or PCW) is unable to sub-delegate without referring back to the delegator registered nurse.

78. The following points summarise the "guide to delegation decisions" within the Decision-making framework and are relevant to the ANMF revised classification structures:

    (a) Delegations are made to meet people's needs and to ensure timely safe and effective access to healthcare services.

    (a) The delegation relationship exists when a registered nurse (the delegator) delegates aspects of nursing practice in any setting to another person (the delegatee).

    (b) Delegation is different from allocation or assignment of tasks.

    (c) The delegator retains accountability for the decision to delegate, monitoring performance and evaluating outcomes.

    (d) The delegatee is at all times responsible for their actions and is accountable for providing delegated care.

(e) A delegatee is a health professional or health worker who is delegated aspects of nursing care.

79. The role of the registered nurse as delegator is to make a daily assessment of the residents' care needs, noting any fluctuations or changes in care needs and to ensure that those care needs are met by care staff with appropriate skills, training and competence to carry out the activities necessary to deliver care. The registered nurse allocates staffing resources based on the available skills mix of the staff, so for example may direct more staff to a resident who has deteriorated in health. Once allocated, staff work within the scope of their job description, or for registered nurses and enrolled nurses, within their scope of practice, and in accordance with their capability.

80. Delegation is a core aspect of nursing practice as both outlined and governed by the Registered Nurse Standards of Practice. Delegation is implicit in the care plan and in the delivery of care to meet the requirements of the care plan.

81. The registered nurse is responsible for making appropriate delegations, which requires an assessment of the skills, experience and competence of the delegatees. Once a delegation is made, responsibility for the delegated activities rests with the delegatee. If a registered nurse makes an inappropriate delegation, for example asking that work be performed by a person who doesn't have the necessary skill to perform the work competently, the registered nurse is accountable for that inappropriate delegation.

82. In a residential care setting there will be occasions where AINs and PCWs perform work that is not delegated by the registered nurse, for example they may be required to assist an allied health professional, or other staff member, with work that does not fall within the registered nurse's scope of practice.

The RN Standards for Practice

83. Registered nurses (like enrolled nurses and nurse practitioners) must be registered with the NMBA, and meet the NMBA's registration standards in order to practise in Australia. Nurses must meet these standards annually to maintain their registration with the Australian Health Practitioner Regulation Agency (**AHPRA**) in accordance with the *Health Practitioners Regulation National Law* (**National Law - ANMF 2**).

84. The relevant Standards for Practice outline the role of the Registered Nurse (**ANMF 23**), Enrolled Nurse (**ANMF 24**) and Nurse Practitioner (**ANMF 75**) and the expected standards for their practice across all the settings. The Standards are to be read in conjunction with applicable NMBA standards, codes and guidelines, which together comprise the professional

practice framework for nurses. As such, registered nurses must meet the NMBA Registered Nurse Standards for Practice (**RN Standards for Practice**) in order to maintain their registration under the National Law.

85. Standard 3.4 of the RN Standards for Practice provides that the RN accepts accountability for decisions, actions, behaviours and responsibilities inherent in their role, and for the actions of others to whom they have delegated responsibilities.

86. The RN Standards for Practice define accountability to mean:

> *"that nurses answer to the people in their care, the nursing regulatory authority, their employers and the public. Nurses are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing roles including documentation. Accountability cannot be delegated. The RN who delegates activities to be undertaken by another person remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated…"*

87. The RN Standards for Practice also define delegation to mean:

> *"the relationship that exists when a RN delegates aspects of their nursing practice to another person such as an enrolled nurse, a student nurse or a person who is not a nurse. Delegations are made to meet peoples' needs and to enable access to health care services, that is, the right person is available at the right time to provide the right service. The RN who is delegating retains accountability for the decision to delegate. They are also accountable for monitoring of the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the risks and capabilities. In some instances delegation may be preceded by teaching and competence assessment…"*

88. A Registered Nurse, level 1, pay point 1 is registered as a registered nurse under the National Law and must meet the professional practice framework requirements under the National Law, including compliance with the RN Standards for Practice. A RN, level 1, pay point is a fully qualified registered nurse who is considered competent to meet the expectations of a registered nurse.

Consultation with stakeholders and ANMF employees

89. As I noted at the outset of this statement, the ANMF implemented a process for development of the ANMF revised classification structures. I had overall responsibility for the process as I describe below. As part of this process I consulted with a range of stakeholders and ANMF employees with knowledge of and expertise in the aged care sector, as follows:

    (a) On 25 August 2023, I met with academics – Associate Professor Anne Junor, Associate Professor Meg Smith and Honorary Professor Ian Hampson, who each provided expert evidence in Stage 1 of this proceeding (the **academic group**).

(b) On 28 August 2023 I met with ANMF Professional Officers- Julie Reeves (ANMF Federal Office), Joanne Wagner (ANMF SA), Matthew Richardson (QNMU), Jamie Shepherd (QNMU), Helen Macukewicz (NSWNMA) and Rachel Halse (ANMF Vic), who are each members of the ANMF Professional Advisory Committee.

This group comprises ANMF Branch and Federal Office employees who represent the professional interests of ANMF members (the **professional officer group**). Typically they are registered or enrolled nurses who have experience, knowledge and a high level of understanding of the professional requirements to deliver safe and quality nursing care in aged care.

(c) On 29 August 2023 I met with ANMF Industrial Officers- Kristen Wischer (Senior Federal Industrial Officer), Paul Yiallouros (ANMF Federal Office), Kevin Crank (QNMU), Christopher Blair (NSWNMA), Paul Martin (ANMF SA), Claire Victory (ANMF SA), Kira Saunders (ANMF WA), Tom Kiat (NSWNMA), Leigh Hubbard (ANMF Vic), Shane Klein (ANMF NT), Caroline Saint (ANMF Tas) and Katherine Wild (NSWNMA), who are each members of the ANMF Industrial Advisory Committee.

This group comprises ANMF Branch and Federal Office employees who represent the industrial interests of ANMF members (the **industrial officer group**). Typically, industrial officers will have training, experience and knowledge of the operation of Modern Awards, enterprise bargaining and the wages and conditions of ANMF members working in aged care.

(d) On 6 September 2023, I met with registered nurses working in the aged care sector in senior, managerial roles, being equivalent to the role of Director of Nursing. These representatives, Pamela Cronin, Kylie Cookson and Samantha Miller have extensive experience in the management of aged care facilities, and an in depth understanding of the practical implications of any changes to the award classification structures underpinning employment in aged care (the **DON group**).

90. Not everybody had identical views. The object of the process I describe above was for me to be exposed to a range of views, from a range of viewpoints, and then—based on all of those inputs and interests—to synthesise a position which, in my view, balanced the various inputs and interests.

91. After consulting with the stakeholders and ANMF employees I mention above, and drawing also on my own knowledge and experience, I advocated for the ANMF to accept the ANMF revised classification structures.

92. Following this process, the ANMF organisationally endorsed the ANMF revised classification structures. In the rest of this statement, I refer to the outcomes of this process as the "**ANMF position**". I will refer to the whole process I describe in this the "**classification development process**".

Variations to the Nurses Award classification structure

93. In the following paragraphs I address each of the key proposed variations to the Nurses Award classification structure.

94. Based on the classification development process (and my own understanding of the way in which care is delivered in the aged care sector), the ANMF position is, and my view is, that the current AIN definition and classification structure in the Nurses Award and the PCW classification structure in the Aged Care Award do not reflect the reality of contemporary practice in aged care facilities or the regulatory and policy framework for the delivery of nursing care as discussed in the paragraphs above.

A new definition for AINs working in aged care

95. The ANMF revised classification structures propose a new definition for aged care nursing assistants as follows:

> *"Aged care nursing assistant means an aged care employee, other than an RN, EN, student EN or Nurse practitioner, who is subject to the supervision, delegation and direction of an RN and whose employment is to assist in the provision of nursing care to aged persons."*

96. The new definition differs from the current definition in a number of ways. The reasons for the differences are elaborated on in the paragraphs below. For ease of reference, the current definition is as follows:

> *"Nursing assistant means an employee, other than one registered with the Nursing and Midwifery Board of Australia or its successor or one who is in training for the purpose of such registration, who is under the direct control and supervision of a Registered Nurse (RN) nurse and whose employment is solely to assist an RN or Enrolled nurse(EN) in the provision of nursing care to persons."*

97. The new definition applies only to AINs working in aged care because of the scope of this application and the outcome of Stage 1, which provided wage increases only for those employees covered by the Nurses Award who work in aged care.

98. The new definition is intended to reflect contemporary practice in aged care and the way in which work is conducted in the aged care setting. It is also intended to reflect the applicable policy and regulatory framework.

AINs as distinct from other classifications in the Nurses Award

99. The new definition maintains the distinction between AINs and the other classifications contained in the Nurses Award.

100. The current definition makes specific reference to AINs being employees who are not registered with the NMBA. This part of the definition was not replicated in the proposed new definition, because it was considered to be unnecessary. AINs working in aged care are employees who are engaged in the delivery of nursing care in an aged care setting, but who are not performing the roles of enrolled nurse, registered nurse, or nurse practitioner. Those roles are distinct because they require a nursing qualification in order to perform the role. While these titles are protected and subject to registration with the NMBA, this distinction does not of itself assist in defining what an AIN is.

101. I refer to [48]-[70] above with respect to steps that have been taken towards registration of AINs and PCWs and further anticipated policy and legislative changes that will regulate care workers. The proposed definition will, as discussed above, 'future proof' any need for a further variation to the definition, for aged care employees at least, in the event that a registration scheme is introduced, whether under the auspices of the NMBA or another registration body.

102. The classification development process, particularly my consultations with the professional officer group, confirmed in my mind that continuing to work with the Government towards implementing Recommendations 77 and 78 in full is an important step in ensuring safe and quality care in aged care. In addition, steps towards registration and greater regulation of care workers, recognises the increasing professionalisation of this part of the aged care workforce. The revised ANMF classification structure recognises that development.

Deletion of 'direct control'

103. The current definition refers to AINs being "under the direct control and supervision of a RN". The ANMF position is that this definition is antiquated and not reflective of applicable regulations and policy, including the Decision-making framework and Standards of Practice referred to above. Both the Decision-making framework and Standards of Practice address the delegation of aspects of nursing practice to an unlicensed health worker. Neither document suggests or requires the registered nurse delegating nursing work to provide "direct control and supervision of that work".

104. Participants in the DON group, for instance, commented that in an aged care setting, direct control is difficult to maintain as a direct line of sight on all care workers is not always possible.

105. The use of the word “control” now carries negative connotations, which are no longer appropriate as a descriptor in a contemporary document, particularly in the context of nursing, where nursing care is delivered through the combined efforts of the nursing team. Members of the DON group expressed the view that supervision is a more appropriate way to describe the role of the registered nurse in the definition, rather than one exercising “direct control”, which is an antiquated way of viewing the relationship between members of the nursing team.

106. While AINs perform nursing work under the supervision of a registered nurse, such supervision will not require the registered nurse delegating nursing work to retain immediate or direct supervision over the performance of that work in an aged care setting. In practice, a registered nurse does not always retain immediate control over the performance of that work, whether in the residential or home care setting. For this reason, and for the avoidance of doubt the word “direct” has been omitted from the proposed new definition.

107. A registered nurse will be present on site as a result of the introduction of RN 24/7 legislation, and it is the case that even prior to becoming a mandatory requirement, the majority of residential aged care facilities had a registered nurse on site. The presence of a registered nurse means that the capacity for supervision is always available.

Supervision, delegation and direction

108. The work of an AIN in aged care is performed under the supervision of a registered nurse. The registered nurse is responsible for developing a care plan and ensuring that it is implemented by staff with the appropriate skills, knowledge and training to carry out what is required by the plan. The registered nurse’s role is to provide supervision in the implementation and carrying out of what is required in the care plan. Supervision may be direct or indirect.

109. The new definition establishes two further means by which an AIN works with registered nurses. In addition to being subject to supervision, which is the overarching framework by which care work is delivered by the nursing team, AINs may also be subject to delegation and direction from a registered nurse.

110. The reference to delegation is based on the Decision-making framework. The essence of this is that the registered nurse is responsible for delegating care to appropriately qualified and skilled staff, including AINs. Once delegated, the delegatee is responsible for carrying out the delegated work. The ultimate responsibility rests at all times with the registered nurse. So, for example, a registered nurse must be satisfied that the person to whom they have delegated has the necessary skills, qualifications and training to perform the work.

111. Participants from the professional officer group and the DON group confirmed that the Decision-making framework is the key document in this regard, as it sets out how decisions to delegate are made by the registered nurse. The registered nurse makes decisions to delegate based on the skills, training and competence of each member of the nursing team. Once an appropriate delegation has been made, each team member operates within the scope of that delegation and therefore the supervision required can be either direct or indirect.

112. The AIN, as the person to whom work has been delegated—"the delegatee"—is then responsible for carrying out what has been delegated.

113. The reference to delegation and direction also reflects standard 6.4 of the RN Standards for Practice which provides that the registered nurse "provides effective timely direction and supervision to ensure that delegated practice is safe and correct". Members of the professional officer group and DON group confirmed that the RN Standards of Practice are an appropriate reference for considering the definition of an AIN as it is in this framework that the work is performed.

114. The inclusion of the word "direction" in the new definition is also intended to reflect more "hands on" instruction or requests to perform certain work. This may, for example, include a direction to assist a registered nurse in performing a specific task. This is intended to be distinct from the broader concepts of delegation and supervision. Participants in the professional officer group noted this was an important distinction to make, as the definition should include the capacity for registered nurses to direct specific tasks be done, in addition to what is more broadly encompassed in delegation and supervision of work.

Deletion of the word 'solely' and change to the scope of assisting

115. The current definition describes the role of the AIN as being one "whose employment is solely to assist a registered nurse or enrolled nurse in the provision of nursing care to persons."

116. The ANMF position is that the word "solely" should be deleted. An AIN performing aspects of nursing care in aged care will do so in accordance with a delegation from a registered nurse.

117. The work of assisting in the delivery of nursing care is viewed more holistically, as its purpose is primarily to assist the older person. In practice the AIN will assist a wider range of people in delivery of nursing care to aged persons than the current definition allows. The academic group said that it was desirable to reference the skill and knowledge in the sector without micro-prescription. The ANMF position is that the amendment accords with the role and work performed by AINs.

Addition of the words 'aged persons'

118. The addition of the words "aged persons" is to reflect the fact that those words currently appear in the definition of "aged care employee" and will continue to apply.

Other

119. The new definition of an AIN is intended to be expressed in clearer language than the current definition.

120. Both the current and new definition refer to AINs as being distinct from student enrolled nurses. Student enrolled nurses are included in the Nurses Award, to reflect the now-obsolete pathway to becoming an enrolled nurse, in which enrolled nurses qualified for the role through on-the-job training. This pathway to qualification was closed in 2010, and since then requires obtaining a Diploma in a tertiary education setting.

121. The new definition is adopted at each grade of the new AIN classification structure, reflecting the interrelated work of all members of the nursing team, under the supervision, delegation and direction of the registered nurse.

The current classification structure for AINs

122. The current classification structure for AINs comprises four points within the classification. The first three points are based on years of experience in the role, being 1st year, 2nd year and 3rd year and thereafter. These points do not require a qualification. Progression through these points is based on a year of service at each point.

123. The fourth point is attained on the basis of holding a relevant Certificate III qualification. There is no further progression provided for an AIN regardless of experience, training or further qualification.

124. The current Nurses Award does not provide descriptors for the existing levels within the AIN classification, beyond the current definition of Nursing Assistant at Schedule A.1 and the work described under the definition of Nursing Care at Schedule A.2.

The new classification structure for AINs

125. The new classification structure is expressed in Grades, from Grade 1- 5, inclusive of a Grade 4A. It is proposed that each Grade will have a description which is based upon, but not identical, to the current descriptors for each equivalent Level under the Aged Care Award for personal care workers.

126. The ANMF proposes variations to the AIN structure for aged care employees for a number of reasons:

(a) The ANMF position is that the current structure is too limited and does not provide adequate recognition of the skill, training and experience that an AIN in aged care brings to the role and which continues to develop.

(b) The ANMF position is that recognition of advancement in skill, responsibility and complexity of the work, is necessary to attract and retain care workers in aged care.

(c) Safe and quality nursing care cannot be delivered without skilled AINs. The ANMF position is that both residents and people receiving aged care services at home will be the beneficiaries of a more-developed classification structure that allows AINs to progress, commensurate with the acquisition of greater skills, training and experience in aged care.

(d) Greater opportunity to progress is already in place in the Aged Care Award. The ANMF position is that AINs should not be disadvantaged because of the title under which they are employed, noting that use of the AIN title reflects longstanding industrial and employment practices.

(e) It is the ANMF's position is that AINs under the Nurses Award and PCWs under the Aged Care Award perform markedly similar work and there is no material difference in their skills or qualifications the work value.

(f) The new classification structure will be clearer and easier to understand for employers and employees.

(g) The position is intended to avoid industrial arrangements that fail to adequately recognise the character of feminised work.

127. Each of the above dot points reflects the ANMF position based on the classification development process as to how to ensure that the aged care sector attracts, retains and recognises the role of AINs. It was a common view across participants in the classification development process that promoting a skilled, trained and competent workforce is essential to the provision of safe and quality care.

128. In the following paragraphs, the key features of the proposed new classification structure and the basis for adopting these changes is explained.

Preface

129. Each Grade is prefaced by a reference to the work performed in the Grade as being subject to the supervision, delegation and direction of a registered nurse. This reflects the wording of the new definition and makes clear that as an AIN progresses or is appointed to each Grade,

the work performed is part of nursing care performed by all members of the nursing team, under the supervision, delegation and direction of the registered nurse.

130. That work is at all times done under the supervision of the registered nurse, but may also be work that is delegated or directed to be done by the registered nurse.

131. As the preface for each Grade refers to the employee at that grade being subject to supervision, delegation and direction by a registered nurse, references to being subject to supervision in the body of the Grade descriptor have been omitted.

Progression

132. The ANMF position is that it is appropriate for an entry level employee at Grade 1 to progress to Grade 2 after six months of service, rather than the current full year of service. It is the ANMF position that an entry level AIN will have gained sufficient experience over the course of 6 months of service to warrant progressing to Grade 2

133. This provides recognition and incentive to that employee, and is appropriate given the still relatively-low rate of pay at the entry level. The academic group emphasised that skill development through experience occurs along a continuum, and it is appropriate to prescribe an average in a national award. They noted that proficiency development based on workplace learning gives rise to such matters as the Spotlight refenced qualities of fluency, problem solving and sharing. This observation was directed generally to a classification structure. The group also noted that employees can be assumed as "likely to progress" based on experience.

134. Grade 3 is described as qualified, being a relevant Certificate III or possessing equivalent knowledge and skills. A person holding a relevant Certificate III would automatically be classified at Grade 3 where the skills and knowledge gained from that qualification are used in the performance of their work. In addition, there is scope to recognise equivalent knowledge and skill, which is not provided for in the current structure.

135. It is now common and often an employer requirement for an AIN to hold a Certificate III, and it is expected that Grade 3 will be the classification in which most AINs will be classified as a starting point. As identified in my previous statement at [89], the 2020 Aged Care Workforce Census report identified that 66 percent of PCWs held a Certificate III or higher in a relevant direct care field, and another two percent were studying for a Certificate III or higher.

136. Progression to higher grades is based on work being performed at a greater level of skill, responsibility and/or training.

137. Participants in the DON group noted that it is a current shortcoming of the existing classification structure that attaining additional qualifications or training does not result in

progression. Participants in the industrial officer group reported that it is a common feature of enterprise bargaining to build in recognition of additional experience and qualifications into agreements. This is done to attract greater remuneration, which in turn promotes attraction and retention to the aged care sector.

Addition of new Grades above the current Certificate III level.

138. Work in aged care has become more complex, and requires greater levels of skill, responsibility and training, of the employees delivering aged care services. All of this has been recognised in this proceeding, and reflected in the interim decision of 4 November 2022. It is the ANMF position that the classification structure for AINs should reflect the reality and evolution of the work performed.

139. The new classification structure proposes three new points, sitting above the Grade 3 level, in order to provide recognition of the nature and complexity of the work and to provide career progression for AINs. The ANMF position is that this is important to promote aged care as a viable career choice and to assist with attraction and retention of care workers to aged care. The academic group suggested a focus on qualifications only, without reference to experience, workplace learning and role, fails to adequately recognise feminised work.

Grade 4- Senior aged care nursing assistant

140. Grade 4 position adopts descriptors that reflect the equivalent position in the Aged Care Award, being an "Aged care employee—direct care—level 5". The descriptor differs, however, in that it includes the following:

> *"may be required to assist aged persons with self-administration of medication and hold a relevant unit(s) of competency."*

141. AINs who have completed a relevant unit of competency relating to assisting clients with medication, and who have been assessed by the supervising registered nurse as having the appropriate skills, experience and competence, may assist aged persons to take medication. This may include activities such as assisting with opening pill bottles, bringing a glass of water and checking that the person has had their medication in accordance with the prescription. The ANMF position is that the additional skill required to assist aged persons with taking their medication is appropriate to recognise in the classification structure.

142. The role of senior aged care nursing assistant is also intended to recognise an increasing level of accountability and skill in prioritising work. At this level, a senior AIN may also assist in the supervision of others.

143. The new descriptor also introduces a reference to having basic knowledge of digital technology or being required to use a digital device on a regular basis. This change is in part

to update the descriptor in the Aged Care Award, which refers to use of a computer and also to recognise that AINs are required to gain and use skills in relation to digital technology. AINs use this technology to assist residents with their own communication, but also for recording information and interacting with other entities involved in the care of residents. Such skill is also highly relevant to provision of home aged care. The academic group said that it was important to avoid descriptions that, instead of recognising skill and the work performed in the sector, operate to disentitle employees to the benefit of a classification appropriate to their work.

Grade 4A- Specialist aged care nursing assistant

144. The ANMF position is that Grade 4A should be inserted into the Nurses Award in order to recognise the development of increased skill and experience associated with the work in particular roles. In addition, an AIN may be classified at this level if they have skills, training or experience in dementia care or palliative care.

145. As recognised by the Royal Commission and in Stage 1 of this proceeding, the number of residents with dementia is increasing and will continue to increase as a percentage of the people in residential care. I refer in particular to [149] of my previous statement with respect to the increase in the need to provide dementia care in aged care settings.

146. Similarly, the ANMF position is that provision of palliative care in a residential setting is skilled work that is appropriate to attract a more advanced position in the classification structure.

147. The skills and responsibilities at Grade 4A build on those described in Grade 4.

Grade 5- Aged care nursing assistant supervisor

148. The current classification structure makes no provision for AINs who wish to progress in their careers and remain in the role of AIN. The ANMF position is that Grade 5 should be added to enhance an alternative career pathway to that of progressing to becoming an enrolled nurse or registered nurse.

149. This recognises that AINs, in addition to developing direct care skills and knowledge, may also choose to advance in roles that could be described as more administrative in nature. This could include delegated supervision of less experienced AINs, preparing rosters in conjunction with the registered nurse, facility planning and reporting or staff training

150. Grade 5 may require a Certificate IV, or relevant skills, training or experience. The ANMF position is that the qualification of a Certificate IV should be recognised as enhancing an employee’s skills and knowledge.

Student EN, EN, RN and NP classification structure

151. The ANMF does not propose any change to the classification structure definitions as it currently applies to ENs, RNs and NPs.

152. A registered nurse who has met the requirements for registration and who is then registered with the NMBA is fully registered. Other than requirements for maintaining registration on an annual basis, there is no further requirement for a registered nurse to demonstrate competency in order to maintain full registration. Once a registered nurse is registered, they are considered competent to meet the responsibilities of a registered nurse.

The Aged care Award Draft Determination

153. The ANMF proposes changes to the Aged Care Award classification structure. The ANMF position is that as with AINs, PCWs are part of the nursing team and are engaged in the delivery of direct care. The care work performed by PCWs is nursing care involving care delegated by a registered nurse in accordance with the Decision-making framework and the RN Standards for Practice.

154. The ANMF position is that the structure proposed for AINs as set out above should be replicated in the Aged Care Award. It is appropriate to align the two structures so that employers are not given an incentive to employ under one structure rather than the other. In addition, depending on the employment and or industrial setting, both role titles are utilised. The ANMF position is that the classification structure for AINs and PCWs under the respective awards should be maintained.

Variations to the descriptors

155. The ANMF proposes variation to the current classification structure for direct care workers under the Aged Care Award to reflect the same changes as those proposed for the AIN structure in the Nurses Award, save that lifestyle officers are included under the Aged Care Award, but not the Nurses Award.

156. On this basis, and for the same reasons as outlined at paragraphs 129 above, each proposed Grade is prefaced with the words that an employee at this grade is “subject to the supervision, delegation and direction of a Registered nurse (RN)”. The preface describes the nature of the supervision for each grade of employee. The amendments reflect what the academic group described concerning “communities of practice”, such that engagement and experience in the workplace provide for employees to become part of the socialised culture of delivering nursing care.

157. The current Aged Care Award refers to direct care employees at Levels 1-7. The ANMF instead proposes the adoption of "Grades" as were identified in the Aged Care Award classification structure for direct care workers prior to 30 June 2023.

158. PCWs at current Level 2 (proposed Grade 1) are described as "being capable of prioritising work within established routines, methods and procedures."

159. The ANMF position is that this should be amended, on the basis that at entry level, an unqualified and inexperienced PCW is likely to require direction in the prioritising of work. The ability to prioritise work can only be gained after some experience in the role. The academic group drew attention to the position that "routine" in the nursing and care environment was something established by staff themselves through experience and contingency planning. Staff are not so much following a routine, as creating routines themselves arising from the skill and experience of the work.

160. The proposed Grades 4, 4A and 5 replicate the proposed new grades in the Nurses Award.

Career pathway- vertical and lateral/sectoral

161. In my discussions with the industrial officer group and the professional officer group, I was told, and it is my understanding, that direct care workers will commence working in aged care as AINs and PCWs and may then study to become an enrolled nurse or registered nurse. There is a career pathway embedded in the Nurses Award that many AINs follow. Maintaining the current pathway within the Nurses Award provides a visible career progression pathway for AINs who are seeking to progress to qualified nursing roles.

Annie Butler

1 November 2023

Australian Government
Department of Health and Aged Care

AB 9

Care minutes and 24/7 registered nurse responsibility guide

29 September 2023

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Purpose

The purpose of the Care minutes and 24/7 registered nurse responsibility guide (the Guide) is to provide information to approved providers on their current care minute targets, and legislative responsibility in relation to care minutes and the incoming 24/7 registered nurse responsibility. The Guide explains the categories of workers that can deliver care minutes, the activities that can qualify as care minutes, care minutes targets for services and how these are calculated, the 24/7 registered nurse responsibility, and reporting obligations.

From 1 July 2023, approved providers will be required to have a registered nurse on-site and on duty at all times in each residential facility. From 1 October 2023, care minutes will be introduced as an approved provider responsibility. Upon commencement, these responsibilities will be governed by the applicable aged care legislation.

Disclaimer

Approved providers of residential aged care services are responsible for understanding and complying with all legislation that is relevant to the delivery of residential care and respite care provided in a residential setting. This Guide is a general guide only and aspects of the policy and legislation, including proposed legislation, have been simplified for ease of understanding. It is not a substitute for, and is not intended to replace, independent legal advice or legal obligations under the aged care legislation or provide any interpretation of the legislation, or proposed legislation.

Residential aged care providers and care recipients should consider the need to obtain their own independent legal advice relevant to their particular circumstances.

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Guide updates

Date	Version	Content
9/11/2022	1.0	• Initial publication
28/11/2022	1.1	• Section 1.5 – information about future work on the care minutes and 24/7 registered nurse requirements • Section 2 – clarification around AN-ACC funding for registered nurses, enrolled nurses and personal care workers • Section 2.1 – update to definition of Registered Nurse • Section 2.2 – update to definition of Enrolled Nurse • Section 5.4 – project work regarding workforce shortages and alternative models of care • Section 6.4 – project work on review of data collected in reports • Section 7.1 – options to include the 24/7 registered nurse requirement in Star Ratings • Section 8.4 – information about QA of worked hours trends • Section 8.5 – project work on auditing of reports • Appendix 2 – update to example – Melanie (Grade 4 personal care worker, Level 5 Award)
22/12/2022	1.2	• Section 3.1 – revised information on direct care activities • Section 4.4 - revised information on care minutes targets, including calculations • Appendix 3 – revised calculation example
5/01/2023	1.3	• Section 4.3 – update to respite care minutes • Appendix 2 – enrolled nurse care worker example • Appendix 3 – revised calculation example
10/01/2023	1.3.1	• Appendix 3 – update to calculation example
15/2/2023	1.4	• Section 2 – update to registered nurse, enrolled nurse and personal care worker definitions • Section 4.4 – update to care minutes targets calculation • Section 6 – update to Quarterly Financial Report (QFR) requirements • Section 8 – update to quality assurance and QFR data validation process • Appendix 3 – revised table 6 and inserted table 7, including explanatory content
28/2/2023	1.5	• Update of 'requirement' to 'responsibility' through document • Section 1.5 – explanation of provider/service/facility • Section 5.1 – more information on co-located services • Section 5.2 – information on services with multiple locations • Section 5.3 – expanded rationale for 24/7 RN exemption • Section 6.3 – expanded information on 24/7 RN reporting

Date	Version	Content
20/3/2023	1.5.1	• Update to formatting and minor revisions in Sections 2, 5.3 and 6.3
21/4/2023	1.6	• Workforce initiatives moved from Section 2 to Appendix 2 • Added section 1.6 on Regulation of care minutes and the 24/7 registered nurse responsibility
8/5/2023	1.7	• Section 1.2 updated to include new AN-ACC funding in the 2023-24 Budget • New Section 1.7 on changes to care minutes from 1 October 2023 • Update to section 4 to include new care minutes allocations and information on estimating targets prior to 1 October 2023
12/5/2023	1.7.1	• Correction to respite care minutes in Table 3
16/5/2023	1.7.2	• Correction to care minutes in Table 2
2/6/2023	1.8	• Section 1.4 – definitions of on-site and on duty • Section 5.1 – update on co-located services • Section 5.6 – information on receipt of 24/7 RN supplement, and update to Table 5 on 24/7 RN supplement rates • Section 5.7 – information on temporary threshold for 24/7 RN supplement • Section 6.3 – information on 24/7 RN reporting, including the impact on the 24/7 RN supplement • Appendix 4 – new case studies for on-site and on duty
15/6/2023	1.8.1	• Section 6.3 – more detail on 24/7 RN reporting, including lists of common absence reasons and alternate arrangements used in reporting
20/6/2023	1.8.2	• Correction to Section 6.3.2 on utilisation of 24/7 RN report data

Date	Version	Content
21/6/2023	1.8.3	• Restoring some removed data to Section 6.3
29/09/2023	1.9	• Revisions throughout the guide to account for the 1 October 2023 transition to mandatory care minutes • Provision of further guidance on 24/7 RN reporting

Paula Jones

Section 1: Introduction

1 Introduction

Care minutes refers to the minimum direct care time provided to residents by approved residential aged care services through registered nurses (RNs), enrolled nurses (ENs), and personal care workers and assistants in nursing (PCW/AINs), who are performing direct care activities that are consistent with the activities set out at Section 3.

The Royal Commission into Aged Care Quality and Safety (Royal Commission) found that the routine care of older people in residential aged care often did not meet expectations for assistance with the activities of daily living, with many examples of substandard care in providing for the most basic of human needs.

The Royal Commission's Final Report:

- identified staffing levels as vital to the quality of care that older people receive
- recommended introducing minimum care minutes responsibility to increase care time for the people living in aged care homes across Australia
- recommended linking a minimum care minutes responsibility to a casemix-adjusted funding model like the Australian National Aged Care Classification (AN-ACC) funding model.

For more information, see Recommendation 86 of the Final Report.

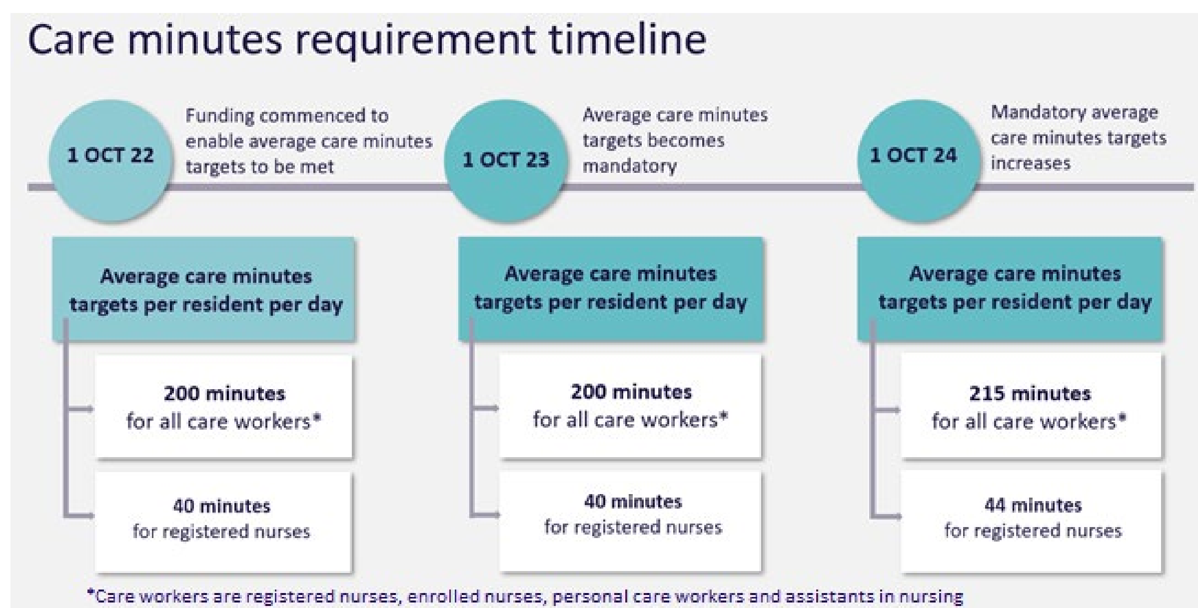
Funding for care minutes is delivered through the AN-ACC model, to ensure approved services are funded to provide residents with an appropriate standard of skilled care. The provision of allied health and lifestyle services is not included as part of care minutes but is funded separately under AN-ACC and is required under legislation for all residents who need these services (see Section 3.2.1).

1.1 Care minutes implementation timeline

The Australian Government (Government) is implementing care minutes in stages:

- from 1 October 2022, providers were funded to meet non-mandatory care minutes **targets** set at a sector average of 200 care minutes per resident per day, including a minimum of 40 minutes of RN time per day
- from 1 October 2023, providers are required to meet their **mandatory** care minutes targets set at a sector average of 200 minutes per resident per day, including a minimum of 40 minutes of RN time per day
- from 1 October 2024, care minutes targets will be increased to a sector average of 215 minutes per resident per day, including a minimum of 44 minutes of RN time per day.

Figure 1 Care minutes timeline



The target shown above are averages across the residential aged care sector. Each service has individual targets based on their resident casemix, which may differ from the sector-level averages. Providers are required to meet the individual target for their services not the sector average of 200 total minutes, including 40 RN minutes. For more information on individual targets, see Section 4.2.

1.2 Funding under AN-ACC

The AN-ACC funding model includes funding to cover the cost of providing direct care (through RNs, ENs and PCW/AINs) to residents, including the wages for these aged care workers. This includes a funding uplift of $5.4 billion over 4 years that commenced on 1 October 2022, to enable residential aged care services to meet their initial care minutes targets and their mandatory responsibilities from 1 October 2023.

An additional $1.9 billion ($0.8 billion in 2024-25, and $1.1 billion in 2025-26) was allocated in the October 2022-23 Budget to increase the average care minutes across the sector from 200 to 215 minutes from 1 October 2024. This funding uplift covers the costs of wages for RNs, ENs, and PCW/AINs, to meet the increased care minutes.

In the 2023-34 Budget, the Government invested a further $10.1 billion in AN-ACC funding (over 4 years from 2023-24), with an increase to the AN-ACC price to $243.10 from 1 July 2023, including:

- $7.6 billion to align with the Fair Work Commission award wage increase (at 200 care minutes)
- $2.5 billion in indexation to cover other cost increases since the initial AN-ACC price was set.

An additional $743 million (over 3-years from 2024-25) was also committed to align with the award wage increase and cover increased costs of delivering 215 care minutes. For more information, see Funding higher wages in residential aged care.

It is anticipated that this will assist in attracting workers to the sector and support retention of the existing workforce.

1.3 Care minutes obligations

Care minutes establish a minimum quantity of care (by RNs, ENs and PCWs/AINs) that is required to be provided to residents from 1 October 2023. The care minutes responsibility is established by

amendments to the *Quality of Care Principles 2014* made through the *Aged Care Legislation Amendment (Care Minutes Responsibilities) Principles 2023*.

This responsibility is in addition to the existing responsibility of approved providers under the *Aged Care Act 1997* (the Act) to maintain an adequate number of appropriately skilled staff to ensure the care needs of care recipients are met and to provide safe, respectful and quality care and services (see obligations under the *Aged Care Quality Standards* (Quality Standards) in Schedule 2 to the *Quality of Care Principles 2014*.

1.4 Registered nurse on duty 24 hours a day

From 1 July 2023, approved providers must ensure that there is at least one RN on-site and on duty 24 hours a day, 7 days a week, at each residential facility they operate (24/7 RN requirement). The 24/7 RN responsibility is established by section 54-1A of the Act.

For the purposes of the 24/7 RN requirement:

- On-site means an RN must be within the confines of the residential facility or the immediate surrounds.
- On duty means the RN must be available to provide care to care recipients and oversight of the care provided by other care staff as needed.

1.5 Difference between service/facility

The care minutes responsibility applies to residential care services. A residential care service is the undertaking through which subsidy is paid to an approved provider of residential care.

The 24/7 RN responsibility applies to residential facilities. For the purposes of the 24/7 RN responsibility, a residential facility is ‘a building or complex of buildings (inclusive of their immediate surrounds) used for a specific purpose’, with the relevant specific purpose being to provide residential aged care.

1.6 Regulation of care minutes and the 24/7 RN responsibility

The Aged Care Quality and Safety Commission (Commission) has published a Regulatory Bulletin Workforce-related responsibilities – including 24/7 registered nurse and care minutes (RB 2023-19).

The bulletin explains how the Commission will regulate the 24/7 RN responsibility from 1 July 2023 and mandatory care minutes from 1 October 2023. The Commission held a related webinar on 18 April 2023.

The Commission has stated that it is unlikely to consider escalated compliance action in relation to providers not meeting the 24/7 RN or care minutes responsibilities where a provider makes genuine ongoing effort to meet these responsibilities, is providing safe and quality care to consumers, and there are no other concerns about their compliance or performance.

1.7 Changes to care minutes from 1 October 2023

From 1 October 2023, the Government is adjusting care minutes allocations associated with each AN-ACC and respite class, which are used to determine care minutes targets. These changes are being made to better align each service’s average care time responsibility with its overall class AN-ACC funding.

Most services will only see a very small change in their service-level care minutes targets, because quarterly care minutes targets are averaged across all residents in a service.

Providers can access their new service-level care minutes targets for the October 2023 –December 2023 quarter in the My Aged Care Service and Support Portal.

The table of care minutes associated with each AN-ACC classification from 1 October 2023 is in Section 4.3.

For more information, see Care minutes changes.

1.8 Future work on the care minutes and 24/7 registered nurse responsibility

The government is undertaking work to further develop and refine care minutes and the 24/7 RN responsibility. This includes:

- modelling aged care RN workforce shortages by region to better inform future exemption arrangements
- developing clinically appropriate alternative models of care to ensure safe and quality care is delivered when a RN is not available due to workforce shortages
- including the 24/7 RN responsibility in Star Ratings
- improvements to care minutes data collection in the Aged Care Financial Report (ACFR) and Quarterly Financial Report (QFR)
- developing a care time assessment program for 24/7 RN and care minutes reporting.

We may undertake targeted consultation with a range of stakeholders on the proposed approaches in 2023 to ensure that they are appropriate for different workforce situations, particularly for services located in rural and remote areas.

Further information on these projects can be found in the relevant sections of this guide.

Section 2: Care minutes: care workers

2 Care workers

Care minutes can only be delivered by the following specified care workers:

- registered nurses (RN)
- enrolled nurses (EN)
- personal care workers and assistants in nursing (PCWs/AINs).

Providers are funded through AN-ACC to have a sufficient mix of RNs, ENs and PCWs/AINs on duty to meet the care needs of residents at all times. This is so providers can deliver safe and quality care to residents living at their residential aged care services. For example:

- RNs provide nursing care including complex patient assessment, care plan development and evaluation of care
- ENs provide nursing care as delegated by the RN which includes but not limited to patient assessment, wound management and administration of prescribed medications
- PCWs/AINs assist with daily living routines and perform tasks as delegated by nurses.

More detail on the definitions of RN, EN and PCWs/AIN can be found in this section below.

Nurses in Australia are registered by the Nursing and Midwifery Board of Australia (NMBA). The NMBA are assisted in performing their functions under the Health Practitioner Regulation National Law (National Law) by the Australian Health Practitioner Regulation Agency (AHPRA). The titles of ‘nurse’, ‘registered nurse’ and ‘enrolled nurse’ are protected under the National Law and only those appearing on the Register of practitioners published by AHPRA may use the titles.

2.1 Registered nurse

An RN is a person who has completed the prescribed education preparation, demonstrates competence to practice and is registered under the National Law as an RN in Australia.

In Victoria, an RN may also be known as a division 1 nurse.

To maintain their registration, an RN must continue to meet the core registration standards including recency of practice, continuing professional development, professional indemnity insurance as well as all relevant professional codes and guidelines including the codes of conduct and ethics and registered nurse standards for practice.

An RN has supervisory responsibilities for ENs and PCWs/AINs as well as delegating care and responsibilities to the care team.

2.2 Enrolled nurse

An EN is a person who provides nursing care under the direct or indirect supervision of an RN. They have completed the prescribed education preparation and demonstrate competence to practice under the National Law as an EN in Australia. ENs are accountable for their own practice and remain responsible to an RN for the delegated care.

In Victoria, an EN may also be known as a division 2 nurse. The labelling of an EN as a division 2 nurse does not make them a RN for the purposes of care minutes reporting.

In order to maintain their registration, an EN must continue to meet the core registration standards including recency of practice, continuing professional development, professional indemnity insurance as well as all relevant professional codes and guidelines including the codes of conduct

and ethics and enrolled nurse standards for practice.

An EN works with an RN as part of the care team and demonstrates competence in the provision of person-centered care. Core practice generally requires an EN to work under the direct or indirect supervision of an RN. At all times, an EN retains responsibility for their actions and remains accountable in providing delegated nursing care. The need for an EN to have a named and accessible RN at all times and in all contexts of care for support and guidance is critical to patient safety.

Direct supervision is when the supervisor is actually present and personally observes, works with, guides and directs the person who is being supervised.

Indirect supervision is when the supervisor works in the same service or organisation as the supervised person but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, the needs of the resident receiving care and the needs of the person who is being supervised.

Minutes of care provided by ENs cannot be counted towards RN-specific care minutes. However, ENs can perform appropriate nursing tasks that allow RNs more time to provide RN-specific care minutes. An EN's time providing direct care to residents is included in the service's total care minutes (see Figure 1 in Section 1.1).

2.3 Personal care worker (PCW) and assistant in nursing (AIN)

For the purposes of care minutes:

- a PCW is an employee classified under Schedule B.2 in the Aged Care Award 2010 as an Aged Care employee – direct care Level 2 (Grade 1 PCW) to Aged Care employee – direct care Level 7 (Grade 5 PCW) (excluding Aged care employee- direct care Level 6), or in an equivalent role in an equivalent award or enterprise agreement or individual contract/agreement, and
- an AIN (or Nursing Assistant) is an employee classified under Schedule B.2.1 in the Nurses Award 2020

PCWs and AINs work under the supervision and guidance of a nurse (RN/EN).

Activities of a PCW/AIN that can be reported as care minutes include assisting residents with:

- daily living routines and direct care activities (such as self-care or personal care) for example, assistance with eating and drinking, monitoring fluid intake, skin care, ambulation, bathing and washing, dressing, hair care, mouth care, positioning, shaving, bladder and bowel care (continence management), mobility and transfers (such as getting in and out of bed or to and from the toilet)
- social and emotional support for residents and their families, for example, supporting residents to be and feel connected, heard, valued and fulfilled
- regular monitoring and support of residents' health and wellbeing.

The relevant awards for aged care employees distinguish a PCW/AIN from other employees such as gardeners, drivers, food services assistants, cooks, chefs, clerical, cleaners, laundry hands, and lifestyle coordinators.

Activities not consistent with the PCW/AIN role include, but are not limited to, organising recreational/social activities, allied health (including exercise physiologists) and hotel services such as catering, cleaning, and laundry.

For examples of care workers and the activities they can report as care minutes, see Appendix 2.

2.3.1 Social and emotional support

Social and emotional support is a vital part of residential aged care. PCWs/AINs can, and do, support residents' social and emotional needs as a part of their duties, and this component of their duties can be included in care minutes. Consistent with the need to improve the standard of personal care in residential aged care, social and emotional support should enhance, and not be at the expense of, personal assistance with daily living routines and direct care activities such as bathing and washing, dressing, feeding, getting in and out of bed, getting to and from the toilet and continence management.

Social and emotional support includes activities that support residents to be and feel connected, heard, valued and fulfilled. Examples of the activities that could be counted include, but are not limited to:

- when a PCW/AIN spends social time with a resident to have a conversation
- assists them personally to undertake personal interests (for example reading or playing a game)
- assists them personally to participate in a group activity.

Running group lifestyle activities (for example painting, singing, bingo, excursions, etc.) do not count towards care minutes. However, a PCW/AIN personally assisting a resident to take part in these activities can be counted.

2.4 Workforce support

For department programs to help recruit and retrain care workers, see Aged care workforce.

Section 3: Care minutes: direct care activities

3 Direct care activities

Only direct 'clinical care' and 'personal care' activities provided by specified workers (RNs, ENs or PCWs/AINs) can be counted for the purposes of meeting the care minutes responsibility.

Direct care activities may include both direct in person assistance and those that are not face to face (for example writing up care plans or organising a referral for an allied health service are considered direct care activities that are not carried out face-to-face).

Only direct care activities provided by a specified care worker on-site can count towards a service's care minutes targets. This means support provided through on-call and virtual telehealth arrangements can not contribute towards the care minutes targets.

See Appendix 2 for examples of what different activities by different care workers can count towards care minutes.

3.1 Activities included in care minutes

Time spent by RNs, ENs or PCWs/AINs providing direct 'clinical care' and 'personal care' activities that can be counted towards care minutes include but are not limited to:

Table 1: Care minutes activities

Direct care type	Activities	Examples
Clinical care	Treatments and procedures	• Medication management • Nutrition and hydration management • Pressure care management
	Assistance in obtaining health practitioner services	• Engaging with health providers including arranging and supporting to attend appointments to ensure residents' needs are met
	Assistance in obtaining access to specialised therapy services	• Engaging with allied health services, such as speech therapists, podiatrists, occupational or physiotherapy practitioners to ensure residents' needs are met
	Nursing services	• Assessing residents' clinical needs, including collecting clinical data such as vital signs, weight and other body measurements • Providing advice about or performing Wound management • Diabetes and other chronic disease management • Behavioural management • Identifying and documenting changes to a resident's health status • Developing care plans and strategies • Liaising with residents and families on care issues including family meetings

Direct care type	Activities	Examples
Personal care	Resident social activities	• Assisting a resident to take part in social activities such as group lifestyle classes • (Only to the extent of one-on-one assistance to a resident to participate in the activities, and excludes the planning or delivery of activities to a group of residents)
	Daily living activities assistance	• Continence management • Bathing and washing residents • Grooming or shaving residents where the resident cannot perform these tasks • Mobility assistance
	Emotional support	• Social and emotional support to residents (person-centred holistic care)
	Recreational therapy	• Accompanying residents on outings to assist residents with direct care activities • (Only to the extent of one-on-one assistance to a resident to participate in the activities, and excludes the planning or delivery of activities to a group of residents)
	Support for residents with cognitive impairment	• One-on-one support to residents with cognitive impairment (for example, dementia and behavioural disorders), including individual therapy activities and specific programs designed to prevent or manage a particular condition or behaviour and to enhance the quality of life

3.2 Activities not included in care minutes

Non direct care activities that are not counted as care minutes include but are not limited to:

- rostering and other administrative tasks
- funding management related tasks including assessing residents for the purposes of determining whether to ask for an AN-ACC reclassification
- recruitment
- facility-level planning and reporting
- staff training
- catering
- laundry
- hotel services

- room cleaning
- decorating rooms
- craft activities
- maintenance
- gardening
- planning and running recreation and lifestyle activities.

3.2.1 Allied health and lifestyle exclusions

Allied health and lifestyle services are excluded from care minutes reporting, however are funded under the AN-ACC funding model. The AN-ACC funding model provides residential aged care services with sufficient funding to supply residents with allied health treatment and lifestyle services consistent with their individual care plans, including rehabilitation support and therapy services.

Allied health and lifestyle services are an important component of residential aged care. Providers must continue to provide these services to residents who need them, consistent with the *Aged Care Act (1997)* and the Quality Standards. This includes specified care and services that must be provided without cost to residents who need them, as detailed in Schedule 1 of the Quality of Care Principles 2014.

Residents and carers with concerns about the provision of allied health in a service can contact the Older Person's Advocacy Network (OPAN) on 1800 237 981 for advocacy services and assistance working with the service.

3.2.2 Performance of direct care activities

Only worked time is counted towards care minutes. This excludes all staff leave, training and unpaid breaks.

Where a specified worker is employed in a hybrid role, for example, performing both personal and/or clinical care activities and non-care activities, only the portion of the worker's time on 'direct care' activities will count towards care minutes.

Where a specified worker works across separate services, their time should only be counted at a service based on the time they are allocated to and perform the specified personal care and clinical care activities in relation to residents at that service.

Section 4: Care minutes: targets

4 Care minutes targets

Care minutes targets indicate the average amount of care time in minutes that must be given in each aged care home.

4.1 Sector-wide targets

The sector-wide care minutes targets are set at an initial average of 200 minutes per resident per day, including 40 minutes of RN time per days. This will increase to 215 minutes per resident per day, including 44 minutes of RN time from 1 October 2024.

4.2 Service-level targets

Each service has specific care minutes targets based on the assessed care needs (that is, the AN-ACC and respite assessments) of their residents (see Section 4.3), that they are required to meet on average over the quarter.

These targets are calculated based on the casemix of permanent residents (including palliative care recipients) and respite residents that were in care during the target calculation period. The target calculation period is the three months, one month before the responsibility period starts. For example, for the October to December quarter of 2023, the period used to calculate the targets is June-August 2023). See Table 2 below for the target calculation periods for upcoming quarters.

Table 2 Target calculation periods for upcoming quarters

Performance quarter	Oct-Dec 2023	Jan-Mar 2024	Apr-Jun 2024	Jul-Sep 2024
Targets are calculated based on residents in care from:	Jun-Aug 2023	Sep-Nov 2023	Dec 2023 – Feb 2024	Mar-May 2024
Target publication date	15 Sep 2023	15 Dec 2023	15 Mar 2024	15 Jun 2024

This approach is used to allow the targets to be published in advance of the quarter, giving providers certainty over their staffing requirements. Residents on leave, for example social or hospital leave, are included in the target calculation, but residents without a classification (i.e. those with a default AN-ACC class) are not included in the care minute target calculation.

The service-level care minutes targets need to be met on a quarterly basis.

A service with mainly higher needs residents will have higher care minutes targets than a service with mainly lower needs residents. For example, a service with higher needs residents might have a target of 210 minutes per resident per day, while a service with lower needs residents could have a target of 190 minutes per resident per day.

4.2.1 Delivery of quarterly targets

Services are required to deliver their care minutes target multiplied by the number of occupied bed days (permanent and residential respite residents) during the performance period.

For example, a service with a total care minutes target of 190 minutes per resident per day for the October-December quarter, that had 1000 occupied bed days during this quarter, is required to deliver 190,000 minutes of care from RNs, ENs and PCWs/AINs for the quarter.

- **Unclassified residents** (i.e. those assigned to a default class), while not included in the care minutes target calculation, are counted as an occupied bed day for the purposes of care minutes, and so for each day an unclassified resident is in care in the above example, an additional 190 minutes needs to be delivered in the quarter.
- **Residents on leave** are also counted as an occupied bed day for the purposes of care minutes performance, except where the resident is on hospital leave for 29 consecutive days. In this instance, the first 28 days of leave are included, but not the 29th and subsequent days.

Residential aged care services can access their current care minutes targets in the My Aged Care Service and Support Portal. See My Aged Care – Provider Portal User Guide: Part 2 Team Leader and Staff Member Functions.

4.3 Care minute allocations by AN-ACC and respite class

Under the AN-ACC funding model, each resident receives an independent assessment and is assigned an AN-ACC class or a respite class. There are 13 AN-ACC classes and 3 respite classes. Each class has specific care minutes allocations that reflect the care needs of residents in that class, as outlined in Table 3 below. They are based on data from the Resource Utilisation and Classification Study and are matched to the level of class funding provided under the AN-ACC funding model.

For more information on AN-ACC and respite classes, or the AN-ACC assessment process, see the AN-ACC Funding Guide.

The Government adjusted the allocation of care minutes associated with each AN-ACC and respite class. These amended AN-ACC class care minutes have been used for the calculation of service level targets that apply from 1 October 2023. For more information, see Care minutes changes. Previous care minute allocations associated with each AN-ACC and respite class are available in Appendix 4.

Table 3 Care minutes allocations associated with each AN-ACC and respite class

AN-ACC class	Total care minutes allocation	RN minutes allocation
Class 1	317	57
Class 2	110	30
Class 3	143	32
Class 4	115	28
Class 5	157	39
Class 6	152	34

Class 7	186	36
Class 8	200	38
Class 9	202	46
Class 10	282	56
Class 11	274	41
Class 12	269	42
Class 13	317	57
Class 101 – Respite	120	31
Class 102 – Respite	165	36
Class 103 – Respite	273	48

4.4 Calculation of quarterly care minutes targets

The service-level care minutes targets are calculated based on the average resident casemix (the number of care days delivered in each AN-ACC and respite class) in target calculation period.

Total care minutes and RN care minutes are each calculated by:

1. multiplying the number of care days delivered in each resident class by that class' care minutes target (outlined in Table 3 in Section 4.3)
2. summing the total minutes of every class
3. dividing that sum by the total number of care days delivered over the quarter to residents with an AN-ACC or respite classification.

4.5 Accessing and viewing care minutes targets and performance in meeting care minutes

Actual service-level care minutes targets are published on the 15th of the month prior to the commencement of each quarter (see Table 2 for upcoming dates), and are available in the My Aged Care Service and Support Portal.

Targets that apply from October 2023 onwards are published at Care minutes targets in residential aged care by service so that aged care residents, their family members and other interested members can see their services current care minute targets.

Service level care minutes performance is published on the My Aged Care Find a Provider as part of each services Staffing Star Rating page.

In early 2024, targets will be available in the Government Provider Management System.

4.6 Publication of EN care minutes

From October 2023, care minutes delivered by ENs will be published alongside Star Ratings on the Staffing page via the My Aged Care 'Find a Provider' tool in line with the announcement made at the

2023-24 Budget.

The publication of EN care minutes delivered is not an indicator that EN specific targets are being introduced, but to provide transparency for older people and their representative when comparing services and will support providers to monitor, compare and improve their care delivery.

Care time delivered by ENs will continue to contribute towards the overall service-level care minutes targets.

Section 5: 24/7 registered nurse responsibility

5 24/7 registered nurse responsibility

From 1 July 2023, approved providers of residential aged care must have at least one RN on-site and on duty at each residential facility they operate 24 hours a day, 7 days a week.

The implementation of the 24/7 RN responsibility is well-aligned with providers' existing responsibilities under the *Aged Care Act (1997)* and the Quality Standards to provide safe and quality care at all times.

For the purposes of the 24/7 RN responsibility:

- on-site means an RN must be within the confines of the residential facility or the immediate surrounds
- on duty means the RN must be available to provide care to care recipients and oversight of the care provided by other care staff as needed.

The responsibility aims to:

- reduce the risk of resident harm that can occur when qualified and experienced care staff are not available at a residential facility to identify and address potential risks
- give residents better access to care in a residential facility, enabling RNs to manage some issues as first responders, improving resident safety and preventing unnecessary trips to hospital emergency rooms.

For purposes of the 24/7 RN responsibility, a residential facility is a building, or a complex of buildings (inclusive of their immediate surrounds), used for providing residential care. For more information on the difference between service, and facility, see Section 1.5.

A list of registered nurse coverage in residential aged care by facility is available on the department's website. Also available is information by State and Territory on the Registered nurse coverage in residential aged care dashboard.

5.1 Co-located services

Where 2 or more services belong to the same approved provider and are co-located at a single address, or across neighbouring addresses that effectively form a single location, they may form a single residential facility for the purposes of the 24/7 RN responsibility.

In assessing whether co-located services form a single facility, the department will also take into consideration other features that indicate they operate as a single facility, such as:

- a single governance or management structure across the services
- common policies, procedures, systems and processes
- clinical and care staff are shared across the services
- easily accessible, common resources such as dining and/or recreational areas.

Compliance with the 24/7 RN responsibility for co-located services will be considered with respect to the residential facility as a whole. This means co-located services will only be required to have one RN on-site and on duty at all times across the 2 or more residential aged care services.

Where 2 or more services are situated on the same site but are operated by different providers,

each service will be treated as a separate facility and must have their own RN on-site and on duty.

An approved provider of co-located services can choose to combine services. Information on combining residential aged care services is available at Combining and transferring residential aged care places.

5.2 Services with multiple locations

Some services deliver care at multiple physical locations (that is, not at the same site or across neighbouring addresses that effectively form a single location). These are considered split services for the purposes of the 24/7 RN responsibility.

Split services will be required to have at least one RN on-site and on duty at each site, as the different locations are considered different facilities.

5.3 Exemption from the 24/7 RN responsibility

Residential facilities with 30 or less operational places in Modified Monash Model (MMM) 5-7 locations may be eligible for an exemption from the 24/7 RN responsibility until 30 June 2024. To receive an exemption, the provider must demonstrate it has taken reasonable steps to ensure that the clinical care needs of the residents at the facility will be met during the exemption period.

For co-located services, the combined operational places must be no more than 30 at the facility-level to be eligible for an exemption.

The 2020 Aged Care Workforce Census indicated that smaller facilities and facilities in rural and remote areas have low RN coverage. The exemption accounts for RN workforce shortages that impact small facilities in rural and remote areas, to give these facilities flexibility while they address staffing challenges.

An exemption from the 24/7 RN responsibility for a facility does not remove any of the approved provider's other obligations under the *Aged Care Act 1997* and the Aged Care Quality Standards, including the provider's obligations to meet the mandated care minutes responsibility from 1 October 2023.

Exemptions are available until 30 June 2024. The policy regarding exemptions beyond this time is not yet finalised and is a decision of Government. A list of approved providers with an exemption from the 24/7 registered nurse responsibility is now available on the department's website.

The exemption application form is available on the department's website. For enquiries about the exemption process, please contact us at exemptions@health.gov.au.

5.4 24/7 RN funding supplement

A monthly supplement is available to help smaller residential facilities employ extra RNs to deliver 24/7 RN care. It is a non-means tested supplement payable to facilities with, on average, up to 60 residents per day over the month (based on occupied places) and have met the reporting and RN coverage threshold criteria (see section 5.5 for information on eligibility).

There are 2 supplement rates payable (shown in Table 4) depending on whether the facility is in a:

- metropolitan area (MMM 1–4)
- rural, remote and very remote area (MMM 5–7) to account for the additional costs that come with working in these areas.

The supplement is not payable to:

- facilities that have an exemption from the 24/7 RN responsibility
- Multi-Purpose Services (MPS).

Residential facilities with an exemption in place may opt out of the exemption at any time to receive the supplement (if the eligibility criteria are met).

Table 4 24/7 registered nurse monthly supplement funding

Average residents per day in calendar month	Occupied bed days (28 calendar day month)	Occupied bed days (29 calendar day month)	Occupied bed days (30 calendar day month)	Occupied bed days (31 calendar day month)	and facility is in 2019 MMM 1-4	and facility is in 2019 MMM 5-7
>0–5	1-140	1-145	1-150	1-155	**$27,667.00**	**$77,083.00**
>5–10	141-280	146-290	151-300	156-310	**$27,667.00**	**$69,000.00**
>10–15	281-420	291-435	301-450	311-465	**$27,667.00**	**$63,500.00**
>15–20	421-560	436-580	451-600	466-620	**$27,667.00**	**$53,250.00**
>20–25	561-700	581-725	601-750	621-775	**$27,667.00**	**$42,250.00**
>25–30	701-840	726-870	751-900	776-930	**$27,667.00**	**$32,083.00**
>30–35	841-980	871-1015	901-1,050	931-1,085	**$19,167.00**	**$23,833.00**
>35–40	981-1,120	1,016-1,160	1,051-1,200	1,086-1,240	**$14,750.00**	**$17,750.00**
>40–45	1,121-1,260	1,161-1,305	1,201-1,350	1,241-1,395	**$13,167.00**	**$15,750.00**
>45–50	1,261-1,400	1,306-1,450	1,351-1,500	1,396-1,550	**$11,750.00**	**$13,583.00**
>50–55	1,401-1,540	1,451-1,595	1,501-1,650	1,551-1,705	**$9,833.00**	**$11,250.00**
>55–60	1,541-1,680	1,596 -1,740	1,651-1,800	1,706-1,860	**$7,917.00**	**$8,917.00**
>60 residents	Above 1,680	Above 1,740	Above 1,800	Above 1,860	**N/A**	**N/A**

Facilities with more than 60 residents are fully funded through AN-ACC to deliver RN care to residents at all times.

For more information on the supplement, including the previously published rates, see [24/7 registered nurse supplement for residential aged care].

5.5 Eligibility for the supplement

Eligibility for the supplement and the amount of the supplement payable is based on facility-level characteristics. However, the supplement is paid through services, as with all other supplements.

Approved providers of eligible facilities do not need to apply for the supplement.

The supplement will be paid automatically by Services Australia to eligible facilities that:

- have no more than 60 residents per day (based on occupied bed days) on average over a calendar month
- provide a minimum of 20 hours of RN coverage a day, on average over a calendar month
- correctly report their RN coverage at the facility by 11:59pm AEST on the 7th calendar day after the end of the month.

The 24/7 RN supplement will be paid each month to approved providers in respect of care recipients who are eligible to receive the supplement.

Advice of payment will be included in the monthly payment statement from Services Australia. As with other aged care subsidies and supplements, the 24/7 RN supplement is paid in advance and reconciled in arrears, with adjustments appearing on future payment statements.

Each service should submit their correctly completed 24/7 RN report before they submit their monthly claim to Services Australia, to ensure the supplement is paid for the current claim cycle and included in advance payment calculations.

Where the 24/7 RN report is submitted within 7 calendar days, but after the service has made their monthly claim, the payment will be reflected as an adjustment in the subsequent claim month.

Where a service does not provide the 24/7 RN report in respect of a facility within 7 calendar days, the supplement will not be paid for the relevant reporting period.

5.6 24/7 RN supplement for co-located services

In line with the supplement applying at the facility level, eligibility for payment of the supplement for co-located services will also be calculated at the facility level.

This means the number of occupied places at each service that make up the facility will be combined for the purposes of assessing the occupancy criterion (that is, up to 60 residents on average over the month). However, as the supplement is paid through services, each service will receive a proportion of the relevant amount of payment (if eligible) based on the number of residents they had in care for the claim month.

If the co-located services have a combined total of more than 60 residents per day, on average, over the month, the facility will not be eligible for the supplement, even if the individual services have less than 60 residents.

5.7 Threshold for the supplement

The minimum average of 20 hours of RN care a day over a calendar month is a temporary lower threshold for the supplement to help facilities transition to the new responsibility. The threshold allows for unplanned absences and gives providers time to recruit RNs to provide full 24/7 RN coverage.

The temporary threshold will be reviewed later in 2023 and on an ongoing basis.

Payment of the supplement to help eligible facilities meet the cost of providing 24/7 RN care is not the same as compliance with the 24/7 RN responsibility. Providers must work towards providing full 24/7 RN coverage as intended by the new responsibility.

5.8 Workforce shortages and alternative models of care projects

The department is undertaking preliminary work to:

- **model aged care RN workforce shortage by region** – this project may lead to the development of a workforce shortages model to help the department better understand workforce shortages by region to better target workforce supports in the future.
- **develop clinically appropriate alternative models of care** – this project will explore alternative staff skill mixes for specialised residential aged care services and services co-located with a health service and alternative arrangements for safe and quality care in aged care homes for times when a RN is not on-site and on duty due to workforce shortages. The final report for this project is expected to be delivered in late 2023.

Section 6: Reporting

6 Reporting

Approved providers of residential aged care services are required to report care time delivered at the service-level in the Quarterly Financial Report (QFR). The QFR is used to assess each service's performance against their care minutes targets.

The responsibility for approved providers of residential care services to provide a QFR was introduced from 1 July 2022, supplementing the annual Aged Care Financial Report (ACFR).

Providers are also required to report their RN coverage in relation to the 24/7 RN responsibility from 1 July 2023 through the Government Provider Management System (GPMS) portal.

6.1 Purpose of QFR reporting

Information reported in the QFR is used to monitor care staffing time to ensure that additional care minute funding that commenced with the implementation of AN-ACC on 1 October 2022 is being appropriately targeted.

This information may be used for purposes including, but not limited to:

- financial and prudential oversight: to track, monitor, and benchmark the sector
- consumer choice and transparency: to provide information, including on care minutes for the purposes of calculating Star Ratings (see Section 7)
- policy development: to inform policy planning and development
- funding and regulation: to inform the AN-ACC pricing model and monitor direct care minutes delivered by aged care services.

Care data reported in the QFR is used to calculate each service's Staffing Star Rating, which contributes to the overall Star Rating for a service. Incomplete or misleading care minutes reporting may impact a service's overall Star Rating.

Providers that submit late or fail to submit their QFR will be referred to the Aged Care Quality and Safety Commission (Commission). The Commission will consider a range of escalating regulatory actions and will closely monitor those providers who consistently fail to meet their legislated reporting obligations.

Regulatory actions may include issuing a non-compliance notice requiring the provider to take specific actions, and/or proportionate enforcement action.

Providers can submit their QFR at any time through the Forms Administration QFR portal from the first day of the following quarter until the legislated due date.

6.1.1 Performance of services

The residential care labour cost and hours reporting section of the QFR captures the direct care-related labour expenses and hours at the service level. Like the ACFR, this is broken down into care types that include RNs, ENs, and PCWs/AINs.

This information will directly inform the:

- performance of services against their care minutes targets
- Staffing Star Rating and contribute to their Overall Star Rating.

This will allow consumers to easily compare and make choices on residential aged care services.

6.1.2 QFR due dates

The legislated QFR due dates are outlined below:

Figure 2 Legislated QFR dates

Approved providers have a legislated responsibility to submit the QFR by the due date for each quarter. The department has no authority to grant an extension to due dates.

Failure to submit a QFR, or to submit by the due date, will result in a 1 Star Staffing Rating and will subsequently affect the service's overall Star Rating.

Care data reported in QFRs submitted after the due date will not be included in the Star Ratings process. This will result in a 1 Star Rating for the Staffing sub-category.

6.2 QFR support

The template for the QFR is available as an excel spreadsheet on the Forms Administration homepage. This template shows the information that needs to be provided on direct care labour hours and direct care labour costs.

Reporting support is also available on this page through the QFR guides, fact sheets, Frequently Asked Questions (FAQs) register, and QFR definitions.

We recommend approved providers review these documents to understand their QFR reporting responsibility. Approved providers are responsible for ensuring that they have appropriate systems in place to collect and provide quality data for this report. Approved providers may wish to consider whether distinguishing care minutes from other tasks in rosters is appropriate for their service.

A help desk is available to assist providers with the residential care labour cost and hours reporting section of the QFR. Send questions on these topics to health@formsadministration.com.au

Approved providers can also access the following videos to help with their care minutes reporting:

- **Care costs and care minutes reporting**
- **Registered Nurse Care Minutes Reporting**

6.2.1 Allied health reporting

Approved providers must report on all staff time in their ACFR and QFR, including time provided by allied health professionals. Allied health is not counted towards care minutes because these services are funded separately under AN-ACC.

See the allied health reporting video to help with reporting time provide by allied health professionals.

6.2.2 Costing activities

Data from the QFR will contribute to costing and pricing activities undertaken by the Independent Health and Aged Care Pricing Authority for the AN-ACC funding model, for ongoing matching of funding to resident needs and equitable distribution of funding.

6.3 Review of data collected in reports

The department has undertaken a review of how care hours are reported in the ACFR and QFR in preparation for the responsibility becoming mandatory in October 2023. This review included the definitions and explored options for enhancements to these reports. Refinements to the QFR and the supporting definitions based on the recommendations have been implemented or are in the progress of implementation.

6.4 24/7 RN responsibility reporting

Approved providers are required to submit a monthly report in respect of each of their residential facilities in relation to the 24/7 RN responsibility. This is a legislated requirement and applies to all residential facilities, including those that have an exemption from the 24/7 RN responsibility.

Approved providers must report the following information in Table 5 via the GPMS portal for each day of the month. The report can be updated and saved daily or completed in its entirety at the end of the month.

Table 5 24/7 RN reporting information

Reason an RN was not on-site and on duty	Description
Whether or not an RN was on-site and on duty at all times.	An RN is considered to be on duty for the purpose of the 24/7 RN responsibility when taking breaks but remaining on-site during a continuous period of work if those breaks are prescribed in their employment conditions. If an RN goes off-site during a break, they are not considered to be on-site and on duty for the purposes of the 24/7 RN responsibility. The particular employment conditions and staffing arrangements at each residential facility to meet the 24/7 RN responsibility are matters for the relevant approved provider. In some circumstances, the same person may work within a facility in more than one role. In order to count towards the 24/7 RN responsibility, a person needs to be engaged by the provider as an RN with their prime purpose for that shift being to provide care to residents and oversight to other staff. Examples of how to determine when an RN is considered on-site and on duty for the purposes of the 24/7 RN responsibility can be found in Appendix 3.

Reason an RN was not on-site and on duty	Description
Every period of 30 minutes or more (e.g. 45 minutes, 2 hours) on a day that an RN was not on-site and on duty at the residential facility and the reason an RN was not on-site and on duty (or both) for each such period.	The reporting system will only support the selection of one 'reason'. If there is more than one reason, approved providers should select the most relevant reason.
Alternative arrangements that were made to ensure the clinical care needs of residents at the residential facility were met while an RN was not on-site and on duty (or that alternative arrangements were not made) for each such period.	The reporting system will only support the selection of one 'alternative arrangement'. If there is more than one alternative arrangement, approved providers should select the main alternative arrangement.

Approved providers can choose one of the following options in Table 6 to explain why an RN was not on-site and on duty.

Table 6 Reasons an RN was not on-site and on duty

Reason an RN was not on-site and on duty	Reason description
Temporary absence – unplanned	A temporary unplanned leave of absence is a period of time during when an employee is away from work unexpectedly. This includes leave resulting from illness, carer's responsibilities and miscellaneous causes, such as deaths, emergencies and any unauthorised absences.
Temporary absence – planned	A temporary planned leave of absence is a period of time during which an employee is away from work with the approval of the employer. This includes leave such as annual and recreational leave, study leave and other planned personal leave.
S/term (short-term) RN vacancy – successful recruitment last 4 weeks	A period of short-term vacancy (up to one months) that cannot be filled by existing staff and recruitment for the role was successful within 4 weeks from when it became vacant.
S/term (short-term) RN vacancy – unsuccessful recruitment last 4 weeks	A period of short-term vacancy (up to one month) that cannot be filled by existing staff and recruitment for the role was unsuccessful for 4 weeks or more from when it became vacant.
Long term RN vacancy – recruitment last 4 weeks	A period of long-term vacancy (more than one month) and recruitment for the role was undertaken within 4 weeks from when it became vacant.
Long term RN vacancy – no recruitment last 4 weeks.	A period of long-term vacancy (more than 3 months) and no recruitment for the role was undertaken within 4 weeks from when it became vacant.

Approved providers can choose one of the following options in Table 7 to describe the alternative arrangements in place while an RN was not on-site and on duty.

Table 7 Alterative arrangements when RN was not on-site and on duty

Alterative arrangements when RN was not onsite and on duty	Alternative arrangement description
Access to RN in co-located health/aged care service	An arrangement with a co-located health care service (such as a hospital or acute care unit) or aged care service to access their RNs for clinical support via phone or in-person attendance.
EN/PCW on site employed at facility	ENs (including EENs) and PCWs employed at the facility are rostered when an RN is not available and can escalate clinical issues and/or deterioration to an on-call GP, NP, or RN for support and advice on management and treatment.
EN/PCW temporary or agency staff on site	ENs (including EENs) and PCWs not employed at the facility are rostered when an RN is not available and can escalate clinical issues and/or deterioration to an on-call GP, NP, or RN for support and advice on management and treatment.
GP/NP/RN on-call can attend in less than 15 mins	An arrangement with a GP, NP, RN (including RNs employed at the facility) or other clinician who can attend the facility within 15 minutes in response to clinical issues and/or deterioration.
GP/NP/RN on call can attend in more than 15 mins	An arrangement with a GP, NP, RN (including RNs employed at the facility) or other clinician who can attend the facility in more 15 minutes in response to clinical issues and/or deterioration.
GP/NP/RN on-call for advice but unable to attend	An arrangement with a GP, NP, RN (including RNs employed at the facility) or other clinician for on-call support and advice (but cannot attend the facility in person) about clinical issues and/or deterioration.
EN/PCW onsite phone/video access to GP/NP/RN	ENs (including EENs) and PCWs employed at the facility or by an agency with phone and/or video access to off-site RN, GP, or NP for advice and support to manage clinical issues and/or deterioration.
EN/PCW onsite & access to specialist telehealth	ENs (including EENs) and PCWs employed at the facility or by an agency with phone and/or video access to specialist telehealth service (such as wound care and palliative care) for advice and support to manage clinical issues and/or deterioration.
Transfer to local health facility incl. ambulance	Resident will be transferred to a local health facility, such a hospital or acute care unit, in the event of clinical deterioration.
Other	Other arrangements, such as linkages with other health services, phone and video access to general telehealth services etc.
No alternative arrangement	Alternative arrangements not in place during the period an RN was not on-site and on duty.

6.4.1 24/7 RN monthly reporting deadline and implications for the 24/7 RN supplement

The *Accountability Principles 2014* require approved providers to submit a report about the 24/7 RN responsibility for each facility (including an exempt facility) within 7 calendar days (including

weekends and public holidays) after the end of the relevant calendar month (or a later date if advised in writing by the department).

Submission of the 24/7 RN report within the 7-day timeframe is required to be eligible for payment of the 24/7 RN supplement (specifically the report needs to be submitted by 11:59pm AEST of the 7th calendar day after the end of the month).

Timely submission of the 24/7 RN report will allow for the supplement to be paid in the current claim cycle and be included in advance payment calculations. Where the 24/7 RN report is submitted within 7 calendar days, but after the approved provider has made their monthly claim, the payment will be reflected as an adjustment in the subsequent claim month.

Where an approved provider does not provide the 24/7 RN report in respect of a facility within 7 calendar days, the supplement will not be paid for the relevant reporting period.

6.4.2 24/7 RN monthly reporting for co-located services

As the 24/7 RN reporting obligation is at the facility level, co-located services will share the responsibility and submit a single report via the GPMS portal.

The department has notified relevant approved providers of co-located services which service is responsible for submitting their monthly reporting for the facility. Only reports submitted by the reporting service in relation to the facility will be considered for the purposes of the 24/7 RN responsibility.

6.4.3 Utilisation of 24/7 RN report data

The data collected in the 24/7 RN report will be used to:

- support the Commission's regulatory activities relating to the 24/7 RN responsibility
- assist the department in determining eligibility for the 24/7 RN supplement for the month
- support the development of future policy regarding the 24/7 RN exemption
- provide consumers with information about 24/7 RN coverage through the My Aged Care website.

A list of registered nurse coverage in residential aged care by facility is available on the department's website. Also available is information by state and territory on the Registered nurse coverage in residential aged care dashboard.

Section 7: Star Ratings

7 Star Ratings

The Star Ratings system provides simple at-a-glance information on residential aged care services to support older people, their families, friends, and carers, to compare services and make informed choices regarding their care options.

Ratings are based on:

- 5 existing quality indicators
- compliance ratings
- consumer experience
- staffing minutes derived from reporting under the QFR.

Star Ratings are made up of an overall quality rating and 4 sub-category ratings, including Staffing (based on care minutes). Staffing is displayed as a rating out of 5 stars. This provides a quick way to compare approved residential aged care services based on the amount of care they deliver.

Star Ratings are published on My Aged Care through the Find a provider menu option.

For more information, including the algorithm for the Staffing Rating, see the Star Ratings Provider Manual.

Section 8: Quality assurance

8 Quality assurance

8.1 Data validation

The department will look closely at provider reporting to ensure only care time that fits within the scope of care minutes as outlined in this Guide is counted.

The department will undertake a data validation process to check the reasonableness of submitted data for care hours and labour costs. These checks will be conducted as QFRs are submitted to the department and will include the following:

- care funding claimed compared with care hours reported
- care funding claimed compared with care expenses reported
- average hourly rates for RNs, ENs and PCWs/AINs compared with average hourly rates reported across the sector
- consistency compared with previously submitted care hours and expense data.

Quality checking will identify discrepancies and questionable patterns that suggest inaccurate information has been reported, or that non-care activities are being counted as care minutes.

8.1.1 Re-submission of data

Providers will be notified in writing if data submitted needs to be reviewed and re-submitted.

Re-submissions must be made within the data validation period, which is approximately 3 weeks from the QFR due date.

The re-submission due date will be advised by the department in the written notice. Providers must re-submit their data by this date to allow the department sufficient time to review the re-submitted data for Star Rating purposes.

Any data that is submitted after the notified re-submission due date will not be accepted.

If providers leave their data unchecked or the re-submitted data has not met the reasonableness checks, it will not be included in the Star Ratings process. This means the service will receive a 1 Star Rating for the Staffing sub-category, which will negatively impact a service's overall Star Rating.

8.2 Worked hours trends

Worked hours data collected for RNs, ENs and PCWs/AINs at the services level through the QFR will be monitored by the department for any trends around hours delivered by ENs over time to determine if providers are reducing ENs' time in favour of PCWs/AINs' time.

In addition, this data will be provided to the Commission, which may use this information along with other regulatory intelligence to monitor the nursing skills mix within services, including whether services have an appropriately qualified EN workforce. Residential aged care providers that have an insufficient nursing workforce are at risk of not meeting Quality Standard 7 and may be subject to regulatory action taken by the Commission.

8.3 Assessment of care time reports

In late 2023, the department introduced an ongoing program of reporting assessments to examine the accuracy of care time data submitted in QFRs/ACFRs and RN coverage data submitted in the

monthly 24/7 RN reports.

This involves cross checking the information submitted in QFRs/ACFRs and 24/7 RN reports against other information sources.

If discrepancies are identified, action may be taken to protect the integrity of the Commonwealth's expenditure and the accuracy of information published through the residential aged care Star Ratings system.

The design of the reporting assessments program involves desktop review activities. Information may be referred to the Commission, for appropriate action, in relation to services that may be at risk of not meeting care time and 24/7 RN responsibilities.

If members of the public have concerns around the accuracy of a provider's 24/7 RN or care minutes reporting these can be raised by emailing anaccreportingassessments@health.gov.au.

8.4 Complaints

Staff, residents, and carers with concerns about level of care may complain to the Commission. Complaints may be lodged online, or by contacting the Commission directly on 1800 951 822. Complaints may be open, confidential, or anonymous. The Commission can also provide support with information and options.

Appendices

Appendix 1: Support

Table 8 Aged care funding reform resources

Information source	Description
Resources	Resources are located here.
Social media	Follow us on Facebook, X, LinkedIn and Instagram.
Subscriptions	Subscribe to the department's newsletters here for aged care updates.
Ageing and Aged Care Engagement Hub	Find engagement activities and register interest to be involved in workshops, focus groups, webinars, and surveys. Website: https://www.agedcareengagement.health.gov.au/
My Aged Care service provider and assessor helpline	For help with the My Aged Care system or technical support for providers and assessors. Phone: 1800 836 799 The helpline is available from 8:00am to 8:00pm Monday to Friday and 10:00am to 2:00pm Saturday, local time across Australia.

QFR-related guides, fact sheets, FAQs, and definitions are available on the Forms Admin homepage.

The department has established a help desk to assist providers with the residential care labour cost and hours reporting section of the QFR. Questions in relation to the QFR can be sent to health@formsadministration.com.au.

The following videos are also available to help with care minutes and allied health reporting responsibility:

- QFR Guide – Care Costs and Care Minutes Reporting for Residential Aged Care Providers
- QFR Guide – Registered Nurse Care Minutes reporting for Residential Aged Care Providers
- QFR Guide – Allied Health reporting for Residential Aged Care Providers.

Appendix 2: Care worker examples for care minutes

Lifestyle Staff

Liza - Lifestyle Activities Officer, Level 3 Award

Liza is employed as a Lifestyle Activities Officer at Service X and spends her day providing recreational and lifestyle services to residents including spending time with residents and planning and assisting with recreational and social activities and facilitating community participation. She also assists residents to decorate their rooms, organises craft activities for residents, and helps them engage in community activities outside the service and social gatherings in the service.

For the purposes of reporting of care minutes, care time provided by a Lifestyle Activities Officer are not care minutes. Liza's time worked in her role as a Lifestyle Activities Officer is captured under the Lifestyle heading in the QFR.

Registered Nurse and Care Management Staff

Beth - Registered Nurse and Care Manager

Beth is a qualified Registered Nurse and is employed as a Care Manager at Service X. Beth spends 60 per cent of her time undertaking administrative duties such as staff training, rostering, recruitment, facility-level planning and managing communication in the multidisciplinary team. This is not considered as direct care and time spent doing these activities are not care minutes. Beth spends the other 40 per cent of her time providing high-level clinical advice to residents and families, assessing residents' clinical needs, and overseeing and developing individual care plans for residents. This is considered direct care and is therefore care minutes.

Enrolled Nurse

Georgia – Enrolled Nurse

Georgia has a Diploma of Nursing and is employed as an Enrolled Nurse at Service X. Georgia spends 100 per cent of her time administering medication under the guidance of a RN; checking and recording residents' temperature, pulse, blood pressure, and respiration; and helping residents with their activities of daily living. This is considered direct care and is reported as care minutes.

Personal Care Worker and Assistant in Nursing Staff

Ingrid - Grade 1 Personal Care Worker, Level 2 Award

Ingrid is employed as a Personal Care Worker at Service X and spends most of her time (80 per cent) attending to the basic daily needs of residents including bathing and washing residents, dressing residents, helping residents eat, assisting residents with toileting and accompanying residents on daily outings to assist with these basic daily needs. This is considered direct care and is therefore care minutes. Ingrid also helps in the kitchen (20 per cent of her time) as a Kitchen Assistant with food prepping for residents. For example, Ingrid sometimes helps the Chef to plate up food and serves food to residents in the dining room. This is not considered direct care and cannot be counted towards care minutes.

Kate - Grade 2 Personal Care Worker/Lifestyle Activities Officer, Level 3 Award

Kate is employed as a Grade 2 Personal Care Worker and Lifestyle Activities Officer, Level 3 Award at Service X and spends half of her rostered time on duty (50 per cent) attending to the basic daily needs of residents including toileting, bladder, and bowel management, helping residents with mobility, and transferring and caring for existing pressure areas. While attending to their basic daily needs, Kate also provides social and emotional support to residents by listening to their concerns and feelings to provide person-centered holistic care. This is considered direct care and can be counted towards care minutes.

Kate spends the other half of her day (50 per cent) as a Lifestyle Activities Officer, organising and running

activities and social outings, including community events outside the service. The time Kate spends performing these duties is not considered direct care and cannot be counted towards care minutes.

Frank - Grade 3 Personal Care Worker, Level 4 Award

Frank is employed as a Grade 3 Personal Care Worker and is also a qualified Handyperson as per Level 5 Award at Service X. Frank spends most of his time attending to the basic daily needs of residents and assisting residents with feeding, bathing and washing, dressing, getting in and out of bed, getting to and from the toilet and continence management, routine hygiene and shaving or personal grooming. Frank also spends a few hours every week maintaining the gardens. Only the portion of time that Frank spends with residents attending to their basic daily needs can be counted towards care minutes. The time Frank spends on duty as a gardener cannot be counted towards care minutes.

Melanie - Grade 4 Personal Care Worker, Level 5 Award

Melanie is employed as a Grade 4 Personal Care Worker at Service Y which is run as a household model. The model sees around 20 residents live as part of a household, with a shared kitchen, dining room, and living room. There are no set routines for residents, with the emphasis on making the service like a home. Melanie spends around 40% of her time undertaking personal care tasks such as assisting with eating and drinking and bathing and washing residents, around 10% or her time planning and leading lifestyle activities, and the other 50% of her time working with food preparation and cleaning of the facility. As only 40% of Melanie's time is spent undertaking Personal Care Worker activities, only 40% of her hours can be counted towards care minutes, even though she is employed as a Personal Care Worker under the award.

Peter – Nursing Assistant (or Assistant in Nursing), 3rd year

Peter is employed as an Nursing Assistant (as per the Nurses Award 2020) 3rd year classification at Service X. Peter spends his time attending to the basic daily needs of residents, under the direction and supervision of Registered Nurses and Enrolled Nurses, including assisting with positioning and mobility care. He also applies simple wound dressings, tests residents' blood sugar levels and assists in the collection of residents' clinical data such as weighing and measurements and clinical observations. All the duties performed by Peter in this role are considered direct care and can be counted towards care minutes.

Clinical Funding Manager

Miles – Enrolled Nurse and Clinical Funding Manager

Miles is a qualified Enrolled Nurse and employed in a hybrid role both caring for residents and performing a funding management role at Service X. Miles spends around 50 per cent of their time undertaking assessments of residents for the purposes of finding opportunities for AN-ACC reclassifications to achieve higher funding levels. These activities are not considered direct care and therefore should not be reported as care time. Miles spends the other 50 per cent of their time caring for and monitoring residents including attending to their basic daily needs such as toileting, helping with mobility and monitoring vital signs. These activities are considered direct care and should be reported as enrolled nurse care time.

Appendix 3: 24/7 RN responsibility on-site and on duty

Scenario 1: hybrid role - RN and Care Manager

Beth is a qualified RN and is employed as a Care Manager. As Beth's primary role is care manager, her time working in that role does not generally count towards the 24/7 RN responsibility. However, at times Beth covers some shifts, or part shifts where the regular RNs are not available. At these times, Beth's primary role is to care for residents and oversee care provided by other staff as needed, and as such this time counts towards the 24/7 RN responsibility.

Scenario 2: hybrid role - RN and Service Manager

Caroline is trained as an RN and after completing her MBA qualification now works as a Service Manager for 2 residential aged care services which are run by the same approved provider. She works in the office located in the largest residential care service in her management role. As Caroline is registered with the Nursing and Midwifery Board of Australia (NMBA) as an RN, she occasionally works some shifts as an RN in the facilities she manages and provides clinical care to care recipients, for example when the rostered RN is unavailable.

The 2 RNs rostered for the 8-hour morning shift at the same service where Caroline works have both called in sick. An agency RN is available to cover the second half of the morning shift. Caroline is only available to provide care to care recipients for the first 2 hours of the shift, setting aside her work as the service manager. After that, she must resume her role as service manager to attend an off-site meeting and is therefore no longer considered to be on-site and on duty for the purposes of the 24/7 RN responsibility. This means there is a 2-hour gap in RN coverage before the agency RN arrives. The approved provider must record the 2-hour gap in 24/7 RN coverage at the residential facility when no RN was on-site and on duty.

Scenario 3: Service Manager was formerly an RN

Justine is the manager of a residential facility. She used to be an RN but her registration with the NMBA has lapsed. Justine cannot cover any unexpected RN absences in a capacity as a RN, nor can her time working at a residential facility be counted towards the 24/7 RN responsibility.

Scenario 4: The RN is running late

Jo is an RN whose car breaks down on the way to work and it takes 45 minutes to arrange a tow driver and transport to the residential facility. Since there are no RNs available on-site to provide care to care recipients while Jo is off-site, the approved provider must record the 45-minute absence in the monthly 24/7 RN report.

Scenario 5: The RN leaves for part of a shift

Simone is an RN. She schedules a break for an hour with her manager's approval to attend her child's school assembly, which is away from the residential facility. While Simone is off-site, if another RN is not on-site and on duty, the approved provider must report the one-hour absence in the monthly 24/7 RN report.

Scenario 6: An RN is on-site but not on duty

Michael and Simone are RNs who are undertaking further study and are required to complete an online workshop as part of their training requirements. During the training period, Michael and Simone are unable to provide care to care recipients and oversee care provided by other staff at the residential facility at which they work. If the approved provider is unable to organise another RN to be on-site and on duty during the time that Michael and Simone are at training, the approved provider must record the absence of an RN for the period in their monthly 24/7 RN report.

Scenario 7: The RN is absent but there is an EN on-site

The rostered RN has been unable to make their shift. Gloria is an EN and has nearly completed her RN

training. Gloria offers to cover the shift. The approved provider is still required to report the absence of an RN in their monthly 24/7 RN report and Gloria cannot carry out duties restricted to fully qualified RNs.

Scenario 8: Co-located services that operate as a single residential facility

Sally works the late shift as an RN in services A and B, which are located in adjoining properties and operated by the same approved provider. Services A and B operate in practice as a single facility with shared staffing, shared management, common policies and procedures and easy access between the 2 services. The Department considers the 2 services comprise one residential facility, which means that when Sally is on site and on duty, her time can be counted towards an approved provider meeting its 24/7 RN responsibility in respect of that facility for both services.

Scenario 9: Aged care service is located in a facility with a health service

Amanda is an RN who works in a small rural residential facility with both a residential aged care service and a health service, and therefore the facility has a purpose of providing residential aged care. She is employed to work across the 2 services as needed, but generally spends around 40 per cent of her time doing work related to the residential aged care residents and the remaining 60 per cent of her time doing work related to the health service. She is available flexibly to provide care to care recipients and oversee care provided by other care staff at any time during a shift.

As she is working in a residential facility, employed to work across the aged care and health services and is available to provide care to aged care recipients as needed, Amanda is considered to be on-site and on duty for the purposes of the 24/7 RN responsibility. However, only the time Amanda spends providing care to care recipients of the residential aged care service (and not those in the health service) will be able to count towards the RN care minutes responsibility in future.

Scenario 10: RN has accommodation at the residential facility

Pari is an RN who moved to a regional town to take up a role at the aged care facility. As part of her employment, she was offered accommodation on-site at the residential facility.

The facility was unable to find an RN to fill a night shift on a particular night. Although she had already worked a shift that day, Pari agreed to be on-call overnight. Staff could wake her to deal with an emergency if one arises. Pari is considered to be on-call but not on duty for the night shift and as such does not count towards the 24/7 RN responsibility. The approved provider must record the absence of an RN for the whole shift, unless Pari is called to provide care to a care recipient, in which case she is considered to be on-site and on duty for the period of time she is providing care.

Appendix 4: Previous allocations of care minutes by AN-ACC and respite class

Table 9 Care minutes allocations associated with each AN-ACC class from October-December quarter of 2022 to July-September quarter of 2023

AN-ACC class	Total care minutes allocation per day	Registered nurse minutes allocation per day
Class 1	284	53
Class 2	135	32
Class 3	157	34
Class 4	139	30
Class 5	169	39
Class 6	166	35
Class 7	189	37
Class 8	200	38
Class 9	200	44
Class 10	261	52
Class 11	254	41
Class 12	250	42
Class 13	284	53

Table 10 Care minutes allocation associated with each respite class from October-December quarter of 2022 to July-September quarter of 2023

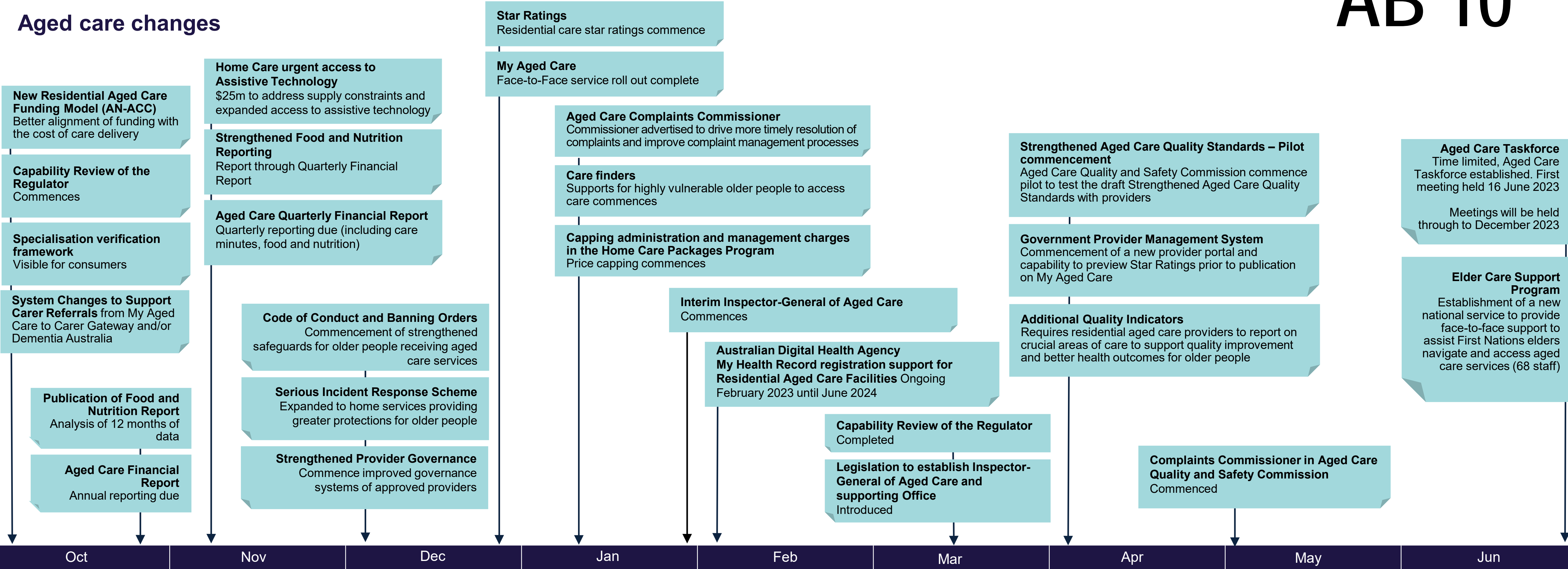
Respite class	Total care minutes allocation per day	Registered nurse minutes allocation per day
Class 101	137	33
Class 102	173	37
Class 103	257	46

Australian Government
Department of Health and Aged Care

Aged Care Reform Activity to 30 June 2023

Version: V2 .0
Last updated: 12 October 2023
Subject to change

AB 10



Subordinate legislation: Implementing Aged Care Reforms Consultation (1 Nov – 30 Apr)

Subordinate legislation: Royal Commission Response Act Consultation (1 Sep – 30 Nov)

Inspector-General Bill Consultation (5 Dec – 27 Jan)

Accommodation design in residential aged care Workshops (19 Sep – 31 Jan)

Aged Care Data Strategy Consultation (5 Oct – 30 Nov)

National Dementia Action Plan Consultation (1 Dec – 31 Jan)

Aged Care Regulatory Framework Design Consultation (starts Oct)

SIRS Expansion explanatory paper Available (1 Nov – 15 Nov)

Aged Care Workforce Roundtables (5 – 6 Dec)

CHSP Specialist Support Services Workshops (10 – 17 Oct)

Short-term restorative care Survey (17 Oct – 14 Nov)

ACAR transition Workshops (17 Nov – 9 Dec)

Sector Support and Development Community of Practice (went live 18 Nov)

First Nations comms planning Consultation (14 Nov – 31 May)

In-Home Aged Care Discussion paper & workshops (18 Oct – 22 Nov)

Quarterly Financial Report Webinar (8 Dec)

Quality Standards Consultation (17 Oct – 25 Nov)

In-Home Aged Care Webinar #3 (7 Dec)

Aged Care Data Strategy Webinar (5 & 7 Oct)

Independent Capability Review ACQSC Consultation (31 Oct – 2 Dec)

Digital Transformation Tech Talk Webinar (6 Dec)

Aged Care Volunteer Visitor's Scheme Grant round Webinar (19 Oct)

AN-ACC Webinar (17 Nov)

Star Ratings Webinar (18 Nov)

Overview of Aged Care Reforms for PHNs (6 Dec)

Workforce- Webinar #2 with DEWR (26 Oct)

Communicating with Diverse Audiences Webinar (29 Nov)

Home Care Packages Admin's cap & management charges Webinar (1 Dec)

Dementia Respite Grant Webinar (12 Dec)

NSW Seniors Festival Expo (2 – 3 Feb)

Care & Ageing Well Expo Melbourne (11 – 12 Feb)

National Volunteering Conference Reform stand (13 – 14 Feb)

Aged Care survey for older people Survey (8 Feb – 24 Mar)

In-Home Aged Care Targeted consultation on policy proposition consultation (end Jan – end Feb)

Carer Gateway - Workshops on Streamlining respite bookings (Feb)

Workforce Webinar (1 Feb)

Closing the Gap Day Adelaide (16 March)

COTA Seniors Expo Katherine (Mar)

24/7 registered nurse responsibility – Exemption process Webinar (15 Mar)

AC Volunteers Visitors Scheme briefing Webinar (28 Mar)

Home care workforce support – Webinars: QLD 2/3, NSW/ACT 7/3, VIC/TAS 16/3, SA/NT 23/3, WA 30/3

Digital Transformation Tech Talk Webinar (2 Mar)

Nursing & Health Expo Melbourne (1 Apr)

ACCPA Queensland State Conference Gold Coast (18-20 Apr)

A new model for regulating aged care Consultation (Apr - May)

Home Care Package inclusions & exclusions Webinar (4 & 18 Apr)

24/7 registered nurse responsibility - Exemption process Webinar (12 Apr)

Digital Transformation Tech Talk Webinar (19 Apr)

ANZSGM Conference (10 – 12 May)

AgFest TAS (4-6 May)

Aged Care Digital Transformation Forum (23 – 24 May)

Aged Care Provider Workforce Survey (end Apr – mid Jun)

ACCPA NSW State Conference Sydney (29 – 31 May)

COTA NT Seniors Expo – Darwin (27 May)

Australian Dementia Research Forum (29–31 May)

A new model for regulating Aged Care – Webinar (9 May)

Residential Aged Care Funding Budget Update Webinar (16 May)

Reforming In-Home Aged Care Webinar (18 May)

Digital Transformation Tech Talk Webinar (24 May)

ACQSC National Provider Conference (8-9 Jun)

Seniors Lifestyle and care expo, Bundaberg (9 Jun)

ACCPA conferences – (VIC 13 Jun, WA 30 Jun)

6th Annual Future of Aged Care Summit (21-23 Jun)

Residential Aged Care 24/7 RN Responsibility Webinar (1 Jun)

Aged Care industry Labour Agreement Webinar (15 Jun)

Aged Care Wage Increase Webinar (15 Jun)

Upcoming reporting requirements Webinar (30 Jun)

Readiness activities

Key
- Consultation
- Webinar
- Event

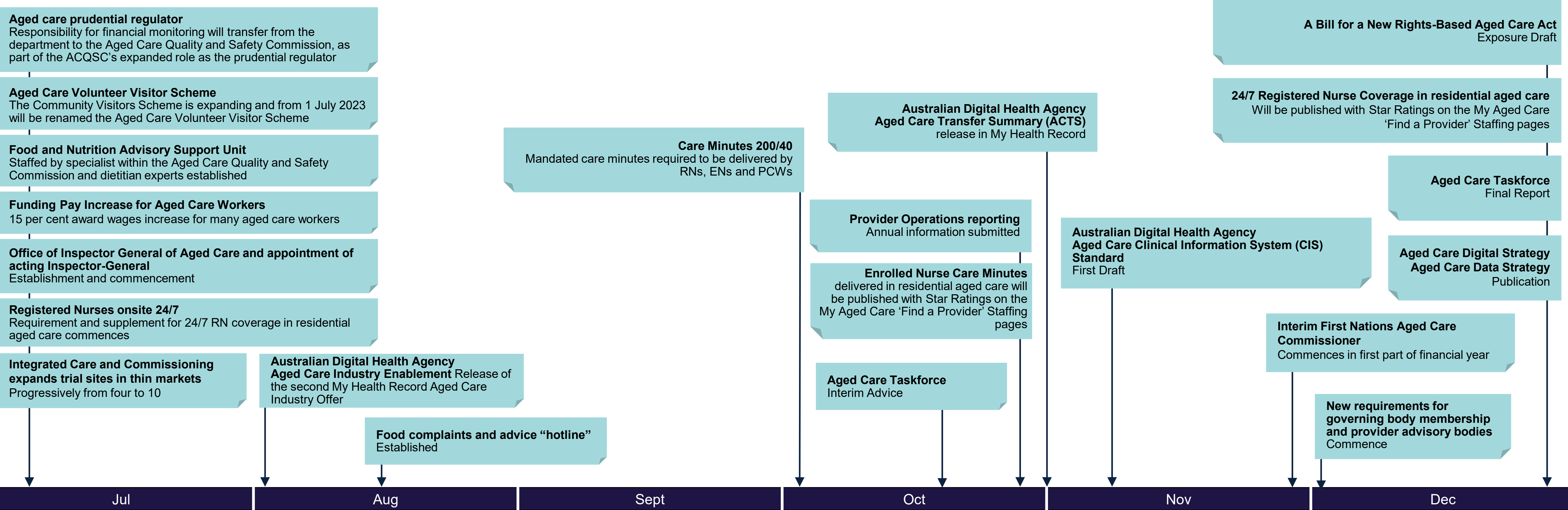
The Aged Care Reform Activity roadmap represents a point-in-time overview of major reform activities. Actual timing and activities are dependent on a number of factors and are subject to change.

Australian Government
Department of Health and Aged Care

Aged Care Reform Activity Jul to Dec 2023

Version: V2 .0
Last updated: 12 October 2023
Subject to change

Aged care changes



Accommodation Framework
Infrastructure Stocktake Survey and opportunity to provide feedback on draft National Aged Care Design Principles and Guidelines (Aug - Sep)

Support at Home Targeted engagements with stakeholders' (Oct 2023 to Mar 2024)

Support at Home
Trial of assessment tool (Jul)

Draft Aged Care Digital Strategy
Consultation (Aug – Oct)

Support at Home
Consultation on higher levels of care at home (Nov)

Foundations of the New Aged Care Act
Consultation (4 Aug – 8 Sep)

Accommodation Framework Architectural Design Ideas Competition (Oct 2023 – Mar 2024)

Aged Care Taskforce Draft aged care funding principles (4 Aug - 31 Aug)

COTA and OPAN Consultations on the Foundations of the New Act and the Taskforce funding principles (Aug - Sep)

Jul
- **Townsville Aged Care Expo** (4 Jul)
- **Musgrave Park Family Day Brisbane** (7 Jul)
- **Aged and Community Care Reform Summit –** Sydney (19 – 20 July)
- **Home Care assurance review** Webinar (27 Jul)
- **Digital Transformation** Tech Talk Webinar (5 Jul)

Aug
- **Positive Ageing Expo Cairns** (2 Aug)
- **National Nursing Forum Adelaide** (9 -11 Aug)
- **Care Expo Melbourne** (11 - 22 Aug)
- **Care and Ageing Well Expo Perth** (12-13 Aug)
- **COTA Seniors Expo Alice Spring** (22 Aug)
- **Catholic Health Australia** Conference (28 - 30 Aug)
- **New Aged Care Act.** Webinar (10 Aug)
- **Improving quality of Residential Care** Webinar (24 Aug)
- **Digital Transformation** Tech Talk Webinar (16 Aug)

Sept
- **Brisbane Care** Expo (1 – 2 Sep)
- **Aged Care Quality Safety and Risk Forum** (12 -13 Sep)
- **Home Care Reform Forum** (12-13 Sep)
- **Illawarra Dementia Forum** (20 Sep)
- **COTA Seniors Festival Canberra** (21 Sep)
- **Oceanic Palliative Care Conference – Sydney** (13 – 15 September)
- **Mandatory Care Minutes 200/40** Webinar (5 Sep)
- **Digital Transformation** Tech Talk Webinar (7 Sep)

Oct
- **Celebration Day VIC** (Oct)
- **Disability Ageing & Lifestyle Expo** Adelaide (13-14 Oct)
- **ACCPA National Conference** (25 - 27 Oct)
- **Quarterly Financial Reporting – What's Changed** Webinar (5 Oct)
- **Aged Care COVID-19 Outbreak Supports** Webinar (10 Oct)
- **Aged Care Data and Digital Strategy – Workforce** Webinar (24 Oct)

Nov
- **Australian Association of Gerontology Conference , Gold Coast** (14 – 17 Nov)
- **Care Expo Sydney** (10 – 11 Nov)
- **Aged Care Workforce Leaders Forum Sydney** (14 -15 Nov)
- **Have a Go Day Perth** (15 Nov)
- **National Aged Care Alliance Conference**(16-17 Nov)
- **National Multicultural Health and Wellbeing Conference, Sydney** (21 - 22 Nov)
- **Digital Transformation** Tech Talk Webinar (1 Nov)
- **Improving quality of care in residential aged care** Webinar (2 Nov)
- **Aged Care Data and Digital Strategy – Consumer** Webinar (7 Nov)
- **Quarterly Financial Reporting – launch on GPMS and greater transparency** Webinar (28 Nov)

Dec
- **Digital Transformation** Tech Talk Webinar (6 Dec)
- **Support at Home 18 months to go** Webinar (14 Dec)

Readiness activities

Key
- Consultation
- Webinar
- Event

The Aged Care Reform Activity roadmap represents a point-in-time overview of major reform activities. Actual timing and activities are dependent on a number of factors and are subject to change.

Australian Government
Department of Health and Aged Care

Aged Care Reform Activity Jan 2024 to Dec 2025

Version: V2 .0
Last updated: 12 October 2023
Subject to change

Aged care changes

Home Care Workforce Support Program Goal of approximately13,000 new personal care workers recruited over past 2 years to support growth in Aged Care including In-Home Aged Care (Mar 2024)

Increased transparency Publication of increased information about residential and home care providers' finances and operations on My Aged Care (Feb 2024)

Australian Digital Health Agency My Health Record registration support for Residential Aged Care Facilities Ongoing February 2023 until June 2024

Residential aged care places assigned to people Greater choice and control over which approved provider delivers their care

Elder Care Support Program National service to provide face-to-face support to assist First Nations elders navigate and access aged care services (110 staff)

July 2024:

New Regulatory Model Commences

Quality Standards Commence

Commonwealth Home Support Programme 12 month grant extension

National Worker Screening for Aged Care Commences

Accommodation Framework Commencement of New National Aged Care Design Principles and Guidelines to create more home like environments which better meet the needs of residents

Single Assessment System Commences

New Rights-Based Aged Care Act Passage of the new Aged Care Act

Care Minutes 215/44 Improve access to direct clinical care for older people in residential care (Oct 2024)

Elder Care Support Program Full establishment of a new national service to provide face-to-face support to assist First Nations elders with 250 staff across Australia (Apr 2025)

July 2025:

Expansion of the National Aged Care Mandatory Quality Indicator Program To include enrolled nurses, allied health and lifestyle staffing measures in residential aged care and work to expand quality indicators to In-Home aged care

English language and ongoing training requirements for Personal Care Workers Commence

Support at Home Program A seamless system of care with choice for older people

First Nations Aged Care Assessment System Commences

2024												2025											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec

Readiness activities

Support at Home Targeted engagements with stakeholders' Consultation (Oct 2023 – Mar 2024)

Support at Home online engagements with older people (July 2023 – Mar 2024)

Accommodation Framework Architectural Design Ideas Competition (Oct 2023 – Mar 2024)

Support at Home NSW trial of Assistive Technology (Mar)

Single Assessment System National Training Tour (Mar)

Support at Home Roadshow (May – Jun)

Support at Home Webinar # 6 (Jun)

Support at Home Webinar # 7 (Dec)

Support at Home National Training Tour (Mar)

Support at Home Roadshow (April)

Support at Home Webinar # 8 (Mar)

Support at Home Webinar # 9 (June)

Key
- Consultation
- Webinar
- Event

The Aged Care Reform Activity roadmap represents a point-in-time overview of major reform activities. Actual timing and activities are dependent on a number of factors and are subject to change.

IN THE FAIR WORK COMMISSION

Matter No.:	**AM2020/99, AM2021/63 & AM2021/65**
Re Applications by:	**Australian Nursing and Midwifery Federation and others**

FURTHER STATEMENT OF JULIANNE BRYCE

I, Julianne Bryce of Level 1 365 Queen Street, Melbourne in the State of Victoria say:

1. I am a member of the ANMF and I make this statement based on my experience as a registered nurse in the nursing profession and an employee of the ANMF. I have held the position of Senior Federal Professional Officer of the ANMF since December 2008.
2. This statement is to be read together with my previous statement in these matters dated 29 October 2021 (**my previous statement**) adopting the definitions used therein.

Educational accreditation standards

3. The National Law legislates the National Registration and Accreditation Scheme (NRAS) for health practitioners. Section 4(3) of the National Law sets out the scheme's six objectives, which include:
   a. to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.
4. As identified in my previous statement, the Australian Nursing and Midwifery Accreditation Council (ANMAC) was appointed under the National Law to ensure that programs of study leading to registration or endorsement as a nurse or midwife in Australia meet the Nursing and Midwifery Board of Australia's (NMBA) approved accreditation standards. ANMAC is the independent accreditation authority for nursing under the NRAS.
5. To become a registered nurse, enrolled nurse or nurse practitioner in Australia an individual must first complete a program of study accredited by the ANMAC and approved by the

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NMBA. ANMAC has published the following accreditation standards:

a. *Registered Nurse Accreditation Standards 2019* (**JB 1**);

b. *Enrolled Nurse Accreditation Standards 2017* (**JB 2**); and

c. *Nurse Practitioner Accreditation Standards 2015* (**JB 3**).

6. ANMAC uses the accreditation standards to evaluate education programs against these standards before making recommendations on their acceptance to the NMBA in line with section 48 and 49 of the Schedule to the National Law.

7. Education providers who deliver registered nurse and nurse practitioner ANMAC accredited and NMBA approved programs must be registered with the Tertiary Education Quality and Standards Agency (TEQSA) as a university or higher education provider. Education providers who deliver enrolled nurse ANMAC accredited and NMBA approved programs must be registered with the Australian Skills Quality Authority (ASQA) or other state regulator, as an Australian Registered Training Organisation (RTO) with a listing on the national register for training in Australia of an approved scope that incorporates the qualification of Diploma of Nursing under the current National Health Training Package at Australian Qualification Framework (AQF) Level 5.

8. The *Registered Nurse Accreditation Standards*, Standard 1 (Safety of the public) at 1.2 stipulates that the program is delivered in Australia to prepare graduates for safe and ethical practice. Standard 3 (Program of study) provides at 3.5(a) that the program's content and subject learning outcomes ensure achievement of the NMBA *Registered Nurse Standards for Practice*. The NMBA *Registered Nurse Standards for Practice* are contained in the ANMF tender bundle at ANMF 23.

9. The *Enrolled Nurse Accreditation Standards*, Standard 4 (Program content) and Standard 5 (Student assessment) stipulate that the program content and assessment must comprehensively address and robustly measure student achievement of the NMBA *Enrolled Nurse Standards for Practice*. The *NMBA Enrolled Nurse Standards for Practice* are contained in the ANMF tender bundle at ANMF 24. Further, Standard 8 (Management of workplace experience) at 8.7 stipulates that assessment of student practice against the NMBA *Enrolled nurse standards for practice*, within the context of workplace experience, is undertaken by an appropriately qualified registered nurse.

10. To apply to become a nurse practitioner in Australia, registered nurses must first have completed a program of study accredited by ANMAC and approved by the NMBA. Programs of study eligible for accreditation are delivered by a TEQSA accredited university or other higher education provider. These programs lead to the award of a Master of Nurse

Practitioner. The *Nurse Practitioner Accreditation Standards*, Standard 4 (Program content) and Standard 5 (Student assessment) stipulate that the program content and assessment must comprehensively address and robustly measure achievement of the NMBA *Nurse Practitioner Standards for Practice*. The NMBA Nurse Practitioner Standards for Practice are contained in the ANMF tender bundle at ANMF 75. Further, Standard 8 (Management of integrated professional practice) at 8.7 stipulates that clearly articulated models of supervision, support, facilitation and assessment must be in place so students can meet the NMBA *Nurse Practitioner Standards for Practice*.

Standards for practice

11. All nurses have a responsibility to provide high quality, safe and competent nursing care consistent with the national Professional Practice Framework. Nurses have a professional responsibility to meet the NMBA Standards for practice and to have a contemporary knowledge and skill base in order to deliver safe nursing care.
12. As regulated health practitioners, registered nurses (RNs) are responsible and accountable to the NMBA. The NMBA *Registered Nurse Standards for Practice* are for all RN's across all areas of practice. They are to be read and applied in conjunction with other NMBA national professional practice framework documents including the:
    a. *Code of conduct for nurses* (ANMF 76);
    b. *NMBA Decision-Making Framework for Nursing and Midwifery,* as contained in the ANMF tender bundle at ANMF 78, but updated in August 2022. The updated *NMBA Decision-Making Framework for Nursing and Midwifery* is **JB 4**.
    c. *Ahpra and National Boards Supervision guidelines and Supervised practice framework* (**JB 5** and **JB 6** respectively);
    d. *Guidelines for mandatory notifications* (ANMF 81(c)); and
    e. *NMBA Registration standards – Criminal history, English language skills, Continuing professional development, Recency of practice, Professional indemnity insurance arrangements and Endorsement as a nurse practitioner* (ANMF 83, ANMF 84, ANMF 85, ANMF 86, ANMF 87 and ANMF 88).
13. Together with the NMBA standards, codes and guidelines, the *Registered Nurse Standards for Practice* should be evident in current practice, and inform the development of scopes of practice of all RN's.
14. The *Registered Nurse Standards for Practice* articulate the expectations of RN practice. They inform the education standards for RNs; the regulation of nurses and determination of the

nurse's capability for practice; and guide the public, employers and other stakeholders on what to reasonably expect from an RN, regardless of the area of nursing practice or years of nursing experience.

15. A RN Level 1, pay point 1 would not be subject to required supervision unless there is a condition or undertaking on their registration.
16. Provisional registration (usually for a period of 12 months) is generally granted by the NMBA to allow those who have not practised as a nurse or midwife for between 5 to 15 years and have previously held registration in Australia, are not currently registered and are now seeking to re-enter practice to complete a period of supervised practice or an NMBA approved re-entry to practice program.
17. As regulated health practitioners, enrolled nurses (EN's) are responsible and accountable to the NMBA. The *Enrolled Nurse Standards for Practice* are the core practice standards that provide the framework for assessing EN practice. They communicate to the public the standards that can be expected from all EN's. These standards reflect the role of the EN within the health environment. The EN works with the RN as part of the health care team and demonstrates competence in the provision of person-centred care. Core practice requires the EN to work under the direct or indirect supervision of the RN. At all times, the EN retains responsibility for his/her actions and remains accountable in providing delegated nursing care. The need for the EN to have a named and accessible RN at all times and in all contexts of care for support and guidance is critical to the delivery of safe nursing care.
18. Nurse practitioners (NP's) provide high levels of clinically focused, autonomous nursing care in a variety of contexts in Australia. The NP scope of practice is built on the platform of RN scope of practice and must meet the regulatory and professional requirements for Australia (the national professional practice framework). The *Nurse Practitioner Standards for Practice* build and expand on those required of an RN. NP's practice at an advanced practice level. They can practice independently and work collaboratively with other health practitioners and health professionals. The *Nurse Practitioner Standards for Practice* are the minimum standards expected of NP's across diverse practice setting and populations for both beginning and experienced NP's.

Julianne Bryce

1 November 2023

Australian Nursing & Midwifery Accreditation Council

JB 1

Registered Nurse
Accreditation Standards 2019

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Acknowledgements

The Board of the Australian Nursing and Midwifery Accreditation Council (ANMAC) gratefully acknowledges the expertise, time and commitment contributed by each member of the Professional Reference Group (PRG) and ANMAC staff, to review and update these Registered Nurse Accreditation Standards.

PRG membership comprised:

- Professor Phillip Della, Educationalist, PRG Chair
- Mr Ethan Althofer, Consumer
- Professor Melanie Birks, Dean/Head of School of Nursing and Midwifery Education Sector (Regional)
- Ms Bronwyn Clark, Health Professions Accreditation Council Collaborative Forum
- Ms Petrina Halloran, Nursing and Midwifery Board of Australia
- Professor Amanda Henderson, senior nursing academic
- Ms Ann Maree Keenan, Australian and New Zealand Council of Chief Nursing and Midwifery Officers
- Ms Julie Reeves, Australian Nursing and Midwifery Federation
- Ms Kathryn Riddell, Australian College of Nursing
- Ms Kim Ryan, mental health nurse/advisor
- Dr Lynne Stuart, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Professor Donna Waters Dean/Head of School of Nursing and Midwifery (Metro)
- Dr Margaret Gatling, Director Accreditation Services
- Dr Wendy Penney, Associate Director Accreditation Services.

ANMAC staff:

- Adjunct Associate Professor Jan Taylor, Consultant
- Ms Frances Rice, Project Lead
- Ms Louise Straughair, Secretariat (to October 2018)
- Ms Kim Porozny, Secretariat (from October 2018).

ANMAC also acknowledges the individuals and organisations who contributed by participating in consultations.

ANMAC commends these accreditation standards to the Nursing and Midwifery Board of Australia (NMBA) and acknowledges the support of the NMBA in their review and revision.

1. Preamble

To become a registered nurse in Australia an individual must first complete a program of study accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the Nursing and Midwifery Board of Australia (NMBA).

ANMAC uses accreditation standards to accredit and assess programs of study leading to eligibility to apply to the NMBA for registration as a registered nurse.

These Registered Nurse Accreditation Standards 2019 standards replace the Registered Nurse Accreditation Standards 2012. (1)

Education providers who deliver ANMAC accredited and NMBA approved programs, must be registered with the Tertiary Education Quality and Standards Agency as a university or higher education provider.

The *Health Practitioner Regulation National Law Act 2009* (the National Law) (2) legislates the National Registration and Accreditation Scheme for health practitioners.

Section 4(3) of the National Law sets out the scheme's six objectives:

a. to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and

b. to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

c. to facilitate the provision of high-quality education and training of health practitioners; and

d. to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and

e. to facilitate access to services provided by health practitioners in accordance with the public interest; and

f. to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

These objectives (particularly a, c, and f) and the Australian Health Practitioner Regulation Agency's Procedures for the development of accreditation standards (3) underpinned the review of these standards.

Wide-ranging consultation was undertaken for the review of the standards. Stakeholders had the opportunity to contribute in three separate consultations. Stakeholders could contribute through an online survey, written submission or face-to-face.

The Council of Australian Governments (COAG) Principles for Best Practice Regulation (4) were considered during the review. The Office of Best Practice Regulation assessed the requirement for a regulatory impact statement.

2. Background

2.1 Review of the Registered Nurse Accreditation Standards

ANMAC reviews accreditation standards based on:

- its protocol for the review and development of accreditation standards (5)
- Australian Health Practitioner Regulation Agency's Procedures for the development of accreditation standards (3) which include the COAG Principles for Best Practice Regulation (4).

Principle 6 of the Best Practice Regulation requires regulations to be reviewed from time-to-time to ensure they remain contemporary. The current standards (1) were published in 2012 after approval by the NMBA. In keeping with Principle 6, a review began in 2017.

A PRG (members listed in acknowledgements) was convened to oversee the review and provide advice to ANMAC's Chief Executive Officer. The PRG provided advice on project planning, development of consultation papers, standards development, stakeholder engagement and synthesis of feedback.

The review complied with Section 46(2) of the National Law (1), which states: 'In developing an accreditation standard for a health profession, an accreditation authority must undertake wide-ranging consultation about the content of the standard.' To this end, ANMAC consulted with the PRG to develop a list of stakeholders to participate. Invitations were sent for each consultation.

Three separate consultations offered opportunities for stakeholders to contribute through an online survey, written submission or face-to-face.

Each consultation included a paper which was published on ANMAC's website and circulated to stakeholders. Consultation periods were 30 business days for papers one and two and 20 business days for the third paper.

Public submissions for each consultation were published on ANMAC's website (**www.anmac.org.au**).

2.2 Consultation one

The first consultation (September 2017) involved developing and presenting a paper to inform the development of the standards.

The paper outlined key areas for stakeholders to consider. It was researched and developed by ANMAC staff and reviewed by the PRG before it was circulated to stakeholders. The paper outlined background on relevant issues, including workforce characteristics and influences on practice.

Stakeholders were asked to consider and respond to several issues to assist in developing the draft standards, including:

- **Support mechanisms for students entering registered nurse programs, particularly relating to supporting students from diverse backgrounds and how the standards can address student retention in general.**

  Feedback indicated the need for:

  » *support mechanisms for English language*

  » *cultural safety*

  » *mentoring and academic support*

  » *flexible entry pathways, and flexibility and options for study mode and clinical placement attendance.*

  Strategies to support retention included quality clinical placement, improved selection processes and academic support.

- **English language entry requirements, specifically if the standards should require students to meet the NMBA English language registration standard (6) before enrolling in a Registered Nurse program.**

  Feedback indicated that most supported this inclusion in the standards.

- **Quality improvements to clinical learning—including: clinical learning environments and if a tool similar to the Victorian Department of Health and Human Services Best Practice Clinical Learning Environment (BPCLE) Framework (7) could contribute to high-quality learning environments across Australia, supervision of professional practice experiences (PEP) and practice readiness of graduates.**

  Feedback indicated that these improvements would contribute to quality PEP:

  » *appropriately trained (including cultural safety training) facilitators, educators and preceptors*

  » *contractual arrangements between education and health services providers*

  » *reflection of major health priorities in the standards (especially as they relate to Aboriginal and Torres Strait Islander health)*

  » *explicit reference to the National Safety and Quality Health Service (NSQHS) standards would contribute to quality PEP.*

  Feedback was not conclusive on the use of the BPCLE framework, with some participants stating some of its elements were useful for outcome-based standards. Other participants did not like the health service focus. No other tool for determining quality of PEP was suggested.

- **Use of simulated learning—if simulated learning could be explored as an alternative strategy for meeting learning outcomes and if it could be included in minimum practice hours.**

  Feedback indicated that a clear, accepted definition of simulation was a crucial starting point. So too was evidence based, high-quality approaches and the possible development of a set of simulated learning standards. More research in the Australian context is required to address this option fully.

Feedback was not conclusive on if simulated learning could be included in minimum practice hours; however most respondents agreed that the amount of simulation could be between 10 per cent and 50 per cent. There was lack of evidence to support a specific percentage.

- **Inter-professional learning—how the standards can better support and strengthen inter-professional learning.**

  Feedback indicated strong support for interprofessional learning and that the best learning environment for this was in the clinical setting.

- **Strengths and weaknesses of the Registered Nurse Accreditation Standards 2012 (1)—if the standards should move to a five-standard structure in line with other registered health professions and be supported with an evidence guide.**

  Feedback was that the current standards were comprehensive, rigorous and well-established, although elements of some standards criteria are repeated and there are examples of duplication with university processes. Some feedback indicated that the standards were open to interpretation.

  Feedback indicated some support and some uncertainty for the move to five standards. Feedback in support stated that this move would reduce repetition and better support inter-professional learning around a common core set of competencies. Uncertain feedback stated that the core nursing skills and knowledge may be compromised.

  Feedback indicated that most would support having an evidence guide, to enhance and/or clarify evidence requirements. This would also help assessment teams be consistent with assessing.

- **Clinical placement hours—if the minimum number of clinical practice hours should continue to be mandated.**

  Feedback indicated that most supported continuing to mandate a minimum number of clinical practice hours in the standards; however, some feedback indicated there was a lack of evidence to support the current number of hours.

- **Changes required to registered nurse role and standards—to prepare a workforce for the future.**

  Feedback indicated that these areas should be considered with the registered nurse role:

  » *curriculum content*

  » *Aboriginal and Torres Strait Islander people health, history and culture*

  » *need for a four-year degree*

  » *changing role of the registered nurse (including role expansion and emerging roles).*

  Feedback indicated that these areas should be considered with the standards:

  » *develop technological capacity*

  » *focus on digital health*

  » *introduce models of care*

  » *quality of clinical placement/placement issues*

  » *be aspirational and flexible*

  » *integrate professional practice standards and codes of ethics and conduct*

  » *explicitly reference National Safety and Quality Health Service Standards*

  » *include inherent requirements and fitness to practice.*

ANMAC synthesised all feedback. It was then reviewed by the PRG and published on ANMAC's website. Feedback outcomes influenced the first draft of the standards which were published in the second consultation paper.

2.3 Consultation two

The second consultation (June 2018), involved presenting the first draft of the proposed standards and other areas for consideration.

The consultation paper outlined more detail around the rationale for the move to a five-standard framework. It acknowledged that other accreditation bodies were moving to a similar framework, including the United Kingdom's Nursing and Midwifery Council (8).

The proposed standards were presented to stakeholders, along with references to the criteria they mapped from the Registered Nurse Accreditation Standards 2012 (5).

Stakeholders were asked to consider the following:

- **Draft standards—if they ensure that new graduates meet the NMBA Registered nurse standards for practice (9), if additional criteria need to be included, deleted or amalgamated, and if the structure decreased duplication.**

  Feedback indicated that most considered the draft standards would ensure graduates meet the NMBA Registered nurse standards for practice and that duplication would be reduced.

  Feedback requested that content for mental health theory and practice as a discrete unit be included in the standards and integrated throughout the educational program.

  Feedback requested that several other subject areas be included in curricula.

  Feedback suggested the following:

  » *strengthen English language entry requirements*

  » *consider a four-year program*

  » *further emphasise the responsibilities of education and health service providers in clinical learning for students*

  » *provide an evidence guide.*

- **Safe supply and administration of medicines through a protocol or standing order—if the draft standards support learning outcomes to enable graduates to safely supply and administer medicines through a protocol or standing order.**

  Feedback indicated that most agreed the standards supported learning outcomes for the safe supply and administration of medicines. Issues raised included the need to:

  » *clarify the definition for a 'structured prescribing arrangement'*

  » *ensure assessment of quality use of medicines for each clinical practice placement*

  » *ensure links to National Prescribing Service National Prescribing Competencies.*

- **Simulation—if the proposed definition of simulation should be adopted in the standards.**

  Feedback indicated that most supported adopting the proposed definition if the standards clearly stated that simulation does not replace professional experience placement.

  Feedback also included that staff would need to be appropriately qualified to teach in a simulated environment, that simulation be scaffolded throughout the program and that simulation environments be sufficiently equipped and resourced to achieve learning outcomes.

- **Health informatics and digital health—if the standards can better support inclusion of these two subjects.**

  Feedback indicated that specific content should be included and embedded and that the National Informatics Standards be used to address learning outcomes and competencies.

- **Quality professional learning experiences—if the standards capture required learning outcomes.**

  Feedback indicated that most considered the draft standards adequately captured learning outcomes.

- **Other issues—additional issues raised but needing greater emphasis.**

  Feedback indicated that:

  » *further standardisation for clinical facilitator education was needed*

  » *the professional codes, standards and guidelines should be embedded throughout the program*

  » *a national exam to determine achievement of the NMBA Registered nurse standards for practice be considered.*

  Some feedback proposed increasing professional experience hours on the belief that the current 800 hours are not sufficient to achieve the NMBA Registered nurse standards for practice. Inter-professional learning, mental health content and simulation were highlighted as priority areas.

A consultation forum was held in Melbourne in July 2018. Facilitated discussion focused on the draft standards and issues raised in the second consultation paper. Feedback from the forum was included in the synthesis of feedback for the second stage of consultation and published on ANMAC's website.

Feedback from the second stage of consultation was synthesised using NVivo software and reviewed by the PRG. The feedback received in stage two provided criterion-specific feedback and resulted in most criterion being amended.

ANMAC considered that not all issues presented in the feedback could be resolved in the standards due to lack of evidence-based research to support some suggestions. Research into issues such as the merits of a four-year degree and the minimum number of professional experience placement hours required for a student to achieve the NMBA Registered nurse standards for practice would inform future standards development.

The PRG discussed the request to include mental health-specific content in the standards. While acknowledging that content relating to mental health was included in the draft standards in the context of national health priorities, the PRG determined this needs to be strengthened.

Mental and substance use disorders made up 12.1 per cent of the disease burden in Australia in 2011, making it the third highest disease burden in this country (10, p. 3). Research points to inconsistency within curricula contributing to student preparation for practice with most criticising the lack of mental health content in the preregistration curriculum (11, p. 173). Most programs in Australia include mental health content because it is one of the national health priorities and has been since the First Report on National Health Priority Areas 1996 was published in 1997 (12). Despite this research, mental health was not specifically named within the standards and therefore there was no clear guidance to education providers about the level and extent of mental health content in the curriculum.

2.4 Consultation three

The third and final consultation began in January 2019 when a final draft of the proposed standards was provided to stakeholders, inviting them to provide final written submissions to ANMAC.

Stakeholders were also invited to participate in a workshop to help develop an Essential Evidence companion document to accompany the standards. This is the minimum data set of evidence an education provider must tender to demonstrate that their entry to practice Registered Nurse program meets the Registered Nurse Accreditation Standards.

Feedback provided on the third consultation paper was largely criterion-specific and was reviewed with the PRG before the draft standards were finalised.

The issues that generated the most feedback included requests to clarify:

- responsibility for student supervision while on professional experience placement
- mandatory reporting for students with an impairment
- English language requirements for students enrolling into programs
- wording of criterion relating to medication supply and administration.

These issues were discussed with the PRG and amendments to wording were made accordingly.

The proposal to include a discrete unit of study and embedded content for mental health in the standards generated the most feedback. The Australian College of Mental Health Nurses supported its submission with a literature review into Improving Mental Health Literacy of the future nursing workforce (13) and the College National Framework for mental health content in pre-registration nursing programs 2018 (14). Most feedback supported including mental health as a discrete unit of study.

One higher education provider asked if including such a unit would be a burden to education providers in some parts of Australia. To test this, ANMAC reviewed all entry to practice registered nurse course outlines and found that all programs included a mental health unit, however named. The requirement for a discrete unit had not been linked to a specific mental health placement as contemporary evidence demonstrates that people with challenges to their mental health are present in all health care settings, including community settings.

ANMAC reviewed the evidence that supported including mental health as a discrete unit of study or as a specifically named national health priority in the criterion related to that topic. ANMAC's review confirmed that mental health is a key health issue in Australia and that a number of reports cover the challenges of managing this area of health. The Australian Institute of Health and Welfare publication, Mental Health Services in Australia (10), updated 9 October 2019 (15), reported that 10.2 per cent of the population received Medicare subsided mental health services in 2017–18. This is an increase from 5.7 per cent in 2008–09. The Senate inquiry report, *Accessibility and quality of mental health services in rural and remote Australia,* identified that 'one in five Australians will experience mental illness in any given year, no matter where in Australia they live' (16, p. 1). In response to the report, COAG released the *Fifth National Mental Health and Suicide Prevention Plan* (17). The National Suicide Prevention Implementation Strategy is due for release in 2019 before the final strategy is published in 2020.

ANMAC is responsible for ensuring that entry to practice registered nurse programs of study prepare graduates to meet the NMBA Registered nurse standards for practice and deliver a broad range of care. However, ANMAC must also be mindful that principles of best practice regulation require that a range of options be considered to achieve objectives of regulation. Principle 2 of COAG Principles for Best Practice Regulation (4) clarifies that the overall goal is the effective and efficient achievement of the stated objectives. In the case of the review of the Registered Nurse Accreditation Standards, the objective is to ensure that every registered nurse graduating from an entry to practice program has an understanding

of mental health and its challenges, and to ensure consistency across all programs. Therefore, after further discussion, ANMAC decided to highlight mental health as a key national health priority and include it in the curriculum but not specify that a discrete unit of study be devoted to the subject.

The NMBA provided feedback on the draft standards in relation to ensuring all students have quality professional experience placements. In doing so, the NMBA emphasised the need for an essential evidence document outlining clear instructions to education providers on the evidence they must provide to demonstrate their placements are of sufficient quality.

ANMAC undertook a literature review to confirm that the draft standards included criteria ensuring that professional experience placements included in entry to practice registered nurse education programs are of sufficient quality to prepare students to meet the NMBA Registered nurse standards for practice.

The review included a report commissioned by Health Workforce Australia (HWA)[1] in June 2012 to 'inform the potential development of a national plan for promoting quality in clinical placements' (18, p. v). ANMAC concluded that this aim is in keeping with the desired outcomes of the Registered Nurse Accreditation Standards and reviewed the findings of the report. The literature review informing the HWA report was extensive and involved more than 500 items to:

- identify the elements that exemplify quality in clinical placement
- identify existing frameworks for quality clinical placement
- recommend one framework that could be applied for use in the Australian context of clinical placement.

HWA's report findings identified the BPCLE framework, by Victoria's Department of Health and Welfare (7) to be evidence based, piloted and evaluated. The report stated that it was suitable for adapting for Australian clinical placement needs. (N.B. The report refers to the 2010 BCPLE which has since been updated. The current version (2016) is referenced.)

The Registered Nurse Accreditation Standards 2019 require programs to incorporate the features of quality PEP including:

- appropriate resources and facilities
- effective communication processes
- effective health service—education provider relationships
- best-practice clinical practice.

These elements are integrated throughout the standards in criteria in several domains. The Essential Evidence companion document directs education providers to various criteria relating to quality PEP. Duplication of evidence is not required.

ANMAC notes that all identified elements contributing to quality in PEP were included in the Registered Nurse Accreditation Standards 2012. The instructions in the Essential Evidence companion document provide clear guidance to education providers about the evidence they must provide to demonstrate that their program meets the PEP requirements of the Registered Nurse Accreditation Standards 2019.

1 In the 2014 Budget, the Australian Government announced the closure of Health Workforce Australia. It closed on 6 August 2014 and the essential functions were transferred to the Department of Health.

2.5 Regulatory impact assessment

ANMAC took into account, when reviewing the standards, the COAG Principles for Best Practice Regulation (4). As such, ANMAC presented the draft standards to the Office of Best Practice Regulation during the review for preliminary assessment and consideration of the advantages and disadvantages and burdens of introducing the standards as well as the potential impact for stakeholders.

The Office of Best Practice Regulation considered the standards as presented and determined that a regulation impact statement was not required.

2.6 Ratification and approval

Section 47 of the schedule in the National Law (1) requires the NMBA to approve, refuse to approve or ask ANMAC to review the standards.

ANMAC's Chief Executive Officer reviewed the standards before presenting them to the ANMAC Board to ratify. After ratification, ANMAC presented the Registered Nurse Accreditation Standards to the NMBA for approval.

These standards were approved by the NMBA on 31 October 2019.

3. Introduction

3.1 Use of the Registered Nurse Accreditation Standards

The Registered Nurse Accreditation Standards are principally designed for use by education providers seeking accreditation for an entry to practice Registered Nurse program (Bachelor or Masters degree).

ANMAC evaluates education programs against these standards before making recommendations on their acceptance to the NMBA in line with sections 48 and 49 of the schedule in the National Law (1).

The standards specify the minimum requirements education providers must meet for their program of study to be accredited by ANMAC. Graduates of Australian programs must complete a program of study that is accredited by ANMAC and approved by the NMBA to be eligible to apply for registration with the NMBA.

3.2 Essential evidence

In collaboration with stakeholders, ANMAC has developed an Essential Evidence companion document to support the standards. The companion document is given to education providers with the Registered Nurse Accreditation Standards 2019. It provides information to education providers about the minimum evidence they need to submit to demonstrate that their program of study meets these standards. Education providers applying for program accreditation are required to provide all essential evidence in conjunction with their Registered Nurse Accreditation Standards 2019 Application Pack.

3.3 Glossary

Glossary terms in the Registered Nurse Accreditation Standards 2019 and in the Essential Evidence companion document appear in ANMAC's online glossary. It is available on ANMAC's website (**https://www.anmac.org.au/glossary**).

4. Registered Nurse Accreditation Standards

Standard 1: Safety of the public

1.1 The program's guiding principle is safety of the public.

1.2 The program is delivered in Australia[2] to prepare graduates for safe and ethical practice.

1.3 The program's admission requirements are fair, equitable and transparent. Before making an offer for enrolment, education providers inform applicants of the requirements to:

a. meet the program's inherent requirements

b. demonstrate English language proficiency either by providing a written declaration that English is their primary language or evidence that they have achieved the minimum English language test results as specified in the Nursing and Midwifery Board of Australia's (NMBA) English language skills registration standard (6)

c. meet the requirements of health services where professional experience placements (PEP) occur

d. register with the NMBA on program completion.

1.4 The education provider ensures that organisations in which students undertake PEP have:

a. evidence-based quality and safety policies and processes that meet relevant jurisdictional requirements and standards

b. registered nurses who are prepared for the supervisory role and able to supervise and assess students during all PEP

c. relevant registered health practitioners available to support collaborative teaching and learning opportunities in interprofessional settings.

1.5 Students are registered with the NMBA before starting their first PEP (19).

1.6 The education provider has processes in place to manage students with identified impairments that, in the course of PEP, may place the public at risk. These processes include procedures for mandatory reporting (20) where required.

1.7 The program's progression policies and rules ensure that only students who have demonstrated the requisite knowledge and skills required for safe practice are eligible for PEP.

2 Except as it relates to criteria 2.4 and 3.1.

Standard 2: Governance

2.1 The academic governance arrangements for the program of study include current registration by the Tertiary Education Quality and Standards Agency as an Australian university or other higher education provider.

2.2 The education provider conducting the program has a governance structure that ensures the head of discipline is a registered nurse with the NMBA, with no conditions or undertakings on their registration relating to performance or conduct and holds a relevant post-graduate qualification. The head of discipline is responsible for:

a. academic oversight of the program

b. promoting high-quality teaching and learning experiences for students to enable graduate competence

c. ensuring staff and students are adequately indemnified for relevant activities undertaken as part of program requirements.

2.3 The education provider undertakes consultation into the design and ongoing management of the program from external representatives of the nursing profession, including Aboriginal and/or Torres Strait Islander peoples, consumers, students, carers and other relevant stakeholders.

2.4 All program entry pathways for which students receive block credit or advanced standing (other than on an individual basis) are identified, approved by ANMAC and allow graduates to meet the NMBA Registered nurse standards for practice (9).

2.5 The program's quality improvement mechanisms incorporate evaluation information from a variety of sources and address:

a. risk assessment of student learning environments

b. student evaluations

c. internal and external, academic and health professional evaluations

d. evidence-based developments in health professional education

e. evidence-based developments in health and health care.

Standard 3: Program of study

3.1 The program of study is undertaken in Australia. Where there is an offshore component, it is required to:

a. be no more than one-sixth of the full program completed offshore

b. demonstrate equivalence of learning outcomes.

3.2 The program of study is delivered at an Australian Qualifications Framework Level 7 or above for the award of a Bachelor Degree, as a minimum.

3.3 The curriculum document articulates the nursing and educational philosophies and their practical implementation into the program of study.

3.4 Teaching and learning reflects contemporary practices in nursing, health and education, and responds to emerging trends based on research, technology and other forms of evidence.

3.5 The program's content and subject learning outcomes ensure:

a. achievement of the NMBA Registered nurse standards for practice (9)

b. integrated knowledge of regional, national and global health priorities, including mental health and care of the older person

c. integrated knowledge of safety and quality standards as they relate to health care

d. integrated knowledge of care across the lifespan and across contexts of nursing practice

e. equivalence in all delivery modes in which the program is offered.

3.6 The program's content and subject learning outcomes integrate principles of intraprofessional and interprofessional learning and practice.

3.7 The program's content and subject learning outcomes embed principles of diversity, culture, inclusion and cultural safety for all people.

3.8 The program's content and subject learning outcomes support the development of research skills that include searching and reviewing research and other evidence for translation into practice.

3.9 The program's content and subject learning outcomes support the development of student knowledge and skills in pharmacotherapeutics and quality use of medicines. This includes the supply and administration of medicines.

3.10 The program includes:

a. Aboriginal and Torres Strait Islander peoples' history, culture and health taught as a discrete subject and based on the Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework (21)

b. content relevant to health outcomes of Aboriginal and Torres Strait Islander peoples is embedded throughout the program.

3.11 The program includes content and sequencing that incorporates simulated learning experience to prepare students for PEP.

3.12 The program includes:

a. a minimum of 800 hours of quality PEP completed by all students in a variety of settings, relevant to the curriculum, exclusive of simulation and not exceeding one-sixth of the PEP hours undertaken outside Australia

b. PEP as soon as practicably possible in the first year of study to facilitate early engagement with the professional context of nursing

c. PEP included towards the end of the program, conducted in Australia, to demonstrate achievement of the NMBA Registered nurse standards for practice

d. PEP is underpinned by contractual arrangements between education providers and PEP providers.

3.13 The program's resources are sufficient to facilitate student achievement of the NMBA Registered nurse standards for practice, with attention to human and physical resources supporting all teaching and learning environments, including simulated practice and PEP.

3.14 Staff teaching into the program:

a. are qualified and experienced to deliver the subjects they teach

b. are registered nurses where the subject relates to nursing practice

c. hold one qualification higher than the program of study being taught.

Standard 4: Student experience

4.1 Program information provided to students is relevant, timely, transparent and accessible.

4.2 Student academic learning needs are identified and supported by the education provider.

4.3 Students are informed of, and have access to, grievance and appeals processes.

4.4 Students are informed of, and have access to, pastoral and/or personal support services.

4.5 Students are represented on program advisory and decision-making committees.

4.6 Student experiences have equity and diversity principles observed and promoted.

4.7 Student experiences across all teaching and learning environments are monitored and evaluated regularly with outcomes informing program quality improvement.

Standard 5: Student assessment

5.1 The program's learning outcomes and assessment strategies are aligned.

5.2 The program's subject learning outcomes, with associated subject assessments, are clearly mapped to the NMBA Registered nurse standards for practice.

5.3 The integrity of the program's theoretical and clinical assessments is ensured through the use of contemporary, validated assessment tools, modes of assessment, sampling and moderation processes.

5.4 The program's assessments include the appraisal of competence in pharmacotherapeutics and the quality use of medicines.

5.5 The program has formative and summative assessments that enhance learning and inform student progression. The summative assessment appraises competence against the NMBA Registered nurse standards for practice before successful completion of the program.

5.6 The education provider is ultimately accountable for the assessment of students in relation to their PEP.

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JB 2

Australian
Nursing & Midwifery
Accreditation Council

Enrolled Nurse

Accreditation Standards 2017

enrolled nurse

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Accreditation Council

Enrolled Nurse

Accreditation Standards 2017

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- Ms Gabrielle Koutoukidis, Educationalist, Expert Advisory Group, Chair
- Associate Professor Alison McMillan, Australian and New Zealand Council of Chief Nurse and Midwifery Officers (member from February 2015 to May 2016)
- Ms Ann Maree Keenan, Australian and New Zealand Council of Chief Nurse and Midwifery Officers (member from September 2016)
- Ms Julianne Bryce, Australian Nursing and Midwifery Federation
- Ms June Cox, Australian College of Nursing
- Ms Janine Mohamed, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Mrs Noela Baglot, Consumers Health Forum of Australia
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- Miss Myra Book, Department of Health, Western Australia
- Professor Melanie Birks, Educationalist
- Ms Louise Dearman, Enrolled Nurse, Practice Nurse
- Dr Siobhan Bidgood, National Enrolled Nurse Association of Australia
- Ms Petrina Halloran, Nursing and Midwifery Board of Australia
- Ms Jodie Hughson, Quality and Risk Manager, Health Care Australia
- Ms Debbie Blow, TAFE Directors Australia
- Professor Robert Meyenn, ANMAC, Standards Accreditation and Assessment Committee (Disbanded), Chair
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- Ms Julie Watts, ANMAC, Associate Director
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- Dr Margaret Gatling, ANMAC, Director of Accreditation Services (member from December 2016)
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The intellectual input, collective wisdom and critical thinking provided exemplified the goodwill and professionalism of those committed to advancing the nursing profession in Australia.

ANMAC commends these accreditation standards to the Nursing and Midwifery Board of Australia and acknowledges the NMBA's support in their review and revision.

1 Preamble

1.1 Enrolled nurse education in Australia

Enrolled nurse programs of study support students to achieve the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice. This ensures graduates are able to practice safely and competently with the required attitude, knowledge and skills.

Enrolled nurse education occurs in the Vocational Education and Training (VET) sector and requires students to complete an NMBA approved Diploma of Nursing program through a private or public Registered Training Organisation (RTO) registered with the Australian Skills Quality Authority (ASQA) or other state regulator[1.] The program's structure, design and content is derived from a National Health Training Package, which ensures consistency with Australian Qualification Framework (AQF) requirements and national practice standards.(1) The National Health Training Package is also sequenced to prepare students for workplace experience. Graduates of an NMBA approved program of study can apply to register with the NMBA to practice as an enrolled nurse.

1.2 Health practitioner regulation

The *Health Practitioner Regulation National Law Act 2009* (the National Law), enacted in July 2010, is the national law by which the National Registration and Accreditation Scheme for health practitioners is instituted.

The scheme has six objectives, one of which is:

> **...to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.(2)**

According to the National Law, graduates must have successfully completed an ANMAC accredited and NMBA approved enrolled nurse program of study to be eligible to apply for NMBA registration.

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is responsible for monitoring education providers and programs of study that provide a qualification for the purposes of registration in nursing and midwifery. In addition, through a process of cyclical review, ANMAC maintains the integrity and effectiveness of accreditation standards that underpin the accreditation of programs of study under its mandate.

Professional education accreditation is concerned with the quality of the profession and its work, from the perspective of the public interest and community safety. It is part of a broader process of assuring the community that, having completed an approved program of study, beginning practitioners have achieved agreed professional outcomes and are able to practise in a safe and competent manner because they are equipped with the necessary foundation knowledge, professional attitudes and essential skills. This process, however, relies on two fundamental principles:

1. That the education providers themselves are authorised to issue the relevant qualification and are evaluated to assure continued quality learning outcomes for their graduates.
2. That there is a set of agreed and contemporary practice standards for the profession, against which the capability of graduates of programs is assessed.

1 Other state regulators include Training and Accreditation Council, Western Australia and the Victorian Registration and Qualification Authority

The first principle is discussed in Section 1.3. The second relates to the NMBA Enrolled nurse standards for practice, that came into effect on 1 January 2016. These standards articulate the core practice standards that provide a framework for assessing those wanting to obtain and retain registration as an enrolled nurse in Australia. Education providers use the standards when developing enrolled nurse programs of study and assessing student performance. Employers use them when evaluating registrant performance.

The accreditation process administered by ANMAC is an efficient and effective proxy for externally assessing graduates against standards for practice. Professional program accreditation must balance ensuring professional standards are protected without inhibiting diversity and innovation or constraining continuous quality improvement. As with the national standards for practice, the national accreditation standards are regularly reviewed to ensure relevance in the light of changes in health and education legislation, policy, delivery and ethos.

1.3 Vocational Education and Training sector regulation

ASQA is the regulatory body for the VET sector across all states and territories, with the exception of Victoria and Western Australia, which have retained state regulatory bodies.(3)

ASQA maintains the quality of the VET sector through effective regulation of:

- VET providers
- accredited VET courses
- Commonwealth Register of Institutions and Courses for Overseas Students providers including those delivering English Language Intensive Courses to Overseas Students.(4)

ASQA's regulatory functions are supported by a framework of legislation and standards which is referred to as the 'VET Quality Framework'.(5) This framework includes the Standards for Registered Training Organisations 2015, the purpose of which is to:

- set out the requirements that an organisation must meet to be an RTO
- ensure that training products delivered by RTOs meet the requirements of training packages or VET accredited courses, and have integrity for employment and further study
- ensure RTOs operate ethically with due consideration of needs of learners and enterprises.(6)

The Australian Qualification Framework (AQF) is another component of the VET Quality Framework. The AQF is the national policy for regulated qualifications in Australian education and training. (7) It stipulates the learning outcomes expected within each AQF level and qualification type. It expresses these as dimensions of knowledge, skills and their application. This ensures the integrity of qualifications and standardises them across education providers, settings and delivery modes.

ASQA cyclically reviews courses and training providers to ensure their continued compliance with the VET Quality Framework.

Training packages

ASQA assesses and monitors an RTO's ability to deliver training and assessment in accordance with training package requirements. RTOs that have been authorised by ASQA to deliver training package qualifications or units of competency (training products), have these added to their scope of registration. ASQA can take regulatory action against a RTO if it is found not to comply with training package requirements.(8)

ASQA's quality assurance role in the delivery of training products does not extend to their development, endorsement or maintenance.

As stated on the ASQA website, Skills Service Organisations (SSOs) (formerly Industry Skills Councils) create training packages in response to a nationally recognised training need. SSOs develop and validate training packages by way of a policy-driven process that includes extensive research and consultation with industry stakeholders.

A training package will specify for the RTO the skills and knowledge required to perform effectively in the workplace. It does not advise RTOs on how learners should be trained. A training package comprises:

- units of competency—specifies the required skills and knowledge for effective performance in a workplace context
- a qualifications framework—groups of units of competency ranging from Certificate I to Graduate Diploma level
- assessment guidelines—identifies assessment processes and industry's preferred approach to assessment.(8)

SSOs also supply a Companion Volume Implementation Guide to support RTOs in the implementation of the training package.

Training packages that are Government endorsed and approved for use throughout Australia, are uploaded to the national register: training.gov.au Once published, RTOs are required to transition to delivering the new product within a specified time frame.

When a training package is updated and deemed equivalent to the superseded product, ASQA will automatically add the training product to relevant RTOs scope of registration.

The current qualification for the Diploma of Nursing (HLT54115), derived from the National Health Training Package, was deemed by the SSO to be 'non-equivalent' to the superseded product (HLT51612). As a consequence, RTOs were required to apply to ASQA to have this Diploma of Nursing qualification added to their scope of registration.

A RTO's scope of registration can be viewed on the national register: training.gov.au

1.4 Review of the Enrolled Nurse Accreditation Standards

In February 2009, the Australian Nursing and Midwifery Council published the 'Enrolled Nurses Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia – with Evidence Guide'. These were subsequently approved by the then, newly established NMBA.(9)

As part of the cyclical review of all accreditation standards, the ANMAC Board authorised the review of these accreditation standards to start in July 2015 with stakeholder engagement to be implemented in accordance with Section 46(2) of the National Law, which states:

> **In developing an accreditation standard for a health profession, an accreditation authority must undertake wide-ranging consultation about the content of the standard.(10)**

The ANMAC Board convened an EAG (members are listed in Acknowledgements) to oversee the review. The EAG guided project planning, document development, stakeholder engagement and feedback synthesis. ANMAC sent a letter of invitation to a wide range of stakeholders outlining opportunities for participation. Feedback options included completing an online survey, sending a written submission and/or attending any of the four consultation forums.

The review was an iterative process that included two stages of consultation. Each stage had a separate consultation paper that was made accessible to stakeholders via the ANMAC website, for a period of 6 weeks.

Stage 1–first consultation paper

The first consultation paper and first version of the revised standards was researched and drafted by ANMAC staff, edited by the EAG and approved by ANMAC's Standards Accreditation and Assessment Committee (now disbanded). The paper was circulated to stakeholders in October 2015, with an invitation to attend any of three consultation forums held in Sydney, Melbourne and Adelaide.

The consultation paper encompassed the background, context, purpose and process of the review. It also outlined practice, professional and policy matters shaping Australian health care and the enrolled nurse practice landscape and, as a consequence, enrolled nurse education. The paper also noted an absence of international equivalency with the Australian enrolled nurse role and education programs. Further, it acknowledged the lack of high-level evidence or useful international benchmarks to guide the design and delivery of enrolled nurse programs.

With this background information, stakeholders were asked to consider and provide their perspectives on key content areas in the first version of the revised accreditation standards, including:

- Program development and structure—whether a minimum of 400 hours of workplace experience, not inclusive of simulation activities, should continue to be stipulated in the revised standards.

  Feedback indicated majority support for the continuation of this stipulation.

- Program content—whether content in the National Health Training Package and content in the current accreditation standards relating to chronic disease and mental health were adequately encompassed by proposed revisions to relevant criteria.

  Feedback indicated majority support for proposed program content revisions.

- Student assessment—whether there were facilitators or barriers in the current system to the assessment of students' English language skills (ELS) before undertaking workplace experience. Also whether, as part of this ELS assessment, a required minimum level for students' ELS should be stipulated in the revised standards.

  Feedback indicated that current pre-enrolment ELS testing and specific types of learning and teaching approaches facilitated the assessment of students' English language proficiency before undertaking workplace experience. Reported barriers to undertaking this assessment were the lack of resources, valid and reliable assessment tools, and standardised processes. Feedback also indicated majority support for stipulating a minimum ELS requirement in the revised standard.

- Stakeholders were also asked to review the standards as a whole and to consider their effectiveness and relevance in providing guidance to providers of enrolled nurse education.

  Feedback indicated overall support for the first version of the revised standards, however, there were numerous suggestions for improvement in criteria wording and glossary terms.

The EAG reviewed and synthesised all stakeholder feedback. Outcomes from this process lead to a period of further research and expert consultation, which informed content changes in the next version of the revised standards.

Stage 2–second consultation paper

The second consultation paper, released in January 2017, provided stakeholders with an overview of Stage 1 outcomes. The paper went on to examine available evidence relating to minimum levels of ELS and language, literacy and numeracy (LLN) skills required by students studying in Australian VET and tertiary sectors. Stakeholders were asked to consider this evidence and proposed criteria aimed at establishing enrolled nurse program entry requirements.

Further in Stage 2, stakeholders were invited to attend a summative forum, held in Brisbane. Facilitated discussion at the forum focused on proposed revisions to the standards and content areas of interest to stakeholders.

After reviewing all stakeholder feedback from Stage 2, the EAG met to finalise standards or criteria that stakeholders had commented on. The EAG paid particular attention to criteria stipulating minimum level requirements for students' ELS and LLN skills on program entry.

1.5 Regulatory impact assessment

During the review of the Enrolled Nurse Accreditation Standards, ANMAC undertook a preliminary assessment of the potential regulatory impact of proposed revisions to the standards. This assessment is required by the Australian Government's Office of Best Practice Regulation to ensure that national standard setting agencies, such as ANMAC, have explored the impact of regulation, standards and other quasi-regulation before implementation.

Development of the preliminary assessment was guided by Government resource documents (11, 12) and considered such matters as the benefits and burdens of introducing the revised accreditation standards and the potential impact on stakeholders.

ANMAC's preliminary assessment was submitted to the Office of Best Practice Regulation, which considered the proposed revisions to the NMBA-approved national accreditation standards to be minor and requiring no further regulatory impact assessment.

1.6 Ratification and approval

While ANMAC is responsible for developing the accreditation standards, the NMBA—under section 47(2) of the National Law—decides whether to approve them or ask the accreditation authority to review them.

The EAG and ANMAC's Chief Executive Officer reviewed the final draft of the Enrolled Nurse Accreditation Standards before presenting them to the ANMAC Board to ratify. After ratification, the Enrolled Nurse Accreditation Standards were submitted to the NMBA for consideration of their approval.

These standards were approved by the NMBA on 24 May 2017.

2 Introduction

2.1 Purpose of the ANMAC accreditation process

Professional program accreditation is concerned with the quality of the nursing profession and its work, on behalf of public interest and public safety. In contrast, accreditation (or similar assessment) by national education regulators, such as TEQSA or ASQA, is concerned with quality assurance and risk management. Accreditation by these types of regulators complements professional program accreditation. It is therefore a requirement for ANMAC to assess nursing and midwifery programs of study for accreditation.

ANMAC accreditation evaluates whether education providers, on the evidence they provide, can ensure program graduates have the common and transferable skills, knowledge, behaviours and attitudes as articulated in the relevant national competency standards or standards for practice.

ANMAC's process of accreditation involves comprehensively examining a higher education provider's:

- governance system and quality management framework
- student enrolment processes
- conceptual framework
- structure and content
- learning and teaching approaches
- student support, assessment and workplace experience.

Periodic accreditation of nursing and midwifery programs stimulates education providers to review and assess their own programs. It enables providers to validate the strengths of existing programs, identify areas for improvement and introduce new learning and teaching initiatives.

ANMAC accreditation, therefore, contributes to ensuring public safety and supports, where possible, diversity, innovation and evolution in nursing and midwifery education.

2.2 Enrolled Nurse Accreditation Standards

The Enrolled Nurse Accreditation Standards detail the minimum requirements that RTOs must meet if they want their program of study to be accredited by ANMAC. Graduates cannot apply to register with the NMBA unless their program of study is accredited by ANMAC and approved by the NMBA.

A summary of the nine Enrolled Nurse Accreditation Standards is tabled in Section 3.

2.3 Using the Enrolled Nurse Accreditation Standards

The Enrolled Nurse Accreditation Standards are designed principally for use by education providers seeking to accredit a Diploma of Nursing program of study. ANMAC's Associate Directors, the Enrolled Nurse Accreditation Committee and members of ANMAC assessment teams evaluate programs against these standards and make recommendations to the ANMAC Board for decision making.

While the standards are principally for use by education providers, they are also useful for anyone interested and involved in the education of enrolled nurses.

RTOs seeking accreditation are required to complete an application pack that incorporates the Enrolled Nurse Accreditation Standards 2017 and guidance on addressing them. ANMAC regularly reviews and updates this guidance to help education providers prepare their submissions.

Other materials to assist education providers include the:

- National Accreditation Guidelines: Nursing and Midwifery Education Programs—describes the structures, personnel and processes for accrediting nursing and midwifery education providers and programs of study
- ANMAC Assessor Handbook—provides an overview of the accreditation process.

All ANMAC materials to assist education providers, including the application pack, are available at www.anmac.org.au

3 Enrolled Nurse Accreditation Standards

This is a summary table of each standard in the Enrolled Nurse Accreditation Standards.

STANDARD 1: GOVERNANCE
The education provider has established governance arrangements for the enrolled nurse program of study that develop and deliver a sustainable, high-quality education experience for students, to enable them to meet the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice.
STANDARD 2: CONCEPTUAL FRAMEWORK
The program provider makes explicit, and uses a contemporary conceptual framework for the enrolled nurse program of study that incorporates an educational philosophy and a philosophical approach to enrolled nurse practice.
STANDARD 3: PROGRAM DEVELOPMENT AND STRUCTURE
The program of study is developed in collaboration with key stakeholders reflecting contemporary trends in education and professional nursing; complying in length and structure with the Australian Qualifications Framework (AQF) for the qualification offered and enabling graduates to meet the NMBA Enrolled nurse standards for practice. Workplace experience is sufficient to enable safe and competent enrolled nursing practice by program completion.
STANDARD 4: PROGRAM CONTENT
The program content delivered by the program provider comprehensively addresses the NMBA Enrolled nurse standards for practice and incorporates Australian best practice perspectives on enrolled nursing as well as existing and emerging international, national and regional health priorities.
STANDARD 5: STUDENT ASSESSMENT
The program incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes, including a summative assessment of student performance against the NMBA Enrolled nurse standards for practice.
STANDARD 6: STUDENTS
The program provider's approach to attracting, enrolling, supporting and assessing students is underpinned by values of transparency, authenticity, equal opportunity and an appreciation of social and cultural diversity.
STANDARD 7: RESOURCES
The program provider has adequate facilities, equipment and teaching resources, as well as staff who are qualified, capable and sufficient in number to enable students to attain the NMBA Enrolled nurse standards for practice.
STANDARD 8: MANAGEMENT OF WORKPLACE EXPERIENCE
The program provider ensures that every student is given a variety of supervised workplace experiences conducted in environments providing suitable opportunities and conditions for students to attain the NMBA Enrolled nurse standards for practice.
STANDARD 9: QUALITY IMPROVEMENT AND RISK MANAGEMENT
The program provider is able to assess and address risks to the program, its outcomes and students, and has a primary focus on continually improving the quality of the learning and teaching experience for students and the competence of graduates.

Standard 1: Governance

The education provider[2] has established governance arrangements for the enrolled nurse program of study that develop and deliver a sustainable, high-quality education experience for students, to enable them to meet the NMBA Enrolled nurse standards for practice. (13)

Criteria

The education provider must provide evidence of:

1.1 Current registration by the Australian Skills Quality Authority (ASQA) or other state regulator[3], as an Australian Registered Training Organisation (RTO).

1.2 Current accreditation of the enrolled nurse program of study by ASQA, or other state regulator, detailing the expiry date and recommendations, conditions and progress reports related to the education provider.

1.3 Listing on the national register for training in Australia of an approved scope that incorporates the qualification of Diploma of Nursing, derived from the current National Health Training Package, at Australian Qualification Framework (AQF) Level 5.

1.4 Current documented academic governance structure for the RTO conducting the program which ensures academic oversight of the program and promotes high-quality learning and teaching scholarship and ongoing evaluation across all learning settings.

1.5 Terms of reference for relevant education provider committees and advisory and/or consultative groups, including consumer representation and partnerships with Aboriginal and Torres Strait Islander health professionals and communities.

1.6 Staff delegations, reporting relationships, and the role of persons or committees in decision making related to the program.

1.7 Governance arrangements of the RTO that are responsive to requirements for ongoing compliance with the Enrolled Nurse Accreditation Standards.

1.8 Policies relating to credit transfer or the recognition of prior learning that are consistent with AQF national principles and the graduate's ability to meet the NMBA Enrolled nurse standards for practice.

1.9 Governance arrangements between the education provider and health service providers to monitor students' learning and teaching when undertaking workplace experience including, but not limited to, clinical teaching, supervision and assessment.

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2 Refer to glossary for an operational definition of education provider.

3 Includes registration by Training and Accreditation Council, Western Australia and the Victorian Registration and Qualification Authority

Standard 2: Conceptual framework

The program provider makes explicit, and uses a contemporary conceptual framework for the enrolled nurse program of study that incorporates an educational philosophy and a philosophical approach to enrolled nurse practice.

Criteria

The program provider demonstrates:

2.1 A clearly documented and explained conceptual framework for the program, including underpinning educational and professional nursing philosophies.

2.2 The incorporation of contemporary Australian and international best practice teaching, learning and assessment methodologies and technologies to enhance the delivery of program content, accommodate differences in student learning styles and stimulate student engagement and learning.

2.3 A program of study that is congruent with contemporary and evidence-based approaches to enrolled nurse practice and education and underpinned by principles of safety and quality in health care[4].

2.4 Learning and teaching approaches that:

a. enable achievement of stated learning outcomes

b. facilitate the integration of theory and practice

c. scaffold learning appropriately throughout the program

d. encourage the development and application of reflective and analytical practice

e. engender deep rather than surface learning

f. encourage students to become self-directed learners

g. embed recognition that graduates take professional responsibility for continuing professional development and life-long learning

h. instil in students the desire and capacity to continue to use and learn from research and implement as evidenced-based care throughout their careers

i. promote emotional intelligence, communication, collaboration and teamwork, cultural safety and ethical practice expected of an enrolled nurse

j. incorporate an understanding of, and engagement with, intraprofessional and interprofessional learning for collaborative practice.

4 Including the current *Australian Safety and Quality Framework for Health Care* released by the Australian Commission on Safety and Quality in Health Care. Viewed at: www.safetyandquality.gov.au/wp-content/uploads/2012/01/32296-Australian-SandQ-Framework1.pdf on 5 February 2015.

Standard 3: Program development and structure

The program of study is developed in collaboration with key stakeholders reflecting contemporary trends in education and professional nursing; complying in length and structure with the Australian Qualifications Framework for the qualification offered and enabling graduates to meet the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice. Workplace experience is sufficient to enable safe and competent enrolled nursing practice by program completion.

Criteria

The program provider demonstrates:

3.1 Consultative and collaborative approaches to program design and program organisation between teaching staff, those working in health disciplines, students, consumers and other key stakeholders, including Aboriginal and Torres Strait Islander health professionals and communities.

3.2 Contemporary enrolled nursing and education practice in the development and design of the program.

3.3 A map of units against the NMBA Enrolled nurse standards for practice which clearly identifies the links between learning outcomes, assessments and required graduate outcomes.

3.4 Descriptions of program content and the rationale for its extent, depth and sequencing in relation to the knowledge, skills and behaviours expected of students.

3.5 Opportunities for student interaction with other health professions to support understanding of the multi-professional health care environment and facilitate intraprofessional and interprofessional learning for collaborative practice.

3.6 A minimum of 400 hours of successfully completed workplace experience as an enrolled nursing student, not inclusive of simulation activities, incorporated into the program and providing exposure to a variety of health care settings that support achievement of the NMBA Enrolled nurse standards for practice.

3.7 Content and sequencing of the program of study, as well as the incorporation of simulated learning opportunities, prepare students for workplace experience.

3.8 Workplace experience included as soon as is practically possible in the first year of study to facilitate early engagement with the professional context of nursing.

3.9 Workplace experience placements toward the end of the program, undertaken in Australia, to consolidate the acquisition of competence and facilitate transition to practice. A summative assessment is made at this time against the NMBA Enrolled nurse standards for practice in the clinical setting.

3.10 Equivalence of unit outcomes for programs taught in Australia in all delivery modes in which the program is offered (units delivered on-campus or in mixed-mode, by distance or by e-learning methods).

3.11 Where the structure of the program allows for multiple entry pathways for which students receive credit or advanced standing (other than on an individual basis), evidence that each pathway meets ANMAC's Enrolled Nurse Accreditation Standards.

Standard 4: Program content

The program content delivered by the program provider comprehensively addresses the Nursing and Midwifery Board of Australia's (NMBA) Enrolled nurse standards for practice and incorporates Australian best practice perspectives on enrolled nursing as well as existing and emerging international, national and regional health priorities.

Criteria

The program provider demonstrates:

4.1 A comprehensive program content document structured around the conceptual framework that includes:

a. program structure and delivery modes

b. unit outlines that detail content, objectives, learning outcomes and associated assessment

c. links between unit learning outcomes and their assessment and the NMBA Enrolled nurse standards for practice

d. learning and teaching strategies

e. a workplace experience plan demonstrating opportunities to meet the NMBA Enrolled nurse standards for practice.

4.2 The central focus of the program is enrolled nursing practice, comprising core health professional and specific enrolled nurse knowledge and skills and incorporating national and regional health priorities, health research, health policy and reform.

4.3 Research and evidence-based inquiry underpins all elements of program content and delivery.

4.4 Program content supports the development and application of knowledge and skills in:

a. person-centred care

b. evidence-based care

c. analytical and reflective practice

d. legal, regulatory[5] and ethical requirements for contemporary practice

e. quality and safety principles

f. health informatics and health technology[6]

g. cultural safety.

4.5 Inclusion of subject matter that gives students an appreciation of the diversity of Australian culture, develops their knowledge of cultural respect and safety, and engenders the appropriate skills and attitudes to enable culturally safe practice.

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5 As detailed in NMBA policies, standards, guidelines and codes—available at www.nursingmidwiferyboard.gov.au/

6 Refer to ANMAC Health informatics and health technology: an explanatory note—available at www.anmac.org.au/sites/default/files/documents/20150130_Health_Informatics_Technology_Explanatory_Note.pdf

4.6 Inclusion of a discrete unit specifically addressing Aboriginal and Torres Strait Islander peoples' history, health, wellness, culture and culturally safe practice. Health conditions prevalent among Aboriginal and Torres Strait Islander peoples, including the impacts of racism on health, are also appropriately embedded into other units within the program.

4.7 The Diploma of Nursing qualification, as derived from the National Health Training Package, is delivered within Australia, including workplace experience.[7] Other learning experiences gained outside Australia are not included in the program's unit objectives, learning outcomes or assessment.

4.8 Elective units[8] in the program are relevant to the community's health priorities as determined through consultation with key stakeholders, including industry representatives.

7 Due to there being no international equivalency in enrolled nurse practice or education, off shore components of enrolled nurse programs are not supported.

8 Elective units here mean any approved unit that is not part of the core units.

Standard 5: Student assessment

The program incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes, including a summative assessment of student performance against the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice.

Criteria

The program provider demonstrates:

5.1 Ultimate accountability for the assessment of students in relation to their workplace experience.

5.2 A consistent approach to student assessment across teaching sites and modalities that is periodically reviewed and updated.

5.3 Clear statements about assessment and program progression requirements are provided to students on program commencement and at the start of each unit.

5.4 The level, number and context of assessments are consistent with determining the achievement of the stated learning outcomes.

5.5 Both formative and summative assessment types and tasks exist across the program to enhance individual and collective learning as well as inform student progression.

5.6 A variety of assessment approaches across a range of contexts to evaluate competence in the essential knowledge, skills and behaviours required for enrolled nurse practice.

5.7 Validated instruments are used in workplace experience assessment to evaluate student knowledge, skills, behaviours and achievement of the NMBA Enrolled nurse standards for practice.

5.8 Assessments include the appraisal of competence in pharmacokinetics, pharmacodynamics and the quality use of medicines relevant to the enrolled nurse legislated scope of practice.

5.9 Evidence of procedural controls, fairness, reliability, validity and transparency in assessing students.

5.10 Processes to ensure the integrity of assessment across all modes.

5.11 Collaboration between students, health service providers and teaching staff in selecting and implementing assessment methods.

5.12 Summative assessment of student achievement of the NMBA Enrolled nurse standards for practice conducted by a registered nurse[9] in an Australian clinical context close to program completion.

9 Holds current Australian general registration as a registered nurse.

Standard 6: Students

The program provider's approach to attracting, enrolling, supporting and assessing students is underpinned by values of transparency, authenticity, equal opportunity and an appreciation of social and cultural diversity.

Criteria

The program provider demonstrates:

6.1 Applicants are informed of the following before accepting an offer of enrolment:

a. students that would be required by the Nursing and Midwifery Board of Australia (NMBA) to provide a formal English language skills test when applying for registration[10], must provide a formal English language test result demonstrating they have achieved the NMBA specified level of English language skills, prior to commencing the program

b. students are required to provide evidence[11] of having sufficient language, literacy and numeracy skills to successfully undertake the program's academic and workplace experience requirements, prior to commencing the program

c. education providers will, under the National Law, register students with the NMBA and notify the Australian Health Practitioner Regulation Agency if a student undertaking clinical training has an impairment[12] that may place the public at substantial risk of harm

d. specific requirements for right of entry to health services for workplace experience

e. the NMBA requirements for registration as an enrolled nurse including, but not limited to, the registration standard on English language skills.

6.2 Students are selected for the program based on clear, justifiable and published admission criteria.

6.3 Students are informed about, and have access to, appropriate support services, including counselling, health care and academic advisory services.

6.4 Processes to enable early identification of and support for students who are not achieving academic learning outcomes or with conduct issues.

6.5 All students have equal opportunity to meet the NMBA Enrolled nurse standards for practice. The mode or location of program delivery should not influence this opportunity.

6.6 Processes for student representation and feedback in matters relating to governance and program management, content, delivery and evaluation.

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10 Refer to NMBA English language skills registration standard at www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx

11 Evidence refers to a language, literacy and numeracy (LLN) test result from an Australian Government approved provider (for example, Australian Council for Education Research or Basic key skills builder) at exit level 3 in the Australian Core Skills Framework in both reading and numeracy. Australian students who have successfully completed an Australian Grade 12 certificate with an English subject and students who have undertaken a formal English language skills test (for example, the International Language Testing System) that meets program entry criteria referred to in criterion 6.1a, need only undertake the numeracy component of the LLN test.

12 Impairment is defined in the *Health Practitioner Regulation National Law Act 2009*, as in force in each state and territory. Section 5. Viewed at: www.ahpra.gov.au/Legislation-and-publications/Legislation.aspx on 8 March 2016.

6.7 Affirmative action strategies are adopted to support the enrolment of Aboriginal and Torres Strait Islander students and a range of supports are provided to students as needed.

6.8 Policies are adopted to support the enrolment of students from culturally, socially and linguistically diverse backgrounds, and a range of supports are offered to these students.

6.9 Affirmative action strategies are adopted to support people with diverse academic, work and life experiences to enrol in the program.

Standard 7: Resources

The program provider has adequate facilities, equipment and teaching resources, as well as staff who are qualified, capable and sufficient in number, to enable students to meet the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice.

Criteria

The program provider demonstrates:

7.1 Staff, facilities, online tools, equipment and other teaching resources are sufficient in quality and quantity for the anticipated student population and any planned increase.

7.2 Students have sufficient and timely access to program and clinical teaching staff to support their learning.

7.3 A balance of teaching, clinical, technical and administrative staff appropriate to meeting research or scholarship, governance and teaching commitments.

7.4 Staff recruitment strategies:

a. are culturally inclusive and reflect population diversity

b. take affirmative action to encourage participation from Aboriginal and Torres Strait Islander peoples.

7.5 Documented position descriptions for teaching staff, clearly articulating roles, reporting relationships, responsibilities and accountabilities.

7.6 The Head of Discipline is registered with the NMBA as a registered nurse with no conditions relating to conduct or performance, and holds a post graduate tertiary qualification relevant to their discipline.

7.7 Staff teaching enrolled nurse practice related units are registered with the NMBA as an enrolled nurse or registered nurse, with relevant clinical and academic preparation and experience.

7.8 Teaching staff are qualified in the relevant discipline for their level of teaching, to at least one qualification standard higher than the program of study being taught or with equivalent professional experience.

7.9 In cases where a teaching staff's tertiary qualifications do not include nursing, that their qualifications and experience are relevant to the unit(s) they are teaching.

7.10 Processes to ensure teaching staff demonstrate a sound understanding of contemporary nursing research, scholarship[13] and practice in the unit(s) they teach.

7.11 Learning and teaching, are underpinned by research and staff are engaged in scholarship. Areas of interest, publications, grants and conference papers are documented.

7.12 Policies and processes to verify and monitor the academic and professional credentials, including registration, of current and incoming staff and evaluate their performance and development needs.

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13 See glossary for an operational definition of scholarship.

Standard 8: Management of workplace experience

The program provider ensures that every student is given a variety of supervised workplace experiences conducted in environments providing suitable opportunities and conditions for students to attain the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice.

Criteria

The program provider demonstrates:

8.1 Constructive relationships and clear contractual arrangements with all health providers through which students gain their workplace experience, and processes to ensure these are regularly evaluated and updated.

8.2 Risk management strategies in all environments where students are placed to gain their workplace experience and processes to ensure these are regularly reviewed and updated.

8.3 Workplace experiences provide timely opportunities for experiential learning of program content that is progressively linked to attaining the NMBA Enrolled nurse standards for practice.

8.4 Each student is provided with a variety of workplace experiences reflecting the major health priorities and broad landscape of enrolled nurse practice. Opportunities are provided for intraprofessional and interprofessional learning and the development of knowledge, skills and behaviours for collaborative practice.

8.5 Clearly articulated models of supervision, support, facilitation and assessment are in place for all workplace settings so students can achieve the required learning outcomes and the NMBA Enrolled nurse standards for practice.

8.6 Teaching staff, nurse clinicians and other health professionals engaged in supervising and supporting students during workplace experiences are prepared for this role and seek to incorporate contemporary and evidence-based Australian and international perspectives on nursing practice.

8.7 Assessment of student practice against the NMBA Enrolled nurse standards for practice, within the context of the workplace experience, is undertaken by an appropriately qualified registered nurse.

8.8 Appropriate resources are provided, monitored and regularly evaluated to support students while on workplace experience.

Standard 9: Quality improvement and risk management

The program provider is able to assess and address risks to the program, its outcomes and students, and has a primary focus on continually improving the quality of the learning and teaching experience for students and the competence of graduates.

Criteria

The program provider demonstrates:

9.1 The ability to assess and address risks to the program, its outcomes and students, with a primary focus on continually improving the quality of the teaching and learning experience for students and the competence of graduates.

9.2 Regular evaluation of teaching staff and clinical supervisor effectiveness using feedback from students and other sources; systems to monitor and, where necessary, improve staff performance.

9.3 Professional and academic development of staff to advance knowledge and competence in teaching effectiveness and assessment.

9.4 Feedback gained from the quality cycle is incorporated into the program of study to improve the experience of theory and practice learning for students.

9.5 Regular evaluation and revision of program content to include contemporary and emerging issues surrounding enrolled nursing practice, health care research and health policy and reform.

9.6 Students and staff are adequately indemnified for relevant activities undertaken as part of program requirements.

Glossary

Australian Council for Educational Research (ACER)—organisation that undertakes development and provision of assessment and reporting tools and services for schools, universities, technical and further education institutes and registered training organisations, health professionals, employers and governments in Australia and internationally. ACER offers online assessment tools that are matched to the Australian Core Skills Framework and identify and measure an individual's foundation skills levels in English language literacy and numeracy skills.(14)

Advanced standing—the recognition of prior learning through experience and/or studies.

Australian Core Skills Framework (ACSF)—a tool which assists both specialist and non-specialist English language, literacy and numeracy practitioners to describe an individual's performance in the five core skills of learning, reading, writing, oral communication and numeracy.(15)

Australian Health Practitioner Regulation Agency (AHPRA)—organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. AHPRA supports National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme. AHPRA manages the registration and renewal processes for health practitioners and students around Australia.

Australian Nursing and Midwifery Accreditation Council (ANMAC)—the independent accrediting authority for nursing and midwifery under the National Registration and Accreditation Scheme. In this role ANMAC is responsible for developing the content of accreditation standards and determining whether programs of study for nurses and midwives seeking to practice in Australia meet the required education standards. This contributes to protecting the health and safety of the community.

Australian Nursing and Midwifery Council (ANMC)—evolved into ANMAC following approval as the accrediting authority for nursing and midwifery. ANMC authored the original set of accreditation standards as well as the national competency standards for nursing and midwifery.

Australian Qualifications Framework (AQF)—the national policy for regulated qualifications in Australian education and training. AQF incorporates the qualifications from each education and training sector into a single comprehensive national qualifications framework.

Australian Skills Quality Authority (ASQA)—the national regulator for Australia's vocational education and training sector that regulates courses and training providers to ensure nationally approved quality standards are met.

AQF qualification—the result of an accredited complete program of learning leading to formal certification that a graduate has achieved learning outcomes as described in the Australian Qualification Framework.

Basic key skills builder® (bksb)—an organisation that provides online literacy, numeracy and foundation skills assessment tools. The bksb assessment tool has been mapped to the Australian Core Skills Framework and provides an overview of an individual's learning strengths and determines their English and Maths level.(16)

Collaborative practice—where health professionals work as an effective team, optimising individual skills and talents and sharing case management to reach the highest of patient care standards.

Competence/competent —Competence is the combination of knowledge, skills, attitudes, values and abilities that underpin effective performance in a profession. It encompasses confidence and capability. (17)

Conceptual framework—promotes coherence in the program of study by identifying how underpinning educational and nursing philosophies is used to guide learning and teaching approaches and support program learning outcomes.

Continuing professional development—the means by which members of the professions maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.(18)

Criteria—rules or tests on which a judgement or decision in relation to compliance with the accreditation standards can be used.

Cultural safety—a term that originated in the nursing profession in New Zealand and specifically focuses on the health care experiences and outcomes of First Nations Peoples.(19) It has been adapted to the Australian context for Aboriginal and Torres Strait Islander Australians over the last 15 years, and is often used in conjunction with cultural respect. Cultural safety occurs when Aboriginal and Torres Strait Islander peoples experience health care practices and policies from both individual practitioners and organisational health services that are culturally respectful and free from individual racism.(20-22) The presence or absence of cultural safety can only be determined by Aboriginal and Torres Strait Islander peoples and requires continuous review and change at both individual and systemic levels.(19-22) In terms of his or her individual practice, an enrolled nurse:

> ...delivering a nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.(23)

Education provider—refers, for the purpose of these standards, to the organisational entity responsible for the design, delivery and quality assurance of a program of study in enrolled nursing from which graduates are eligible to apply for registration with the Nursing and Midwifery Board of Australia.

Emotional intelligence—the ability to understand, identify in oneself and others, and manage emotions. Includes the domains of self-monitoring, self-regulation, self-motivation, empathy and social skills.(24)

Enrolled nurse—a person who provides nursing care under the direct or indirect supervision of a registered nurse. They have completed the prescribed education preparation, and demonstrate competence to practise under the Health Practitioner Regulation National Law as an enrolled nurse in Australia. Enrolled nurses are accountable for their own practice and remain responsible to a registered nurse for the delegated care.(25)

Enrolled nurse standards for practice—are the core practice standards that provide the framework for assessing enrolled nurse practice.(13)

Equivalent professional experience—the successful completion of a qualification equivalent to that being taught and sufficient post-graduate professional experience in the discipline being taught, to demonstrate competence in applying the discipline's principles and theory.

Governance—framework, systems and processes supporting and guiding an organisation towards achieving its goals and the mechanisms by which it, and its people, are held to account. Ethics, risk management, compliance and administration are all elements.

Graduate outcomes—knowledge, skills, behaviours and attitudes possessed by graduating students in accordance with the Nursing and Midwifery Board of Australia Enrolled nurse standards for practice and those specified by the education provider.

Head of discipline—lead nursing academic responsible for the design and delivery of the program of study on behalf of the education provider.

Health informatics—the appropriate and innovative application of the concepts and technologies of the information age to improve health care and health.(26)

***Health Practitioner Regulation National Law Act 2009* (the National Law)**—legislation contained in the schedule to the Act, which provides for the full operation of the National Registration and Accreditation Scheme for health professions from 1 July 2010. It covers the more substantial elements of the national scheme, including registration arrangements, accreditation arrangements, complaints, conduct, health and performance arrangements, and privacy and information-sharing arrangements. The purpose is to protect the public by establishing a national scheme for regulating health practitioners and students undertaking programs of study leading to registration as a health practitioner.

Health service providers—health facilities or other appropriate service providers, where students undertake supervised workplace experience as part of a nursing or midwifery program of study.

International English Language Testing System (IELTS)—used to test English language proficiency. The IELTS test is designed to assess the language ability of non-native speakers of English who intend to study or work where English is the language of communication.(27)

Interprofessional learning—when two or more professions learn with, from and about each other to improve collaboration and the quality of care.(28)

Intraprofessional learning—when learners from the one or similar profession learn about, from and with each other to enable effective collaboration and improved outcomes.(29)

Life-long learning—includes learning firmly based in clinical practice situations, formal education, continuing professional development and informal learning experiences within the workplace. Also involves the learner taking responsibility for their own learning, and investing time, money and effort in training or education on a continuous basis.

Nursing and Midwifery Board of Australia (NMBA)—the national regulator for the nursing and midwifery professions in Australia. The NMBA was established under the Health Practitioner Regulation National Law, as in force in each state and territory. Its primary role is to protect the public and set standards and policies that all nurses and midwives registered within Australia must meet.

Pharmacodynamics—study of the biochemical and physiological effects of drugs and the mechanisms of their action in the body.

Pharmacokinetics—study of the bodily absorption, distribution, metabolism, and excretion of drugs.

Practice—any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. Practice is not restricted to the provision of direct clinical care. It includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of health services in the health profession.(30)

Program or program of study—full program of study and experiences that are required to be undertaken before a qualification, such as a statement of completion or attainment, can be awarded.

Program provider—the Registered Training Organisation authorised by the Australian Skills and Quality Authority to deliver the qualification of Diploma of Nursing, as derived from the current National Health Training Package.

Quality use of medicines—part of the National Medicines Policy to ensure the judicious, appropriate, safe and effective use of medicines.(31)

Recognition of prior learning—refers to an assessment process for the students formal and informal learning to determine the extent they achieved required learning outcomes, competency outcomes or standards for entry to and/or partial or total completion of a qualification.

Registered Training Organisation (RTO)—training providers registered by the Australian Skills Quality Authority (or, in some cases a state regulator such as the Training Accreditation Council Western Australia or the Victorian Registration and Qualification Authority) to deliver vocational education and training services.(32)

Registered nurse—is a person who has completed the prescribed education preparation, demonstrates competence to practise and is registered under the Health Practitioner Regulation National Law as a registered nurse in Australia.(25)

Preliminary regulatory impact assessment—a tool used by the Office of Best Practice Regulation to assess the potential effects of a regulatory proposal and whether there is a need for further analysis and consultation by way of a Regulation Impact Statement.

Scholarship—application of a systematic approach to acquiring knowledge through intellectual inquiry. Includes disseminating this knowledge through various means such as publications, presentations (verbal and audio-visual) and professional practice. Also includes applying this new knowledge to the enrichment of the life of society.(28)

Simulation—any educational method or experience evoking or replicating aspects of the real world in an interactive manner.

Standard—level of quality or attainment.

State regulators—includes the Training and Accreditation Council, Western Australia and the Victorian Registration and Qualification Authority. All other states and territories are regulated by the Australian Skills Quality Authority.

Student—any person enrolled in a program from which graduates are eligible to apply for registration to practice as an enrolled nurse.

Student assessment—process to determine a student's achievement of expected learning outcomes. May include written and oral methods and practice or demonstration.

Supervision or supervise—can be direct or indirect:

- *Direct supervision* is when the supervisor is present and personally observes, works with, guides and directs the person being supervised.
- *Indirect supervision* is when the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, the needs of the person receiving care and the needs of the person who is being supervised.(13)

Surface versus deep learning—surface learning is when students accept information at face value and focus on merely memorising it as a set of unlinked facts. This leads to superficial, short-term retention of material, such as for examination purposes. In contrast, deep learning involves the critical analysis of new ideas, linking them to already known concepts and principles. This leads to understanding and long-term retention of concepts so they can be used to solve problems in unfamiliar contexts. Deep learning promotes understanding and application for life.(33)

Teaching staff—education provider staff who teach into the program of study, meet the requirements established in Standard 7 of ANMAC's Enrolled Nurse Accreditation Standards, and are engaged in teaching, supervising, supporting and/or assessing students for acquiring required skills, knowledge, attitudes and graduate competency outcomes.

Unit—a unit of study taught within an enrolled nurse program of study. Referred to as 'subject' in other ANMAC accreditation standards. 'Unit' is used here to promote consistency with nomenclature commonly used in the National Health Training Package.

Vocational Education Training (VET)—one of the three major sectors of education and training in Australia, the other two being the school and higher education sectors. VET is provided by industry, adult education, community based and private training providers. VET is supported by the Commonwealth and State governments in Australia primarily through technical and further education (TAFE) Institutes and TAFE divisions in dual sector universities.(34)(31)

Workplace Experience—a component of nursing education, not inclusive of simulation activities, that enrolled nurse students are required to successfully complete, so as to foster sound clinical judgement when applying theoretical knowledge in a practice setting and demonstrate achievement of the Nursing and Midwifery Board of Australia Enrolled nurse standards for practice.

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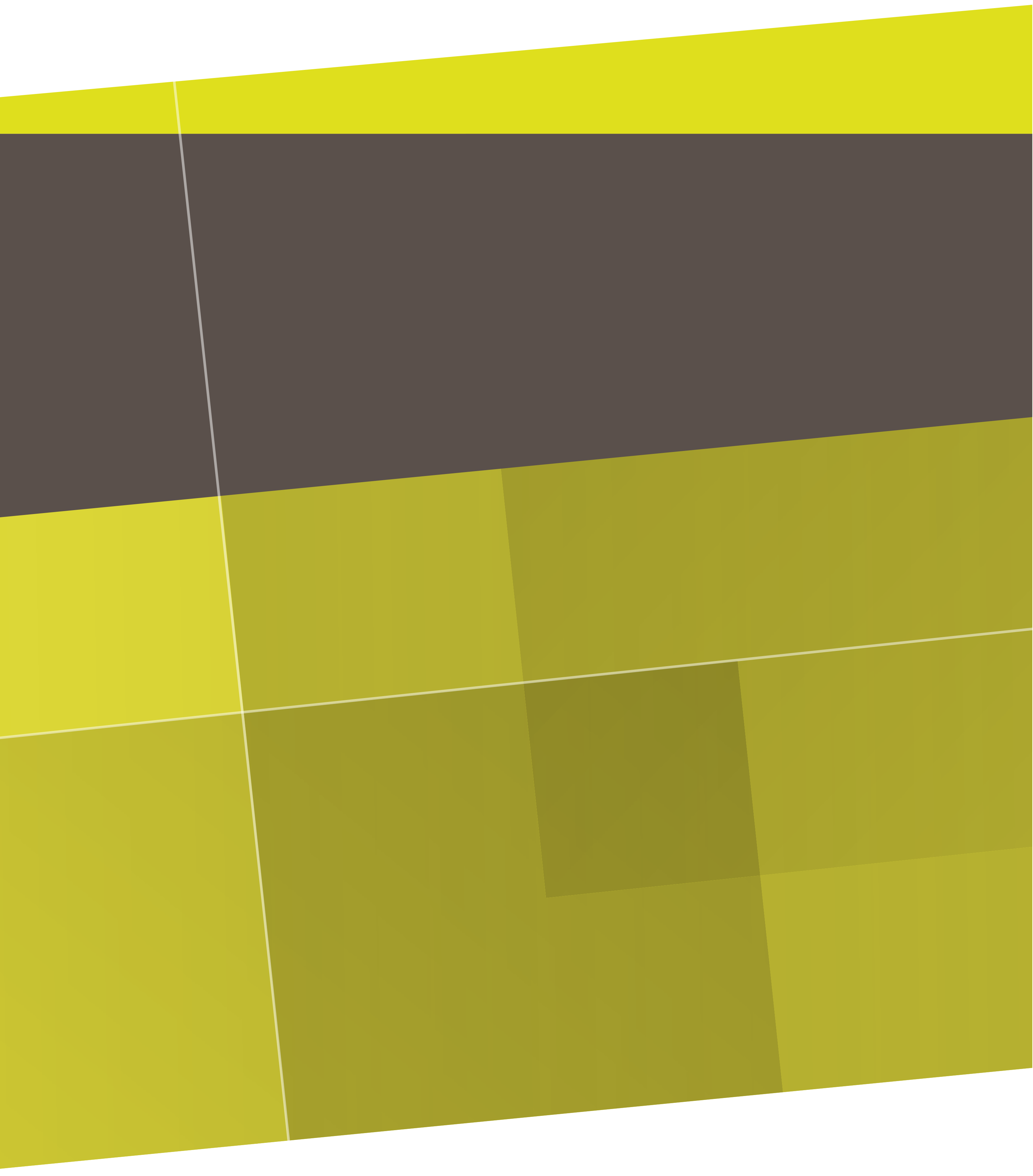

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nurse practitioner

Nurse Practitioner

Accreditation Standards 2015

Australian
Nursing & Midwifery
Accreditation Council

Nurse Practitioner

Accreditation Standards 2015

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1 Preamble

1.1 Nurse practitioner education in Australia

To apply to become a nurse practitioner in Australia, individuals must first have completed a program of study accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the Nursing and Midwifery Board of Australia (NMBA). Programs of study eligible for accreditation are delivered by a government-accredited university or other higher education provider. These programs lead to the award of a Master of Nurse Practitioner.

The Australian regulatory environment in which nurse practitioners are endorsed and programs of study accredited and delivered, has undergone significant change over the last five years. Higher education regulation and quality assurance has also undergone major transformation during this time. Implementation of national reforms in health policy, governance and funding, particularly in relation to eligibility for the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), has also influenced nurse practitioner education. This context underpinned the review of these Nurse Practitioner Accreditation Standards.

1.2 Health practitioner regulation

The *Health Practitioner Regulation National Law Act 2009* (the National Law), enacted in July 2010, is the national law by which the National Registration and Accreditation Scheme for health practitioners is instituted.

The scheme has six objectives, with the first of primary importance:

> **... to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.**[1]

Under Section 49(1) of the National Law, graduates of nurse practitioner programs of study are not eligible to register unless the program is accredited by ANMAC and approved by the NMBA as meeting the educational requirements for endorsement as a nurse practitioner.

After the National Law was introduced, the Australian Nursing and Midwifery Council (ANMC) was appointed under the National Registration and Accreditation Scheme as the independent accreditation authority for all nursing and midwifery education providers and programs of study leading to registration and endorsement in Australia. The name ANMC was changed to ANMAC in November 2010 to reflect its principal role as an accrediting authority.

ANMAC is responsible for monitoring education providers and programs of study leading to qualification for registration in nursing and midwifery. In addition, through a process of cyclical review, ANMAC maintains the integrity and effectiveness of accreditation standards that underpin the accreditation of programs of study under its mandate.

Professional education accreditation is concerned with the quality of the profession and its work, from the perspective of the public interest and community safety. It is part of a broader process of assuring the community that, having completed an accredited program of study, beginning professional practitioners have achieved agreed professional outcomes and are able to practise in a safe and competent manner because they are equipped with the necessary foundation knowledge, professional attitudes and essential skills. This process, however, relies on two fundamental principles:

1 AHPRA (2009). *Health Practitioner Regulation National Law Act 2009*, as enacted in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx on 5 March 2015.

1. That the education providers themselves are authorised to issue the relevant qualification and are evaluated to assure continued quality learning outcomes for their graduates.
2. That there is a set of agreed and contemporary competency or practice standards for the profession, against which the capability of graduates of programs is assessed.

The first principle is discussed in Section 1.3. The second relates to the Nurse Practitioner Standards for Practice[2] developed by the NMBA in 2014. These standards articulate the core competencies used to assess the performance of those wanting to obtain and retain a licence to practise as a nurse practitioner in Australia. Higher education providers use them when developing nurse practitioner curricula and assessing student performance. Employers use them when evaluating new graduate performance.

The accreditation process administered by ANMAC is an efficient and effective proxy for externally assessing graduates against standards for practice. Professional program accreditation must ensure that professional standards are protected without inhibiting diversity and innovation or constraining continuous quality improvement. As with the national standards for practice, the national accreditation standards are regularly reviewed to ensure relevance in the light of changes in health and education legislation, policy, delivery and ethos.

1.3 Higher education regulation

The Tertiary Education Quality and Standards Agency (TEQSA) was established in July 2011 as an independent national body to regulate and assure the quality of all types of higher education and fulfil the Government's commitment to:

> **... accredit providers, evaluate the performance of institutions and programs, encourage best practice, simplify current regulatory arrangements and provide greater national consistency.[3]**

Recent Australian Government directions are intended to assure quality while reducing the higher education regulatory burden.[4] Consequently, there is now emphasis on improving the focus, timeliness and efficiency of TEQSA's regulatory activities.[5]

A part of TEQSA's regulatory responsibility is to evaluate the performance of universities and other higher education providers within a period that does not exceed seven years or when there is evidence that standards are not being met. The Higher Education Standards Framework sets a legislated standard by which TEQSA accredits higher education providers.[6] These standards apply to all higher education providers offering Level 5 (diploma) to Level 10 (doctoral) qualifications as described in the Australian Qualifications Framework (AQF).[7] Consequently, all higher education institutions offering degree programs in nursing are regulated and accredited by TEQSA.

The AQF is the national policy for regulated qualifications in Australian education and training. It incorporates the qualifications from each education and training sector into one comprehensive framework comprising 10 levels of qualification, with a Masters Degree sitting at Level 9.

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2 NMBA (2014). *Nurse Practitioner Standards for Practice*. Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx on 10 March 2015.

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The AQF stipulates the learning outcomes expected within each AQF level and qualification type. It expresses these as dimensions of knowledge, skills and their application. This ensures the integrity of qualifications and standardises them across education providers, settings and delivery modes. All institutions offering nursing programs are required to comply with AQF criteria for learning outcomes.

1.4 Health reforms

Major reforms in the governance, funding and provision of health services[8] over recent years have aimed to increase national integration and local control of the health care system. The reform is intended to improve patient access and the performance, transparency and accountability of health services, while ensuring funding sustainability.

As part of the Australian Government's health reform, nurse practitioners have been supported in having a greater role in the delivery of patient care.[9] The reform proposes that nurse practitioners, working within the hospital setting, would support and contribute to such national initiatives as:

- four-hour national access target for emergency departments
- increased number of sub-acute care beds
- reduced waiting times for elective surgery.[10]

In 2010, funding was provided to allow eligible nurse practitioners access to the MBS and the PBS with the purpose of improving access to primary health care services and promoting multidisciplinary team-based approaches to health care.[11] MBS access enables eligible nurse practitioners to:

- treat patients with a broad range of medical conditions in a variety of settings, including aged care facilities
- access a number of telehealth clinical support items
- perform certain pathology tests and request a range of pathology and diagnostic services
- refer patients to specialists and consultant physicians within their scope of practice.[12]

Access to MBS and PBS would also provide nurse practitioners with an opportunity to have a greater role in non-acute settings, including in the areas of primary care, aged care and in rural and remote Australia[13], although a recent study suggests that more MBS access is necessary for viability of the nurse practitioner primary health care role.[14]

These health reforms are influencing both nurse practitioner practice and education.

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8 Australian Government (2010). *A National Health and Hospitals Network for Australia's Future* and *A National Health and Hospitals Network: Further Investments in Australia's Health*. Viewed at: www.budget.gov.au/2010-11/content/glossy/health/download/health_overview.pdf on 9 April 2015.

9 Australian Government (2012). Health Workforce, Nurse Practitioners. Viewed at: www.health.gov.au/internet/main/publishing.nsf/Content/work-nurse-prac on 8 April 2015.

10 ibid.

11 ibid.

12 Australian Government (2013). Medicare: Primary Care (GP, nursing, allied health), Midwives and Nurses. Viewed at: www.health.gov.au/internet/main/publishing.nsf/Content/midwives-nurse-practitioners on 8 April 2015.

13 Australian Government (2012). Health Workforce, Nurse Practitioners. Viewed at: www.health.gov.au/internet/main/publishing.nsf/Content/work-nurse-prac on 8 April 2015.

14 Helms C, Crookes J & Bailey D (2015). Financial viability, benefits and challenges of employing a nurse practitioner in general practice. *Australian Health Review,* 39(2), 205–2010, http://dx.doi.org/10.1071/AH13231.

1.5 Background

The original Nurse Practitioner Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia—with Evidence Guide were developed in February 2009 by the ANMC with key industry stakeholders, including regulators, professional bodies, consumers and academics. The standards were approved by the newly established NMBA in 2010.[15]

As the external accreditation authority for nursing and midwifery programs, ANMAC has, since 1 July 2010, used the current standards to undertake accreditation assessments of programs of study leading to nurse practitioner endorsement. During this time, education providers have submitted valuable feedback on the accreditation standards, as have independent assessment team members and ANMAC Associate Directors for Professional Programs.

As part of the cyclical review of all accreditation standards, the ANMAC Board authorised the review of the Nurse Practitioner Accreditation Standards to start in January 2014 with stakeholder engagement to be implemented in accordance with National Law, which states:

> **In developing an accreditation standard for a health profession, an accreditation authority must undertake wide-ranging consultation about the content of the standard.**[16]

1.6 Review of the Nurse Practitioner Accreditation Standards

The ANMAC Board convened an EAG (see Acknowledgements) to oversee the review of the Nurse Practitioner Accreditation Standards. The EAG provided input into a project timeline and identified a wide-ranging list of stakeholders to consult. A letter of invitation was sent to stakeholders outlining the process and options for providing comment and feedback throughout the review. Feedback options included completing an online survey, sending a written submission and/or attending one of three consultation forums.

The review was an iterative process including two stages of consultation, each focused on a separate consultation paper.

Stage 1—first consultation paper

The first consultation paper and first version of the revised standards was prepared with a consultancy firm, edited by the EAG, approved by the ANMAC Board and sent to stakeholders to consider in May 2014.

This paper covered the background, context, purpose and process of the review. It also addressed key areas of change in education and health care policy pertinent to revising the nine Nurse Practitioner Accreditation Standards. Stakeholders were asked to consider specific content areas in the first version of the standards, including:

- defining and implementing the concept of 'capability' as understood by nurse practitioners
- attaining national prescribing competencies
- replacing 'professional experience' terminology
- strengthening viva voce assessment
- specifying program entry criteria
- specifying supernumerary clinical hours

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15 ANMC (2009). *Registered Nurse Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia—with Evidence Guide*, February 2009, Canberra.

16 AHPRA (2009). *Health Practitioner Regulation Law Act 2009* as in force in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-publications/Legislation.aspxon on 6 May 2013.

- specifying program convenors be endorsed nurse practitioners
- developing students' generic and specialty knowledge and skills
- clarifying what is meant by 'a suitably qualified multidisciplinary team member'.

Stakeholders were also asked to consider if the first version of the standards was complete and sufficient to assure the NMBA and Australian community that a graduate of an accredited nurse practitioner program was fit to be endorsed and practise in a safe and competent manner in the context of a contemporary, Australian health care setting.

Feedback indicated overall support for much of the content in the first version of the Nurse Practitioner Accreditation Standards, with a few areas of difference emerging:

1. Specifying 500 hours of supernumerary clinical hours: stakeholders focused on the absence of evidence to guide curriculum design and the potential benefits and/or burdens associated with specifying supernumerary practice.
2. Specifying the program convenor be an endorsed nurse practitioner: stakeholders held varying perspectives on whether the incumbent could maintain their nurse practitioner endorsement and meet the academic demands and educational requirements of this role.
3. Specifying student exposure to generic and speciality practice settings: stakeholder feedback indicated lack of agreement as to what constituted 'generic' and 'speciality' knowledge, skills and practice settings and whether multiple settings were pedagogically required.

Stage 2—second consultation paper

The second consultation paper, released in September 2014, included the second version of the draft Nurse Practitioner Accreditation Standards, which was informed by stakeholder feedback.

In this version, the EAG considered there to be, on balance, support for specifying minimum requirements for integrated professional practice. Previous stakeholder feedback indicated that 500 supernumerary hours was excessive and likely to be a significant burden. Consequently, the minimum requirement was reduced to 300 hours.

Questions posed in the second consultation paper sought clarity on the:

- role of endorsed nurse practitioners in providing the nurse practitioner program of study
- management of integrated professional practice so it supports student preparation for nurse practitioner practice in contemporary health care settings.

Stakeholders were again asked to comment on any other issue, wording, error, gap or duplication in the draft accreditation standards.

Written feedback was collated before the summative consultation forum held on 11 November 2013. A review of each standard and final issues were addressed at the forum. After considering emerging literature and stakeholder feedback, the EAG arrived at these outcomes:

Standard 3. Program development and structure

The minimum of 300 supernumerary hours of integrated profession practice was maintained in the standards in light of case study findings from the CLLEVER Study[17] that reported perceived conflict at times where employed role and student role exist together (that is, lack of supernumerary clinical time allocation) resulting in employment requirements taking precedence over learning and teaching opportunities.

17 Educating nurse practitioners: advanced specialty competence, clinical learning and governance. Also known as the CLLEVER study: NP CLinical LEarning & GoVERnance Project, Final Report 2014. Viewed at: https://acnp.org.au/article/cllever-study on 12 January 2015. NB: Publication not released in time for inclusion in Consultation Paper 2.

Standard 6. Students

The change to the specified amount of advanced level practice experience required on entry to the nurse practitioner program balanced the need for students to demonstrate sufficient depth and length of experience with the need to minimise potential restrictions on advanced practitioners entering a nurse practitioner program. The term 'advanced nursing practice' was introduced into criterion 6.2b so as to align with terminology used in the NMBA's Nurse Practitioner Standards for Practice.

Standard 7. Resources

The academic role of the endorsed nurse practitioner was specified as one that contributes to, rather than is responsible for, the design and development of nurse practitioner curricula, teaching and learning approaches and quality improvement and risk management strategies.

Standard 8. Management of integrated professional practice

Planned health care experiences were needed to support student knowledge and skill development in patient-centred care that are consistent with principles of primary health care and complementary to the student's speciality skills and knowledge.

1.7 Regulatory impact assessment of Accreditation Standards for Nurse Practitioner

During the development of the Nurse Practitioner Accreditation Standards, ANMAC undertook a Regulation Impact Statement Preliminary Assessment. This assessment is required by the Australian Government's Office of Best Practice Regulation so that national standard setting agencies, such as ANMAC, consider the impact of regulation, standards and other quasi-regulation before implementation.

This assessment was undertaken in accordance with the Council of Australian Governments' Best Practice Regulation—A Guide for Ministerial Councils and National Standard Setting Bodies 2007[18] and considered such matters as benefits and burdens of introducing the new accreditation standards and the potential impact on stakeholders.

ANMAC's Regulation Impact Statement Preliminary Assessment was submitted to the Office of Best Practice Regulation which considered proposed changes to the NMBA-approved national accreditation standards to be minor and required no further regulatory impact assessment.

1.8 Ratification and approval

While ANMAC is responsible for developing the accreditation standards, the NMBA is responsible for approving them under the National Law. This same dual regulatory function applies to the accreditation of individual programs of study leading to registration or endorsement as a nurse or midwife.

The EAG and the Standards, Accreditation and Assessment Committee reviewed the final draft of the standards before presenting them to the ANMAC Board to ratify. After ratification, the Nurse Practitioner Accreditation Standards were submitted to the NMBA for review.

The standards were approved by the NMBA on 3 July 2015.

18 Council of Australian Governments (2007). Best Practice Regulation—A guide for Ministerial Councils and national standard setting bodies. Viewed at: www.dpmc.gov.au/sites/default/files/publications/COAG_best_practice_guide_2007.pdf on 5 February 2015.

2 Introduction

2.1 Purpose of the ANMAC accreditation process

ANMAC's accreditation process aims to ensure the quality of the nursing and midwifery professions and their work, on behalf of public interest and public safety. The public needs to know that those who graduate from higher education provider nurse practitioner programs of study are competent to practise safely and effectively and eligible to be endorsed through the NMBA as a nurse practitioner in Australia.

Education providers ensure that graduates have the common and transferable skills, knowledge, behaviours and attitudes (as articulated in the Nurse Practitioner Standards for Practice) required to practice. Accreditation evaluates if the education provider, on the evidence they provide, will meet this goal.

Professional program accreditation is concerned with the quality of the profession and its work, from the perspective of public interest and public safety. This is in contrast to accreditation (or similar assessment) of higher education providers by TEQSA for quality assurance and risk management. However, having TEQSA accreditation is a prerequisite for ANMAC to assess nursing and midwifery programs for accreditation.

External professional (or occupational) accreditation helps assure the community that professionals who have completed an accredited program of study are safe and competent beginning practitioners. It is an efficient and effective proxy for assessing every graduate against the Nurse Practitioner Standards for Practice. Accreditation therefore involves comprehensively examining the higher education provider's:

- governance system and quality management framework
- student enrolment processes, student support, assessment and workplace experience
- curriculum philosophy, curriculum structure and content
- teaching and learning approaches.

Periodic accreditation of nursing and midwifery programs stimulates education providers to review and assess their own programs. It enables providers to validate the strengths of existing programs, identify areas for improvement and introduce new teaching and learning initiatives.

ANMAC's accreditation process supports diversity, innovation and evolution in approaches to education. The standards therefore have minimal prescription of curricula content, core subject inclusion and educational approaches required for program delivery.

2.2 Nurse Practitioner Accreditation Standards

The Nurse Practitioner Accreditation Standards detail the minimum requirements that higher education providers must meet if they want their program of study to be accredited by ANMAC. TEQSA-approved higher education providers must also be accredited. Under Section 49(1) of the National Law, graduates cannot register unless their program of study is accredited by ANMAC and approved by the NMBA.

The nine Nurse Practitioner Accreditation Standards are in Figure 1:

Figure 1: Nurse Practitioner Accreditation Standards

STANDARD 1: GOVERNANCE
The education provider has established governance arrangements for the nurse practitioner program of study that develop and deliver a sustainable, high-quality education experience for students, to enable them to meet the Nurse Practitioner Standards for Practice.
STANDARD 2: CURRICULUM FRAMEWORK
The education provider uses an appropriate and relevant philosophy to make explicit the assumptions about the nature of knowledge that informs the curriculum content and nature of the health service environment that the graduate will enter. In addition, the education provider makes explicit the educational theory that informs the design and delivery of sustainable processes for learning and teaching in the nurse practitioner program.
STANDARD 3: PROGRAM DEVELOPMENT AND STRUCTURE
The program of study, developed in collaboration with key stakeholders, reflects current nurse practitioner practice and learning and teaching approaches; complies with the Australian Qualifications Framework for a Level 9 Masters Degree and has sufficient integrated professional practice to enable graduates to meet the Nurse Practitioner Standards for Practice and to function as a safe, autonomous and collaborative nurse practitioner by program completion.
STANDARD 4: PROGRAM CONTENT
The program content delivered by the program provider comprehensively addresses the Nurse Practitioner Standards for Practice as well as existing and emerging national and regional health priorities across a range of health service delivery contexts.
STANDARD 5: STUDENT ASSESSMENT
The curriculum incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes. This includes a comprehensive summative assessment of student performance against the current Nurse Practitioner Standards for Practice.
STANDARD 6: STUDENTS
The program provider's approach to attracting, enrolling, supporting and assessing students is underpinned by values of transparency, authenticity, equal opportunity and an appreciation of social and cultural diversity.
STANDARD 7: RESOURCES
The program provider has adequate facilities, equipment and teaching resources, as well as staff who are qualified, capable and sufficient in number, to enable students to meet the Nurse Practitioner Standards for Practice.
STANDARD 8: MANAGEMENT OF INTEGRATED PROFESSIONAL PRACTICE
The program provider ensures that every student is given supervised integrated professional practice in environments providing suitable learning and teaching opportunities and conditions for students to meet the Nurse Practitioner Standards for Practice.
STANDARD 9: QUALITY IMPROVEMENT AND RISK MANAGEMENT
The program provider is able to assess and address risks to the program, its outcomes and students, and has a primary focus on continually improving the quality of the teaching and learning experience for students and the competence of graduates.

2.3 Using the Nurse Practitioner Accreditation Standards

The Nurse Practitioner Accreditation Standards are designed principally for use by higher education providers seeking accreditation of a nurse practitioner program of study. ANMAC's Associate Directors for Professional Programs, the Nurse Practitioner Accreditation Committee and members of ANMAC assessment teams evaluate programs against these standards and make recommendations to the ANMAC Board for decision making.

While the standards are principally for use by higher education providers, they are also useful for anyone interested and involved in the education of nurse practitioners.

Higher education providers seeking accreditation have to complete an application pack (available at www.anmac.org.au), which includes the Nurse Practitioner Accreditation Standards and guidance on addressing them. This guidance is regularly reviewed and updated to help education providers prepare their submissions.

Other reference material that may assist education providers (available at www.anmac.org.au) include the:

- National Guidelines for the Accreditation of Nursing and Midwifery Programs Leading to Registration and Endorsement in Australia[19], which describes the structures, personnel and processes of accreditation of nursing and midwifery providers and programs of study
- ANMAC Assessor Handbook.[20]

19 ANMAC (2012). *National Guidelines for Accreditation of Nursing and Midwifery Programs of Study Leading to Registration and Endorsement in Australia*. November 2012. Viewed at: www.anmac.org.au/document/national-guidelines-accreditation-nursing-and-midwifery-programs on 5 February 2015.

20 ANMAC (2012). Assessor Handbook. Viewed at: www.anmac.org.au/sites/default/files/documents/Assessors_Handbook.pdf on 5 February 2015.

3 Nurse Practitioner Accreditation Standards

Standard 1: Governance

The education provider has established governance arrangements for the nurse practitioner program of study that develop and deliver a sustainable, high-quality education experience for students, to enable them to meet the Nurse Practitioner Standards for Practice[21].

Criteria

The education provider must provide evidence of:

1.1 Current registration by the Tertiary Education Quality and Standards Agency (TEQSA) as an Australian university or other higher education provider.[22]

1.2 Current accreditation of the nurse practitioner program of study by the University (or TEQSA for non-self-accrediting higher education providers) detailing the expiry date and any recommendations, conditions and progress reports related to the school.

1.3 Listing on the Australian Qualifications Framework (AQF) National Registry for the award of Masters Degree (Level 9)[23] as a minimum, with the title Master of Nurse Practitioner as the named degree.

1.4 Current, documented academic governance structure for the university or other higher education provider and the school conducting the program (program provider) that ensures academic oversight of the program and promotes high-quality teaching and learning scholarship, research and ongoing evaluation across all learning settings.

1.5 Terms of reference for the relevant program advisory committee demonstrating partnership with key stakeholders[24], including partnerships with Aboriginal and Torres Strait Islander health professionals and communities.

1.6 Staff delegations, reporting relationships, and the role of persons or committees in decision making related to the program.

1.7 Governance arrangements between the university or higher education provider and the school that ensure responsiveness to requirements for ongoing compliance with accreditation standards.

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21 NMBA (2014). *Nurse Practitioner Standards for Practice*. Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx on 10 March 2015.

22 For an explanation of provider categories see: TEQSA, (2011). *Higher Education Standards Framework (Threshold Standards)*. Viewed at: www.teqsa.gov.au/higher-education-standards-framework on 5 February 2015.

23 This is the 'required level' referred to throughout these standards.

24 Key stakeholders include, but are not limited to, consumers and representatives from relevant professional organisations.

1.8 Policies relating to credit transfer or the recognition of prior learning that are consistent with AQF national principles and the graduate's ability to meet the Nurse Practitioner Standards for Practice.

1.9 Governance arrangements between the education provider and health service providers to monitor students' practice experience and learning and teaching in the clinical setting including, but not limited to, program resourcing and clinical teaching, supervision and assessment.

Standard 2: Curriculum framework

The education provider uses an appropriate and relevant philosophy to make explicit the assumptions about the nature of knowledge that informs the curriculum content and nature of the health service environment that the graduate will enter. In addition, the education provider makes explicit the educational theory that informs the design and delivery of sustainable processes for learning and teaching in the nurse practitioner program.

Criteria

The program provider demonstrates:

2.1 A clearly documented and explained framework for the program, including a curriculum philosophy that includes knowledge concepts relating to:

a. a nursing model of health care

b. primary health care principles and contexts

c. capability theory.

2.2 A clearly described educational theory that is applied throughout the nurse practitioner program to:

a. shape, organise and guide the delivery of curriculum content

b. accommodate differences in student learning style and learning contexts

c. stimulate student engagement, innovation and self-directed learning.

2.3 Application of learning and teaching approaches, derived from the stated educational theory, that are responsive to the goals of the stated curriculum philosophy and:

a. enable achievement of stated learning outcomes

b. scaffold learning appropriately throughout the program

c. engender deep rather than surface learning

d. embed contextualised experiential learning and scenario-based evaluation

e. develop and enhance intellectual skills in inquiry, analysis and synthesis in dealing with complex information

f. build clinical leadership and clinical scholarship

g. enable intraprofessional and interprofessional learning for collaborative practice

h. engender cultural safety in patient management and health care delivery.

Standard 3: Program development and structure

The program of study, developed in collaboration with key stakeholders, reflects current nurse practitioner practice and learning and teaching approaches, complies with the Australian Qualifications Framework (AQF)[25] for a Level 9 Masters Degree and has sufficient integrated professional practice to enable graduates to meet the Nurse Practitioner Standards for Practice and to function as a safe, autonomous and collaborative nurse practitioner by program completion.

Criteria

The program provider demonstrates:

3.1 Consultative and collaborative approaches to curriculum design and program organisation between academic staff, nurse practitioners, other relevant clinical experts working in clinical service provision, students, consumers and other key stakeholders including Aboriginal and Torres Strait Islander health professionals.

3.2 A map of subjects against the Nurse Practitioner Standards for Practice that clearly identifies the links between learning outcomes, assessments and required graduate standards for practice.

3.3 A map of subjects against the National Prescribing Competencies Framework[26] that clearly identifies the links between learning outcomes, assessments and required graduate competencies.

3.4 Descriptions of curriculum content and the rationale for its extent, depth and sequencing in relation to the application of the knowledge and skills expected of students at this required level.

3.5 A map of student interaction opportunities with other health professions to facilitate interprofessional learning.

3.6 A minimum of 300 hours of supernumerary integrated professional practice incorporated in the program that provides exposure to a range of health care experiences relevant to the students' learning needs and enables students' achievement of the Nurse Practitioner Standards for Practice.

3.7 Content and sequencing of the program of study and, where appropriate, additional simulated learning opportunities that prepare students for integrated professional practice.

3.8 Equivalence of subject outcomes for programs taught in all delivery modes in which the program is offered (subjects delivered on-campus or in mixed-mode, by distance or by e-learning methods).

25 AQF (2013). Second Edition. Viewed at: www.aqf.edu.au/ on 5 February 2015.

26 NPS: Better choices, Better health, (2012). Competencies required to prescribe medicines—putting quality use of medicines into practice. Sydney: National Prescribing Service Limited. Viewed at: www.nps.org.au/__data/assets/pdf_file/0004/149719/Prescribing_Competencies_Framework.pdf on 5 February 2015.

Standard 4: Program content

The program content delivered by the program provider comprehensively addresses the Nurse Practitioner Standards for Practice as well as existing and emerging national and regional health priorities across a range of health service delivery contexts.

Criteria

The program provider demonstrates:

4.1 A comprehensive curriculum document, based on the framework discussed in Standard 2 that includes:

a. program structure and delivery modes, including online components

b. subject outlines that detail content, objectives, learning outcomes and associated assessment

c. teaching and learning strategies

d. an integrated professional practice plan demonstrating opportunities to meet the Nurse Practitioner Standards for Practice.

4.2 The central focus of the program is application of knowledge and skills at the required level that enable the nurse practitioner to provide a patient-centred health service to consumers:

a. within a range of health care contexts

b. that incorporates national and regional health priorities, research, policy and reform

c. that complies with national and relevant jurisdictional legislative frameworks.

4.3 Program content includes but is not limited to:

a. sciences that underpin all elements of nurse practitioner practice

b. advanced holistic health assessment and diagnostics

c. clinical research and practice improvement methodologies

d. therapeutic practice approaches grounded in a nursing model of care and that incorporate quality use of medicines

e. socio-economic, geographical and political factors that influence nurse practitioner service models, for example health care contexts, funding arrangements and business proficiency.

4.4 Inclusion of content giving students a deep appreciation of the diversity of Australian culture, to further develop and engender their knowledge of cultural respect and safety.

4.5 Inclusion of discrete content specifically addressing Aboriginal and Torres Strait Islander peoples' histories, health, wellness and culture. Health conditions prevalent among Aboriginal and Torres Strait Islander peoples and communities are appropriately embedded across the curriculum and linked to subject objectives, learning outcomes and assessment.

4.6 Inclusion of content specifically addressing the health needs of people with geographically, or culturally, socially and linguistically diverse backgrounds.

4.7 Inclusion of content specifically addressing health informatics and health technology and its role in supporting health care.[27]

4.8 Ensure specialties and/or electives in the program are at the required level and complement nurse practitioner practice.

27 Refer to ANMAC (2014). Health informatics and health technology— explanatory note. Viewed at: www.anmac.org.au/sites/default/files/documents/20150130_Health_Informatics_Technology_Explanatory_Note.pdf on 5 February 2015.

Standard 5: Student assessment

The curriculum incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes, including a comprehensive summative assessment of student performance against the current Nurse Practitioner Standards for Practice.

Criteria

The program provider demonstrates:

5.1 A consistent approach to student assessment across teaching sites and modalities that is periodically reviewed and updated.

5.2 Clear statements about assessment and progression rules and requirements are provided to students at the start of the program.

5.3 The level, number and context of assessments are consistent with determining the achievement of the stated learning outcomes.

5.4 Both formative and summative assessment exist across the program to enhance individual and group learning as well as inform student progression.

5.5 The use of a variety of assessment approaches to evaluate competence in the application of knowledge and skills at the required level and as required for professional practice as a nurse practitioner, including:

a. a comprehensive portfolio of learning and integrated professional practice

b. contextualised, scenario-based assessment strategies

c. *viva voce* clinical assessment

d. observation in integrated professional practice settings.

5.6 A range of instruments, validated where possible, are used in integrated professional practice assessment to evaluate student knowledge, skills, behaviours and capacity to meet the Nurse Practitioner Standards for Practice.

5.7 Ultimate accountability for the assessment of students in relation to integrated professional practice.

5.8 Evidence of procedural controls, fairness, reliability, validity and transparency in assessing students.

5.9 Processes to ensure the integrity of assessment across all modalities.

5.10 Collaboration between the education provider, health service providers and other stakeholders involved in integrated professional practice in selecting, implementing and evaluating assessment methods.

5.11 Comprehensive summative assessment of the student's achievement of the Nurse Practitioner Standards for Practice on program completion. This includes a comprehensive summative clinical *viva voce* within the student's nominated scope of practice, by suitably qualified members[28] of the multidisciplinary team, to demonstrate the achievement of Australian Qualifications Framework Level 9 graduate descriptors.

28 'Suitably qualified members' refers to health care professionals recognised by education and health service providers and clinical peers as having: sufficient qualifications, knowledge and skills to be considered an expert in a clinical field relevant to the scope of practice of the student; a thorough understanding of the role and scope of nurse practitioner practice; and appropriate preparation and training in undertaking student assessment. Nurse practitioners should be included as part of this team where possible.

Standard 6: Students

The program provider's approach to attracting, enrolling, supporting and assessing students is underpinned by values of transparency, authenticity, equal opportunity and an appreciation of social and cultural diversity.

Criteria

The program provider demonstrates:

6.1 Applicants are informed of the following before accepting an offer of enrolment:

a. modes for program delivery and location of integrated professional practice placements

b. specific requirements for entry to the program of study, including English language proficiency

c. compliance with the National Law[29] by notifying the Australian Health Practitioner Regulation Agency if a student undertaking integrated professional practice has an impairment that may place the public at risk of harm

d. specific requirements for right of entry to health services for integrated professional practice experience placements (including, fitness for practice, immunisation and criminal history)

e. requirements specified in the Nursing and Midwifery Board of Australia's Endorsement as a Nurse Practitioner Registration Standard.

6.2 Students are selected for the program based on clear, justifiable and published admission criteria that includes:

a. current general registration as a registered nurse

b. a minimum of two years full time equivalent (FTE) as a registered nurse in a specified clinical field and two years FTE of current[30] advanced nursing practice in this same clinical field

c. a postgraduate qualification at Australian Qualifications Framework Level 8 in a clinical field.

6.3 Students have sufficient English language proficiency and communication skills to successfully undertake academic experience and integrated professional practice requirements throughout the program.

6.4 Students are informed about, and have access to, appropriate support services including counselling, health care and academic advisory services.

6.5 Processes to enable early identification and support for students who are not performing well academically, clinically or have professional conduct issues.

6.6 All students have equal opportunity to meet the Nurse Practitioner Standards for Practice. The mode or location of program delivery should not influence this opportunity.

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29 AHPRA (2009). *Health Practitioner Regulation National Law Act 2009*, as enacted in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx on 5 March 2015.

30 'Current' is within the previous six years.

6.7 Processes for student representation and feedback in matters relating to governance and program management, content, delivery and evaluation.

6.8 Aboriginal and Torres Strait Islander peoples are encouraged to apply and a range of support is provided to those students as needed.

6.9 Other groups under-represented in the nursing profession, especially those from culturally, socially and linguistically diverse backgrounds, are encouraged to apply and support is provided to those students as needed.

Standard 7: Resources

The program provider has adequate facilities, equipment and teaching resources, as well as staff who are qualified, capable and sufficient in number, to enable students to meet the Nurse Practitioner Standards for Practice.

Criteria

The program provider demonstrates:

7.1 Staff, facilities, online tools, equipment and other teaching resources are sufficient in quality and quantity for the anticipated student population and any planned increase.

7.2 Students have sufficient and timely access to academic and clinical teaching staff, including nurse practitioners to support student learning.

7.3 A balance of academic, clinical, technical and administrative staff appropriate to meeting teaching, research and governance commitments.

7.4 Staff recruitment strategies:

a. are culturally inclusive and reflect population diversity

b. take affirmative action to encourage participation from Aboriginal and Torres Strait Islander peoples.

7.5 Documented position descriptions for teaching staff, clearly articulating roles, reporting relationships, responsibilities and accountabilities.

7.6 The Head of Discipline holds current Australian general registration as a nurse with no conditions relating to conduct or performance[31], holds a relevant post graduate qualification, maintains active involvement in the nursing profession, and has strong engagement with contemporary nursing education and research.

7.7 At least one endorsed nurse practitioner is a member of academic staff that teaches into the nurse practitioner program of study and as part of this role contributes to curriculum design and development, supervision and mentorship models, as well as quality improvement and risk management processes.

7.8 Staff teaching and assessing nursing practitioner specific subjects, including those with pharmacology, advanced health assessment and diagnostics (pathology and medical imaging) content, have relevant clinical and academic qualifications and experience.

7.9 Each student's integrated professional practice clinical and professional support team is qualified for their level of teaching and/or supervision. This includes clinical practice expertise in a relevant clinical area and an academic qualification in education or equivalent learning and teaching experience.

7.10 In cases where an academic staff member's tertiary qualifications do not include nursing, their qualifications and experience are directly relevant to the subjects they are teaching.

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31 For definitions related to conduct and performance [refer to Part 1, Section 5] in the *Health Practitioner Regulation National Law Act 2009*, as in force in each state and territory. Viewed at: *www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx* on 22 April 2015.

7.11 Processes to ensure academic staff demonstrate engagement in research, scholarship and practice in the subjects they teach.

7.12 Teaching and learning takes place in an active research environment where academic staff are engaged in research, scholarship or generating new knowledge. Areas of interest, publications, grants and conference papers are documented.

7.13 Policies and processes to verify and monitor the academic and professional credentials of current and incoming staff, including current general registration as a registered nurse and endorsement as a nurse practitioner, where applicable, and to evaluate their performance and development needs.

Standard 8: Management of integrated professional practice

The program provider ensures that every student is given supervised integrated professional practice in environments providing suitable learning and teaching opportunities and conditions for students to meet the Nurse Practitioner Standards for Practice.

Criteria

The program provider demonstrates:

8.1 Negotiated and secure integrated professional practice experiences and an associated clinical and professional support team for each student and a process by which these are assessed as satisfactory prior to the commencement and for the duration of the program.

8.2 Constructive relationships and clear contractual arrangements with all health providers where students gain their integrated professional practice and processes to ensure these are regularly evaluated and updated.

8.3 Risk management strategies in all environments where students are placed to gain integrated professional practice and processes to ensure these are regularly reviewed and updated.

8.4 Each student is provided with a range of health care experiences that supports knowledge and skills development in patient centred care that is consistent with the principles of primary health care and complements the student's speciality skills and knowledge.

8.5 Each student is provided with sufficient integrated professional practice to support the meeting of the Nurse Practitioner Standards for Practice.

8.6 Each student is provided with integrated professional practice experiences that reflect the major health priorities specific to the student's area of practice with opportunities for intraprofessional and interprofessional learning and the development of knowledge and skills and their application for collaborative practice.

8.7 Clearly articulated models of supervision, support, facilitation and assessment are in place so students can meet the Nurse Practitioner Standards for Practice.

8.8 Academics, nurse clinicians and other health professionals engaged in supervising and supporting students during integrated professional practice are adequately prepared for the learning and teaching role and apply contemporary and evidence-based Australian and international perspectives on nurse practitioner practice.

8.9 Nominated professionals in the student's clinical and professional support team undertake assessment of the student against the Nurse Practitioner Standards for Practice within the context of integrated professional practice experience.

8.10 Resources are provided, monitored and regularly evaluated to support students and their supervisors while on integrated professional practice to meet the Nurse Practitioner Standards for Practice.

Standard 9: Quality improvement and risk management

The program provider is able to assess and address risks to the program, its outcomes and students, and has a primary focus on continually improving the quality of the teaching and learning experience for students and the competence of graduates.

Criteria

The program provider demonstrates:

9.1 Responsibility and control of program development, monitoring, review, evaluation and quality improvement is delegated to the school with oversight by the academic board or equivalent.

9.2 Regular evaluation of academic and clinical and professional support team supervisor effectiveness using feedback from students and other sources; systems to monitor and, where necessary, improve staff performance.

9.3 Professional and academic development of staff to advance knowledge and competence in teaching effectiveness and assessment.

9.4 Feedback gained from the quality cycle is incorporated into the program of study in consultation with stakeholders, including health care consumer advocates[32], to improve the experience of theory and practice learning for students.

9.5 Regular evaluation and revision of program content to include contemporary and emerging issues surrounding nurse practitioner practice, health care research and health policy and reform.

9.6 Students, supervisors and staff are adequately indemnified for relevant activities undertaken as part of program requirements.

32 Available through organisations that provide leadership in representing the interests of Australian health care consumers (for example, Consumer Health Forum of Australia).

Glossary and abbreviations

Advanced nursing practice— is a continuum along which nurses develop their professional knowledge, clinical reasoning and judgement, skills and behaviours to higher levels of capability (that is recognisable). Nurses practising at an advanced level incorporate professional leadership, education and research into their clinically based practice. Their practice is effective and safe. They work within a generalist or specialist context and they are responsible and accountable in managing people who have complex health care requirements.

Advanced nursing practice is a level of practice and not a role. It is acknowledged that advanced nursing practice is individually attributed within a regulated nursing scope (enrolled nurse, registered nurse or nurse practitioner).[33]

Australian Health Practitioner Regulation Agency—AHPRA is responsible for the implementation of the National Registration and Accreditation Scheme across Australia. Supports the National Health Practitioner Boards (such as the Nursing and Midwifery Board Australia) in implementing the scheme.

Australian Nursing and Midwifery Accreditation Council—ANMAC is the independent accrediting authority for nursing and midwifery under the National Registration and Accreditation Scheme. ANMAC sets standards for accreditation and accredits nursing and midwifery programs leading to registration and endorsement, and for the providers of those programs.

Australian Nursing and Midwifery Council—the ANMC evolved into ANMAC following approval as the accrediting authority for nursing and midwifery. ANMC authored the original set of accreditation standards as well as the national competency standards or standards for practice for nursing and midwifery.

Australian Qualifications Framework—the AQF is the national policy for regulated qualifications in Australian education and training. It incorporates the qualifications from each education and training sector into a single comprehensive national qualifications framework.

Australian Qualifications Framework qualification—the result of an accredited complete program of learning leading to formal certification that a graduate has achieved learning outcomes as described in the AQF.

Australian Qualifications Framework national register—a register of all AQF qualifications and the organisations authorised to issue them.

Australian university—a higher education provider registered with TEQSA in the 'Australian university' provider category.

33 NMBA (2014). *Nurse Practitioner Standards for Practice*. Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx on 10 March 2015.

Capability—moves beyond competency[34] and is the extent to which an individual can adapt to change, generate new knowledge and continue to improve practice.[35] Capability and its dimensions include:

- knowing how to learn
- working well with others
- being creative
- having a high degree of self-efficacy
- applying competencies to both novel and familiar situations.[36]

Competence—the combination of skills, knowledge, attitudes, values and abilities underpinning effective and/or superior performance in a profession or occupational area (from the National Competency Standards for the Registered Nurse).[37]

Criteria—rules or tests on which a judgement or decision in relation to compliance with the Accreditation Standards can be based.

Cultural safety—can only be determined by those who are receiving healthcare; they will determine if their cultural identity and meanings are being respected and they are not being subjected to discrimination.[38]

Curriculum—the full outline of a program of study, usually built around a conceptual framework with the educational and professional nursing or midwifery philosophies underpinning the curriculum, including:

- program philosophy
- program structure and delivery modes
- subject outlines
- links between subject objectives, learning outcomes and their assessment as well as national competencies or standards for practice
- teaching and learning strategies
- workplace experience plan.

Education provider—university, or other higher education provider, responsible for a program of study, the graduates of which are eligible to apply to the NMBA for nursing or midwifery registration or endorsement.

Equivalent professional experience—successful completion of a qualification equivalent to that being taught and sufficient post-graduate professional experience in the discipline being taught to demonstrate competence in applying the discipline's principles and theory.

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34 O'Connell J, Gardner G and Coyer F, (2014). Beyond competencies: using a capability framework in developing practice standards for advanced practice nursing. *Journal of Advanced Nursing*, doi: 10.1111/jan.12475.

35 Fraser S and Greenhalgh T, (2001). Coping with complexity: educating for capability. *British Medical Journal*, 323, pp. 799–803.

36 Gardner G, Dunn S, Carryer J and Gardner A, (2006). Competency and capability: Imperative for nurse practitioner education. *Australian Journal of Advanced Nursing*, 24 (1), pp. 8–14.

37 Nursing and Midwifery Board of Australia, (2006). Registered Nurse Competency Standards. Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx on 23 September 2014.

38 National Aboriginal Community Controlled Health Organisation, (2011). Cultural Safety Training Standards: A background paper. Viewed at: www.naccho.org.au/promote-health/cultural-safety/ on 9 September 2014.

Governance—framework, systems and processes supporting and guiding an organisation towards achieving its goals and the mechanisms by which it, and its people, are held to account. Ethics, risk management, compliance and administration are all elements.

Head of school or discipline—lead nursing academic responsible for designing and delivering the program of study on behalf of the education provider.

***Health Practitioner Regulation National Law Act 2009* (the National Law)**—this legislation contained in the schedule to the Act, provides for the full operation of the National Registration and Accreditation Scheme for health professions from 1 July 2010 and covers the more substantial elements of the national scheme, including registration arrangements, accreditation arrangements, complaints, conduct, health and performance arrangements, and privacy and information-sharing arrangements. The purpose is to protect the public by establishing a national scheme for regulating health practitioners and students undertaking programs of study leading to registration as a health practitioner. The National Law is legislated in each state and territory. The *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* outlines the administrative arrangements established under the first stage of the National Registration and Accreditation Scheme for the Health Professions (Act A).

Higher education provider—tertiary education provider who meets the Higher Education Standards Framework (Threshold Standards) as prescribed by the *Tertiary Education Quality and Standards Agency Act 2011* and is registered with TEQSA.

Integrated professional practice—an integrated learning approach that enables nurse practitioner students to develop and demonstrate the Nurse Practitioner Standards for Practice within the clinical practice setting. Supports the use and generation of theory to enhance emerging and developed knowledge, behaviours and clinical and professional judgement. Also provides a supported learning environment for the development of clinical practice skills, including, but not limited to:

- comprehensive assessment, diagnosis and management of complete episodes of care
- prescription of medicines
- ordering and interpreting of diagnostic tests
- initiating and accepting referrals from other health professionals for the purposes of care coordination.

The concept includes 'clinical training' as embodied in the National Law.[39]

Interprofessional learning—occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.

Medicare Benefits Schedule—this a listing of the Medicare services subsidised by the Australian Government. The schedule is part of the wider Medicare Benefits Scheme managed by the Department of Health.[40]

Nurse practitioner—a protected title that refers to a nurse whose registration has been endorsed by the NMBA as a nurse practitioner under Section 95 of the National Law.[41]

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39 AHPRA (2009). *Health Practitioner Regulation National Law Act 2009*, as enacted in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx on 5 March 2015.

40 Australian Government, Department of Human Services, Medicare Benefits Schedule. Viewed at: www.medicareaustralia.gov.au/provider/medicare/mbs.jsp on 13 June 2015.

41 AHPRA (2009). *Health Practitioner Regulation National Law Act 2009*, as enacted in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx on 5 March 2015.

Nurse Practitioner Standards for Practice—core standards for practice by which performance and professional conduct is assessed to obtain and retain endorsement as a nurse practitioner.[42]

Nursing and Midwifery Board of Australia—the NMBA is the national regulator for the nursing and midwifery professions in Australia. It is established under the Health Practitioner Regulation National Law (the National Law)[43], as in force in each state and territory. Its primary role is to protect the public and set standards and policies that all nurses and midwives registered within Australian must meet.

Pharmaceutical Benefits Scheme—this is a scheme run by the Australian Government to subsidise prescription medicines for Australians who have a Medicare card. If a medicine is subsidised under the scheme, the patient pays a lower price for the medicine, and the Australian Government pays the rest.[44]

Primary health care—derived from the World Health Organization's Declaration of Alma-Ata and the National Aboriginal Community Controlled Health Organisation definitions which explain primary health care as a holistic approach, incorporating body, mind, spirit, land, environment, culture, custom and socio-economic status to the provision of essential, integrated, quality care based upon practical, scientifically sound and socially acceptable methods and technology. Made accessible to all people, families and communities as close as possible to where they live and through their full participation, in the spirit of self-reliance and self-determination, and at a cost the Australian community can afford.

Primary health care forms an integral part both of Australia's health system and of the overall social and economic development of the community. The policy and provision of primary health care is shaped around the contribution of citizens identifying priorities for the promotion of healthy living, the prevention of disease, injury and disability. In addition, it must meet the health care, treatment, self-management and rehabilitation needs of people, their families and communities; and their desire for humane, safe care throughout their lives.[45] [46]

Program or program of study—the full program of study and experiences that must be completed before a qualification recognised under the AQF, such as a Bachelor or Masters Degree of Nursing, can be awarded.

Program provider—the school or faculty responsible for designing and delivering a program of study in nursing leading to the award of a Bachelor Degree in Nursing as a minimum.

Quality use of medicines—part of the National Medicines Policy[47] to ensure the judicious, appropriate, safe and effective use of medicines.

Recognition of prior learning—assessment process for students' formal and informal learning to determine the extent to which they have achieved required learning outcomes, competency outcomes or standards for entry to and/or partial or total completion of a qualification.

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42 NMBA (2014). *Nurse Practitioner Standards for Practice.* Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx on 10 March 2015.

43 AHPRA (2009). *Health Practitioner Regulation National Law Act 2009*, as enacted in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx on 5 March 2015.

44 NPS MedicineWise. Viewed at: www.nps.org.au/glossary/pharmaceutical-benefits-scheme-pbs on 15 June 2015.

45 Australian Nurses Federation, (2009). Primary Health Care in Australia. A nursing and midwifery consensus view. Viewed at: www.anmf.org.au/documents/reports/PHC_Australia.pdf on 31 March 2014.

46 National Aboriginal Community Controlled Health Organisation (NACCHO), (2009). Towards a national primary health care strategy: fulfilling Aboriginal peoples' aspirations to close the gap. Canberra: NACCHO.

47 Commonwealth of Australia, (2000). National Medicines Policy. Viewed at: www.health.gov.au/internet/main/publishing.nsf/Content/national-medicines-policy on 23 September 2014.

Research—According to the Department of Innovation, Industry, Science and Research specifications for the Higher Education Research Data Collection, research comprises:

- creative work undertaken on a systematic basis to increase the stock of knowledge, including knowledge of man, culture and society, and the use of this stock of knowledge to devise new applications
- any activity classified as research which is characterised by originality; should have investigation as a primary objective and should have the potential to produce results that are sufficiently general for humanity's stock of knowledge (theoretical and/or practical) to be recognisably increased; most higher education research work would qualify as research
- pure basic research, strategic basic research, applied research and experimental development.

Scholarship—application of systematic approaches to acquiring knowledge through intellectual inquiry. Includes disseminating this knowledge through various means such as publications, presentations (verbal and audio-visual) and professional practice. Also includes applying this new knowledge to the enrichment of the life of society.[48]

School—organisational entity of an education provider responsible for designing and delivering a program of study in nursing or midwifery. Where the school of nursing is part of a larger faculty, the school is regarded as the program provider for these standards.

Simulated learning or practice—educational methods or clinical experiences that evoke or replicate aspects of the real world in an interactive manner. As an educational method for nurse practitioner students it can provide learning conditions to develop knowledge and skills such as how to prescribe and write prescriptions.

Standard—level of quality or attainment.

Subject—unit of study taught within a program of study.

Student assessment—formative and summative processes used to determine a student's achievement of expected learning outcomes. May include written and oral methods and practice or demonstration.

Supernumerary—where the student undertakes supervised practice outside their employed position or when they are not counted in the staffing roster.

Tertiary Education Quality and Standards Agency—TEQSA was established in July 2011 to regulate and assure the quality of Australia's large, diverse and complex higher education sector. Registers and evaluates the performance of higher education providers against the Higher Education Standards Framework. Also undertakes compliance and quality assessments.

48 Nursing and Midwifery Board of Australia, (2006). Registered Nurse Competency Standards. Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx on 23 September 2014.

***Viva voce* clinical examination**—method of assessing students' ability to use knowledge in a face-to-face examination. This assessment approach has two basic models:

- The 'short case' model is used as a formative assessment. It focuses on specific skills or sub-skills and can take the form of an objective structured clinical examination or a case presentation on a specific clinical activity.
- The 'long case' model is used as a summative assessment. It seeks to examine the student's ability to apply knowledge in an actual clinical situation. The 'long case' exam requires the student to use professional communications skills to collect, analyse, synthesise and evaluate clinical information, to use differential diagnostic procedures and determine a management plan. It assesses learning outcomes related to deep learning, application and synthesis of knowledge and high-level clinical reasoning.

Framework

Effective 3 February 2020 (updated August 2022)

Decision-making framework for nursing and midwifery

A guide to practice decisions on scope of practice, delegation and supervision for nurse practitioners, registered nurses, enrolled nurses and midwives.

Introduction

The Nursing and Midwifery Board of Australia (NMBA) undertakes functions as set by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The NMBA regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public. The NMBA does this by developing standards, codes and guidelines which constitutes the professional practice framework, and together establish the requirements for the professional and safe practice of nurses and midwives in Australia.

The NMBA *Decision-making framework for nursing and midwifery* (the DMF) is an evidence-based[1] contemporary document that is to be used in conjunction with standards for practice, policies, regulations and legislation related to nursing or midwifery.

Purpose of the decision-making framework

The purpose of the DMF is to guide decision-making relating to scope of practice and delegation and to promote decision-making which is:

- consistent
- safe
- person-centred/woman-centred, and
- evidence-based.

The DMF contributes to flexibility in practice and enables reflection on current practice and practice change.

The decision-making framework

The DMF consists of two parts:

1. **Principles of decision-making**, and
2. Nursing and midwifery **guides to decision-making** that include the:
    a. Guide to nursing practice decisions
    b. Guide to midwifery practice decisions, and
    c. Guide to delegation decisions.

The NMBA also provides the *Decision-making framework summary: nursing* and the *Decision-making framework summary: midwifery* as supporting guidance to be used in conjunction with the DMF.

Background

The DMF provides guidance for registered nurses, enrolled nurses and midwives on:

[1] The DMF is based on research from an academic literature review and stakeholder consultation.

- individual practice decisions
- expanding scope of practice, and
- when registered nurses or midwives can delegate aspects of care to others, such as other registered nurses or midwives, enrolled nurses, students and health workers.

Scope of practice

Registered nurses, enrolled nurses and midwives are responsible for making professional judgements about when an activity is within their scope of practice and, when it is not, for initiating consultation and collaboration with, or referral to, other members of the healthcare team.

Scope of practice decisions should be made in a collaborative way, through professional consensus, consultation and negotiation with the person or woman, relevant family members and other members of the healthcare team.

Decisions about scope of practice should be based on considerations of:

- the person or woman's health status and any relevant social determinants to their healthcare
- lawfulness (legislation and common law)
- compliance with evidence, professional standards, and regulatory standards, policies and guidelines
- context of practice and the health service provider/employer's policies and protocols, and
- whether there is organisational support, sufficient staffing levels and appropriate skill mix for the practice.

Practitioners with notations on registration that reflect limited foundational education must only practice within the scope of practice relevant to that foundational education. This applies to:

Registered nurses who have a sole qualification in mental health, paediatric or disability nursing do not have a qualification that is substantially equivalent to an NMBA approved qualification leading to registration as a registered nurse. Depending on their qualification, these RNs are registered with a notation stating:

  - solely qualified in the area of mental health nursing, or
  - solely qualified in the area of paediatric nursing, or
  - solely qualified in the area of disability nursing.

Enrolled nurses with a notation stating:

  - does not hold a Board approved qualification in administration of medicines, and/or
  - may only practice in the area of mothercraft nursing

Responsibilities for employers of nurses and midwives

Organisations in which nurses and midwives work must ensure there are sufficient resources to enable safe and competent care for the people for whom healthcare services are provided. This includes policies and practices that support the development of nursing and midwifery practice within a risk management framework.

The DMF establishes a foundation for decision-making that is based on competence and the provision of safe quality care. **The substitution of health workers for nurses or midwives must not occur when the knowledge and skills of nurses or midwives are needed.** Under the National Law, nurses or midwives must not be directed, pressured or compelled by an employer to engage in any practice that falls short of, or is in breach of, any professional standard, guidelines or code of conduct, ethics or practice for their profession.

Using the DMF

Using the DMF in all practice settings

The DMF provides a consistent approach to decisions about nursing or midwifery practice in all contexts. The DMF is most relevant for the clinical practice setting but may be modified or adapted for decision-making in other areas of nursing or midwifery practice. Nursing and midwifery practice settings extend to working in a non-clinical relationship with people/women, working in management, leadership,

governance, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the profession and/or use of the nurse's and midwife's professional skills.

How the DMF can be used

The DMF can be used:

- by registered nurses, enrolled nurses and midwives when considering, determining and self-assessing their individual practice
- for purposeful engagement with employers, managers and policy-makers in interpreting, planning for and changing practice
- to initiate discussion about professional issues and to raise awareness in relation to scope of practice and decision-making
- to embed the principles and concepts underpinning the DMF within educational programs that prepare registered nurses, enrolled nurses or midwives for practice, and
- to identify practice that falls outside the accepted scope of nursing or midwifery practice, or decision-making processes that are not consistent with the statements of principle in the DMF.

The DMF also provides guidance about how registered nurses and midwives delegate aspects of nursing and/or midwifery practice. The DMF does not provide guidance regarding appropriate allocation or assignment of tasks.

The DMF should be read in conjunction with NMBA *Registered nurse standards for practice*, *Enrolled nurse standards for practice* and Midwife *standards for practice.*

Part one: Principles of decision-making

A set of principles underpin decision-making for nursing and midwifery practice. The principles support the provision of safe, person-centred/woman-centred and evidence-based care and, in partnership with the person/woman, promote shared decision-making and care delivery in a culturally safe and respectful way. Through the principles, and the guides to practice decisions based on them (Part two of the DMF), nurses and midwives are equipped to make decisions in a consistent way.

The principles that underpin decision-making for the nursing and midwifery practice are:

1. Nurses and midwives should make decisions about everyday practice, and changes to practice over time, that prioritise meeting the health needs of the community.
2. Planning, negotiation and implementation of practice change for individuals or groups of nurses and midwives should be focussed on meeting the health needs of the community.
3. Consent is gained from the person or woman receiving care.
4. The promotion and provision of quality, culturally safe health services should be the drivers for change in practice, which should be made in partnership with the person or woman and the broader community.
5. Nurses and midwives should integrate a comprehensive approach to managing risk into their practice to enhance safety and quality.
6. Evidence-based practice applies to all domains and contexts of practice for nursing and midwifery.
7. Changes to the practice of individuals or groups should be guided by:
    - the needs of and feedback from those receiving care
    - the evolution of new practice areas/capabilities
    - negotiation between health workers, and
    - evolving health service needs.
8. When making decisions about practice change, nurses and midwives should consider the following determinants of practice and how they may limit or enable practice change:
    - legislated authority or restrictions on professional practice
    - professional standards of practice
    - evidence for practice
    - individual scope of practice (education, authorisation and competence for practice)
    - arrangements and decision-making in delegation, and
    - contextual/organisational support for practice.
9. The DMF forms part of the nursing and midwifery professional practice framework and should be used when making decisions about practice change.

Part two: Nursing and midwifery guides to practice decisions

Guide to nursing practice decisions

Decision-making within a sound risk management, professional, regulatory and legislative framework is a considered, rational process that enables nurses to work to their full and potential scope of practice. The statements and actions set out below provide direction to nurses and others about processes that will help to ensure that safety is not compromised when making decisions about scope of practice, about whether to delegate activities to others and for supervision support.

Statement	Actions
1. The primary motivation for any decision about a care activity is to meet people's health needs or to enhance health outcomes.	Decisions about activities should be made: • in partnership with the person, supporting shared decision-making • based on a comprehensive assessment of the person and their health and cultural needs • only where there is a justifiable, evidence-based reason to perform the activity, and • after identifying the potential risks/hazards associated with the care activity and strategies to avoid them.
2. Nurses are responsible for making professional judgements about when an activity is beyond their scope of practice and for initiating consultation with, or referral to, other members of the healthcare team.	Judgements should be made in a collaborative way, through consultation and negotiation with the person, relevant family members and other members of the healthcare team. Decisions should be based on considerations of: • the person's health status and any relevant social determinants to their healthcare • lawfulness (legislation and common law) • compliance with evidence, professional standards, and regulatory standards, policies and guidelines • which is the most appropriate health professional to provide the education and/or competence-based assessment for the activity • context of practice and the service provider/employer's policies and protocols, and • whether there is organisational support, including sufficient staffing levels and appropriate skill mix, for the practice.
3. Expansion to scope of practice occurs when a nurse assumes responsibility for an activity that is currently outside the nurses' scope of practice, or where an employer seeks to initiate a change, because of evaluations of services and a desire to improve access to, or efficiency of, services to groups of people.	Nurses planning to integrate activities that are not currently part of their practice should ensure: • the activity is within the contemporary scope of nursing practice and the relevant standards for practice would support the nurse performing the activity • there is no legislative basis that would prevent a nurse performing the activity • they have any necessary authorisations, qualifications and organisational support to perform the activity • they have the necessary educational preparation, experience, capacity, competence and confidence to safely perform the activity • their competence has been assessed by a qualified, competent health professional or approved provider (who may be a more experienced registered nurse) • that any identified risk has been assessed and if appropriate to proceed, mitigating measures have been adopted • consultation with relevant stakeholders has occurred, if necessary • the person receiving care consents to the activity being performed by a nurse who is undergoing training or expanding their skill set to include that particular activity, and • the organisation in which the activity is to be performed is prepared to support the nurse in performing the activity.

Statement	Actions
4. Registered nurses (the delegator) are accountable for making decisions about who is the most appropriate health professional or health worker to delegate to (delegatee) to perform an activity that is in the nursing plan of care.	Decisions about nursing practice should be made in partnership with the person whenever possible and to ensure that the right health professional or health worker is available at the right time to provide the care needs for the person. Decisions should be based on whether: • the activity should be performed by a particular category of health professional or health worker • there is legislative or professional requirement for the activity to be performed by a particular category of health professional or health worker • the registered nurse has completed a comprehensive health assessment of the person's needs and determined that the activity can be delegated • the person has consented to the delegation of the activity, and reconsented to the activity being undertaken by the nominated delegatee • there is an organisational requirement for an authority/certification/credential to perform the activity • the level of education, knowledge, experience, skill and assessed competence of the delegatee has been previously assessed by a registered nurse to ensure the activity will be performed safely • the delegatee is competent and confident of their ability to perform the activity safely, is ready to accept the delegation and understands their level of accountability for performing the activity • the appropriate level of clinically-focused supervision can be provided by a registered nurse for the delegatee performing an activity delegated to them, and • the organisation in which the registered nurse works has an appropriate policy, quality and risk management framework, sufficient staffing levels, appropriate skill mix and adequate access to other health professionals to support the delegatee performing the activity, and to support the decision-maker in providing support and clinically-focused supervision.
5. Nursing practice decisions are best made in a collaborative context of planning, risk management, and evaluation.	Organisational employers/managers, other health workers and nurses share a joint responsibility to create and maintain: • environments (including resources, education, policy, evaluation and competence assessment) that support safe decisions and competent, evidence-based practice to the full extent of the scope of nursing practice • processes for providing continuing education, skill development and appropriate clinically-focused supervision, and • infrastructure that supports and promotes autonomous and interdependent practice, transparent accountability, and ongoing evaluation of the outcomes of care and nursing practice decisions.

The nursing practice decisions summary illustrates the processes that a nurse would follow in making decisions about nursing practice, taking account of the statements set out above.

Guide to midwifery practice decisions

Decision-making within a sound risk management, professional, regulatory and legislative framework is a considered, rational process that enables midwives to work to their full and potential scope of practice. The statements and actions set out below provide direction to midwives and others about the factors to be considered to ensure that safety is not compromised when making decisions about scope of practice, about whether to delegate activities to others, and for supervision.

Statement	Actions
1. The primary motivation for any decision about a care activity is to meet the woman's health needs, or to enhance health outcomes.	Decisions about activities should be made: • in partnership with the woman, supporting shared decision-making • based on a comprehensive assessment of the woman and their health and cultural needs • only where there is a justifiable, evidence-based reason to perform the activity, and • after identifying the potential risks/hazards associated with the care activity and strategies to avoid them.
2. Midwives are responsible for making professional judgements about when an activity is beyond their scope of practice and for initiating consultation with, or referral to, other members of the healthcare team.	Judgements should be made in a collaborative way, through consultation and negotiation with the woman, relevant family members and other members of the healthcare team. Decisions should be based on considerations of: • the woman's health status and any relevant social determinants to their care • lawfulness (legislation and common law) • compliance with evidence, professional midwifery standards, and regulatory standards, policies and guidelines • which is the most appropriate health professional to provide the education and/or competence-based assessment for the activity • context of practice and the service provider/employer's policies and protocols, and • whether there is organisational support, including sufficient staffing levels and appropriate skill mix, for the practice.
3. Expansion to scope of practice occurs when a midwife assumes responsibility for an activity that is currently outside the midwife's scope of practice, or where an employer seeks to initiate a change, because of evaluations of services and a desire to improve access to, or efficiency of, services to groups of people.	Midwives planning to integrate activities that are not currently part of their practice should ensure: • the activity is within the contemporary scope of midwifery practice and the standards for practice would support the midwife performing the activity • there is no legislative basis that would prevent a midwife performing the activity • they have any necessary authorisations, qualifications and organisational support to perform the activity • they have the necessary educational preparation, experience, capacity, competence and confidence to safely perform the activity • their competence has been assessed by a qualified, competent health professional or approved provider (who may be a more experienced/ midwife) • that any identified risk has been assessed and if appropriate to proceed, mitigating measures have been adopted • consultation with relevant stakeholders has occurred, if necessary • the woman receiving care consents to the activity being performed by a midwife who is undergoing training or expanding their skill set to include that particular activity, • the organisation in which the activity is to be performed is prepared to support the midwife in performing the activity, and • they are confident of their ability to perform the activity safely.

Statement	Actions
4. Midwives (the delegator) are accountable for making decisions about who is the most appropriate health professional or health worker to delegate (delegatee) to perform an activity that is in the midwifery plan of care.	Decisions about midwifery practice should be made by midwives in partnership with the woman and ensure that the right midwife or health worker is available at the right time to provide the care needs for the woman. Decisions should be based on, justified and supported by, considerations of whether: • the activity should be performed by a particular category of health professional or health worker • there is a legislative or professional requirement for the activity to be performed by a particular category of health professional or health worker • the midwife has assessed the woman's needs and determined that the activity can be delegated • the woman has consented to the delegation of the activity, and reconsented to the activity being undertaken by the nominated delegate • the activity should be performed by a particular category of health professional or health worker • there is an organisational requirement for an authority/certification/credential to perform the activity • the level of education, knowledge, experience, skill and assessed competence of the delegate, has been previously assessed by a midwife to ensure the activity will be performed safely • the delegatee is competent and confident of their ability to perform the activity safely, is ready to accept the delegation and understands their level of accountability in performing the activity • the appropriate level of clinically-focused supervision can be provided by a midwife for the delegatee performing an activity delegated to them, and • the organisation in which the midwife works has an appropriate policy, quality and risk management framework, sufficient staffing levels, appropriate skill mix and adequate access to other health professionals to support the delegatee performing the activity, and to support the decision maker in providing support and clinically-focused supervision.
5. Midwifery practice decisions are best made in a collaborative context of planning, risk management, and evaluation	Organisational employers/managers, other health workers and midwives share a joint responsibility to create and maintain: • environments (including resources, education, policy, evaluation and competence assessment) that support safe decisions and competent, evidence-based practice to the full extent of the scope of midwifery practice • processes for providing continuing education, skill development and appropriate clinically- focused supervision, and • infrastructure that supports and promotes autonomous and interdependent practice, transparent accountability, and ongoing evaluation of the outcomes of care and practice decisions.

The midwifery practice decisions summary illustrates the processes that a midwife would follow in making decisions about midwifery practice, taking account of the statements set out above.

Guide to delegation decisions

Delegations are made to meet people's needs and to ensure timely safe and effective access to healthcare services. Delegation is a consultative, multi-level activity, requiring rational decision-making, consent from the various parties involved and a process of risk assessment. Delegation may only take place after education, where required, and an assessment of competence.

The delegation relationship exists when:

- a registered nurse (the delegator) delegates aspects of nursing practice in any practice setting to another person (the delegatee).
- a midwife (the delegator) delegates aspects of midwifery practice in any practice setting to another person (the delegatee).

Delegation is different from allocation or assignment of tasks.

The delegator retains accountability for the decision to delegate, monitoring performance and evaluating outcomes. The delegatee is unable to sub-delegate without referring back to the delegator.
Enrolled nurses work as part of the multidisciplinary team, providing delegated care under the supervision of a registered nurse or midwife. This supervision cannot be replaced or substituted by another health professional.

The decision to delegate an activity to students should align with the educational goals in their program of study and demonstrated level of their individual knowledge and skill.

The delegatee is at all times responsible for their actions and is accountable for providing delegated care.

Registered nurses and midwives (delegators) play a key role in the coordination and delegation of care. Delegation of care should be made following a risk assessment by the registered nurse or midwife identifying the competence of staff.

Registered nurses and midwives are responsible and accountable for the coordination, supervision and delegation of/to enrolled nurses and others who assist them in the provision of care.

The Guide to delegation decisions

Delegation phase	Actions
1. Assessment to determine appropriate delegation	The registered nurse or midwife (delegator) should conduct a risk assessment to determine appropriate delegation for the activity. Factors to be considered in making the decision include whether a nurse or midwife should perform the activity because: • the persons/woman's health status is such that the activity should be performed by a nurse or midwife because specific knowledge or skill is needed • professional standards indicate that the activity should be performed by either a nurse or a midwife • there is evidence that the activity is best performed by a nurse or midwife • any state/territory or Commonwealth legislation specifies that a nurse or midwife should perform the activity • any local or organisational policy, risk matrix, guideline or protocol requires a nurse or midwife to perform the activity, and • the model of care mandates that the activity should be performed by a nurse or midwife.

Delegation phase	Actions
2. Responsibilities when delegating	To maintain a high standard of care when delegating activities, the registered nurse or midwife's responsibilities include: • a comprehensive, collaborative assessment of the needs of the person/woman receiving care • an assessment of the knowledge, skill, authority and ability of the delegatee accepting the delegation • ensuring that the delegatee understands their accountability and is confident, willing and able to accept the delegation • regular review of the delegation, providing guidance, support and clinically-focussed supervision • identification of potential risks/hazards and adoption of mitigation strategies, and • evaluation of outcomes of the delegation.
3. Responsibilities when accepting a delegation	A key component of delegation is the readiness of the delegatee to accept the delegation. The delegatee has the responsibility to: • be aware of the extent of the delegation and the associated monitoring and reporting requirements • at all times, be responsible for their actions and accountable for providing delegated care • not sub-delegate without referring to the delegator • agree the level of supervision needed • seek support and direct supervision until deemed competent to perform the activity, and • participate in an evaluation of the delegation.
4. Delegation to a health worker or student	If the delegator decides that the activity can be performed by a health worker or student, the delegator will need to consider, within a risk management framework, and through professional consensus, who the most appropriate health worker or student is to perform the activity. In making this decision, the delegator will need to decide if: • performance of the activity by a health worker or student will achieve the desired outcomes, and the person/woman consents, if possible, to the activity being performed by a health worker • there is organisational support in the form of local policies/guidelines/protocols for the performance of this activity by a health worker. For students, support from the educational institution for this activity to be delegated to students should also be established • the health worker or student is competent (i.e. has the necessary education, experience and skill) to perform the activity safely • the health worker or student is ready (confident) to perform the activity and understands their level of accountability for the activity, and • there is a registered nurse or midwife available to provide the required level of supervision and support, including education.

Definitions

These definitions relate to the use of the terms in this document and, where possible, align with definitions across other NMBA publications. To note: Person/people is used to refer to those individuals who have entered a therapeutic and/or professional relationship with a nurse or midwife.

Accountability means that nurses and midwives answer to the persons in their care, the NMBA, their employers and the public. Nurses and midwives are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing or midwifery role. Accountability cannot be delegated. The registered nurse or midwife, who delegates activities to be undertaken by another registered nurse, midwife, enrolled nurse, student, another health professional or health worker, remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated.

Activity/activities is a service provided to people as part of a nursing or midwifery plan of care. Activities may be clearly defined individual tasks, or more comprehensive care. The term can also refer to interventions, or actions taken by a health worker to produce a beneficial outcome for a person/woman. These actions may include, but are not limited to, direct care, monitoring, teaching, counselling, facilitating and advocating. In some jurisdictions, legislation specifically prohibits the delegation of nursing care to health workers, and mandates that only midwives can care for a woman in childbirth.

Code of conduct refers to the NMBA Code of conduct for nurses and Code of conduct for midwives. There are other codes of conduct that also impact on the practice of nurses, midwives, other health professionals and health workers, including state and territory employer-based codes, profession specific codes and the National code of conduct for health care workers (for those who are not regulated by Ahpra).

Collaboration/collaborate refers to all members of the healthcare team working in partnership with people and each other to provide the highest standard of, and access to, care. Collaborative relationships depend on mutual respect. Successful collaboration depends on communication, consultation and joint decision making within a risk management framework, to enable appropriate referral and to ensure effective, efficient and safe care.

Competence/competent is the combination of knowledge, skills, attitudes, values and abilities that underpin effective performance in a profession. It encompasses confidence and capability.

Competence assessment is the assessment of an individual's competence that may occur through structured educational programs or a peer review process. Evidence of a nurse or midwife's competence may include:

- written transcripts of the skills/knowledge they have obtained in a formal course
- their in-service education session records
- direct observation of their skill
- questioning of their knowledge base
- assessment from the recipient's perspective using agreed criteria, and
- self-assessment through reflection on performance in comparison with professional standards.

Comprehensive (health) assessment is the assessment of a person's/woman's health status for the purposes of planning or evaluating care. Data are collected through multiple sources, including, but not limited to, communication with the person/woman, and where appropriate their significant others, reports from others involved in providing care to the person/woman, healthcare records, direct observation, examination and measurement, and diagnostic tests. The interpretation of the data involves the application of nursing or midwifery knowledge and judgement. Health assessment also involves the continuous monitoring and reviewing of assessment findings to detect changes in the person's/woman's health status.

Consent is a person's voluntary and informed agreement to healthcare, which is made with knowledge and understanding of the potential benefits and risks involved. Consent requires clear and easy to understand information, so that the patient is able to make an informed decision.

Consultation is the seeking of professional advice from a qualified, competent source and making decisions about shared responsibilities for care provision. It is dependent on the existence of collaborative relationships, and open communication, with others in the multidisciplinary healthcare team.

Context of practice refers to the conditions that define an individual's practice. These include the: type of practice setting (such as healthcare agency educational organisation and/or private practice) location of the practice setting (such as urban, rural and/or remote) characteristics of care recipients (such as health status, age, gender, learning needs and culture) focus of nursing or midwifery activities (such as health promotion, research and/or management) degree to which practice is autonomous, and resources that are available, including access to other health professionals.

Cultural safety concept was developed in a First Nations' context and is the preferred term for nursing and midwifery. Cultural safety is endorsed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), who emphasise that cultural safety is as important to quality care as clinical safety. However, the presence or absence of cultural safety is determined by the recipient of care; it is not defined by the caregiver (CATSINaM, 2014, p.9). Cultural safety is a philosophy of practice that is about how a health professional does something, not [just] what they do. It is about how people are treated in society, not about their diversity as such, so its focus is on systemic and structural issues and on the social determinants of health. Cultural safety represents a key philosophical shift from providing care regardless of difference, to care that takes account of peoples' unique needs. It requires nurses and midwives to undertake an ongoing process of self-reflection and cultural self-awareness, and an acknowledgement of how a nurse's/midwife's personal culture impacts on care. In relation to Aboriginal and Torres Strait Islander health, cultural safety provides a de-colonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in healthcare encounters (CATSINaM, 2017b, p.11). In focusing on clinical interactions, particularly power inequity between patient and health professional, cultural safety calls for a genuine partnership where power is shared between the individuals and cultural groups involved in healthcare. Cultural safety is also relevant to Aboriginal and Torres Strait Islander health professionals. Non-Indigenous nurses and midwives must address how they create a culturally safe work environment that is free of racism for their Aboriginal and Torres Strait Islander colleagues (CATSINaM, 2017a).

Delegator is the person accountable (for this document it means registered nurse or midwife) for making decisions about to who is the most appropriate health professional or health worker to delegate.

Delegatee is a health professional or health worker who is delegated aspects of nursing or midwifery care.

Delegation is the relationship that exists when one member of the multidisciplinary healthcare team delegates aspects of care, which they are competent to perform and which they would normally perform themselves, to another health professional or health care worker.

Activities delegated by a registered nurse or midwife (delegator) to another registered nurse, midwife, enrolled nurse, student, another health professional or health worker (delegatee) cannot be delegated by that person, unless they have since obtained the authority to perform the activity. If changes in the context occur that necessitate re-delegation, a person without that authority must consult again with a registered nurse or midwife.

Education includes formal education courses leading to a recognised qualification and informal educational methods include, but are not limited to:

- reading professional publications
- completing self-directed learning packages
- attending in-service education sessions
- attending seminars or conferences
- individual, one-to-one education with a person competent in the subject or skill, and
- reflection on practice alone or with colleagues.

Practical experience and assessment of competence by a qualified person are key components of any educational preparation for the performance of a care activity.

Enrolled nurse is a person who has completed the prescribed educational preparation and competence for practice, who is registered as an enrolled nurse by the NMBA under the National Law. Enrolled nurses must work under the direct or indirect supervision of a registered nurse or midwife. This supervision cannot be replaced/substituted by another health professional. Enrolled nurses are accountable for their own practice and remain responsible to a registered nurse or midwife for the delegated care.
Evaluation is the systematic collection of evidence, measurement against standards or goals, and judgement to determine merit, worth or significance. It focuses on the persons response to nursing or

midwifery care to review the plan of care. It can also be used to determine the appropriateness of continuing to undertake an activity, or to delegate it. Relevant stakeholders who should be involved in evaluation including any party affected by the activity, such as other health workers.

Health professionals are people who have the necessary education to qualify for registration in their respective professions, to provide a health service for which they are individually accountable. Information about health professionals who are nationally regulated is available at www.ahpra.gov.au.

Health workers and others (also known as unlicensed healthcare workers) are any people who are not registered to practise under the National Scheme. Health workers may have a care-worker qualification or no formal education for their role. Health workers are individually accountable for their own actions and accountable to the registered nurse or midwife and their employer for delegated actions. Routine activities requiring a narrow range of skill and knowledge may be delegated to health workers. An activity is routine if the need for the activity, the recipient's response and the outcome of the activity have been established over time and is therefore predictable.

Legislation/legislative refers not only to National Law, but also to a diverse range of state/ territory and Commonwealth acts and regulations that may affect practice. Examples include the national Aged Care Act and Health Insurance Commission Act, and state/territory mental health acts, radiation safety legislation and drugs and poisons regulations.

Midwife is a person with prescribed educational preparation and competence for practice who is registered by the NMBA under the National Law. The NMBA has endorsed the International Confederation of Midwives definition of a midwife and applied it to the Australian context. This term also includes endorsed midwife.

Nurse − See registered nurse and enrolled nurse.

Organisation/organisational support includes employers/organisations who are responsible for providing sufficient resources to enable safe and competent care for people for whom they provide healthcare services. This includes policies and practices that support the development of nursing and midwifery practice to meet the needs and expectations of people, within a risk management framework. In situations where the nurse or midwife is self employed as a sole practitioner, the nurse or midwife assumes the employer's responsibilities for developing and maintaining a policy and risk management framework.

Person or people refers to those individuals who have entered into a therapeutic and/or professional relationship with a nurse. These individuals will sometimes be healthcare consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities, however named, that are within the nurse's scope and context of practice.

Person-centred care is a collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred care recognises the role of family and community with respect to cultural and religious diversity.

Refer/referral involves a nurse or midwife sending a person/woman to obtain an opinion or treatment from another health professional or entity. Referral usually involves the transfer (all or in part) of responsibility for the care of the person/woman, usually for a defined time and for a particular purpose, such as care or treatment that is outside the referring health professional's expertise or scope of practice.

Registered nurse is a person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered by the NMBA under the National Law as a registered nurse. The term also includes nurse practitioner.

Risk assessment/risk management consists of an effective risk management system, incorporating strategies to identify risks/hazards, assess the likelihood of the risks occurring and the severity of the consequences if the risks do occur, prevent the occurrence of the risks, or minimise their impact.

Scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform. Some

functions within the scope of practice of any profession may be shared with other professions or other individuals or groups. The scope of practice of all health professions is influenced by the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population.

The scope of practice of an individual is that which the individual is educated, authorised and competent to perform. The scope of practice of an individual nurse or midwife may be more specifically defined than the scope of practice of their profession. To practise within the full contemporary scope of practice of the profession may require individuals to update or increase their knowledge, skills or competence. Decisions about both the individual's and the profession's practice can be guided using DMF. When making these decisions, nurses and midwives need to consider their individual and their respective profession's scope of practice.

Student/s refers to those in courses that lead to eligibility to apply for registration as a nurse or registration or as a midwife are an integral part of the healthcare team in many settings. As part of their educational program, they are expected to provide care to people under the supervision of a registered nurse, and to women and babies under the supervision of a midwife. In order to gain the necessary knowledge and skill for professional practice, they may, during their course, undertake under supervision the full range of care activities that are expected of a licensed nurse or midwife. Decisions about what activities a student may perform will be guided by consideration of whether:

- performance of the activity is congruent with the educational goals of the program in which the student is enrolled, and with the professional role (enrolled nurse, registered nurse, midwife) that the student will undertake once they graduate
- the educational institution supports the performance of the activity by the relevant group of students, and
- the student is competent and confident to perform the specific activity for the person in the current context.

Supervision includes managerial supervision, professional supervision and clinically focused supervision as part of delegation. There are two levels of supervision;

Direct supervision where the supervisor takes direct and principal responsibility for the nursing or midwifery care provided (e.g. assessment and/or treatment of individual patients/clients), and

Indirect supervision where the supervisor and supervisee share the responsibility for individual patients. The supervisor is easily contactable and is available to observe and discuss the nursing or midwifery care the supervisee is delivering.

For the purpose of the supervision of enrolled nurses refer to the Enrolled nurse standards for practice .

Volunteers/family members provide service without expectation of financial reward. In some contexts, they provide services similar to those provided by health workers. While they are unpaid and may be said to participate in care rather than be delegated care activities, the accountabilities of a registered nurse or midwife who involves the volunteer/family member in the provision of care are the same as for delegation.

Woman or women refers to those individuals who have entered into a therapeutic and/or professional relationship with a midwife. The word woman in midwifery is generally understood to be inclusive of the woman's baby, partner and family. Therefore, the words woman or women include all the women, babies, newborn, infants, children, families, carers, groups and/or communities, however named, that are within the midwife's scope and context of practice.

Woman-centred care recognises the woman's baby or babies, partner, family, and community, and respects cultural and religious diversity as defined by the woman herself. Woman-centred care considers the woman's individual circumstances, and aims to meet the woman's physical, emotional, psychosocial, spiritual and cultural needs. This care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. Woman-centred care respects the woman's ownership of her health information, rights and preferences while protecting her dignity and empowering her choices. Woman-centred care is the focus of midwifery practice in all settings.

Therapeutic relationships are different to personal relationships. In a therapeutic relationship the nurse is sensitive to a person's situation and purposefully engages with them using knowledge and skills in

respect, compassion and kindness. In the relationship the person's rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power. For further details see the NMBA's Code of conduct for nurses and/or Code of conduct for midwives.

Document control

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Date approved	October 2019
Date commenced	February 2020
Date modified	February 2022 – updated to reflect commencement of *Supervised practice framework* August 2022-updated to include information on RNs and ENs with sole qualifications and notations on their registration.

JB 5

Ahpra
& National
Boards

Supervision guidelines

1 February 2022

Background

The Australian Health Practitioner Regulation Agency (Ahpra) works in partnership with 15 national health practitioner boards (the National Boards) to implement the National Registration and Accreditation Scheme (the National Scheme) and administer the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

The National Boards regulate registered health practitioners in Australia. They:

- set the standards that practitioners must meet through the development of registration standards, codes and guidelines
- register health practitioners and students
- manage notifications about the health, conduct or performance of practitioners.[1]

The core role of the National Boards and Ahpra is to protect the public.

The National Law states that the National Boards can develop and approve codes and guidelines to provide guidance to the health practitioners it registers.[2]

The supervised practice framework

The National Boards[3] have reviewed and consulted widely on the requirements for supervised practice under the National Law. The National Boards approved in June 2021 the Supervised practice framework (the framework).

The framework accommodates the different regulatory purposes of supervised practice and allows for a responsive and risk-based approach across the National Scheme. The framework supports consistency in processes and decision making, and helps supervisees, supervisors and employers understand and comply with supervised practice requirements.

Purpose of the supervision guidelines

The purpose of these supervision guidelines (the guidelines) is to adopt the framework published by National Boards and Ahpra and to replace any previously approved supervision guideline or framework for the following National Boards[4,5]:

- Aboriginal and Torres Strait Islander Health Practice
- Chinese Medicine
- Chiropractic
- Dental
- Medical (excluding international medical graduates (IMGs) who will use the *Guidelines - Supervised practice for international medical graduates*)
- Nursing and Midwifery
- Occupational Therapy
- Optometry
- Osteopathy
- Paramedicine
- Physiotherapy
- Podiatry.

The guidelines enable the current reference to supervision guidelines in registration standards to apply to the framework. Changes to relevant registration standards to explicitly refer to the framework rather than supervision guidelines will be made at a later date.

The framework is published on the relevant National Board website and may be reviewed from time to time.

Review

Date of issue: 1 February 2022

Date of review: These guidelines will be reviewed as required.

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1 In NSW notifications about health, performance and conduct are managed by the Health Care Complaints Commission and the Health Professional Councils Authority. In Qld they are managed jointly by the Office of the Health Ombudsman and the National Boards and Ahpra.

2 Sections 39 and 40 of the National Law.

3 Excluding the Pharmacy and Psychology Boards of Australia who did not take place in the review

4 The Pharmacy and Psychology Boards of Australia do not intend to use these guidelines.

5 The Medical Radiation Practice Board of Australia took place in the review but will not adopt these Supervision guidelines

JB 6

Ahpra
& National
Boards

Supervised practice framework

1 February 2022

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1. Introduction

The primary roles of the National Boards and the Australian Health Practitioner Regulation Agency (Ahpra) include public protection and helping the public access safe health services.

National Boards work with Ahpra to implement the objectives of the National Registration and Accreditation Scheme (the National Scheme) under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

Supervised practice reassures the community, National Boards and Ahpra that a registered health practitioner whose practice is being supervised (the supervisee) is safe and competent to practise and is not putting the public at risk.

National Boards and Ahpra have developed the *Supervised practice framework* (the framework) to create a responsive and risk-based approach to supervised practice across the National Scheme. The framework supports consistency in processes and decision making and helps supervisees, supervisors and employers understand what is expected of them. The framework outlines the National Boards' expectations, gives guidance on how to comply and explains what is necessary to effectively carry out supervised practice.

The framework applies to certain decisions made by National Boards or to meet National Board registration standards, eligibility or suitability requirements, or as required by the National Law.

The framework consists of the following core components; these components support the provision of high-quality, safe and effective supervised practice:

- **Principles** that build on the Regulatory principles for the National Scheme and the guiding principles of the National Scheme set out under the National Law, which apply to all other core components for supervised practice.
- **Levels** of supervised practice to make sure that supervised practice requirements are proportionate to the risk associated with the purpose.
- **Clearly explained expectations** of supervisees, supervisors and employers so they understand their roles and responsibilities.
- **Compliance** processes that monitor the progress and effectiveness of supervised practice requirements.

The framework includes appendices and templates which also contain expectations for supervisees, supervisors and employers and outlines the process for progressing supervised practice. The appendices may be updated from time to time and these will be published on the relevant National Board website. The framework should be read together with the supervised practice arrangement.

In this framework a **supervised practice arrangement** means all the elements of supervised practice approved by the National Board. This includes the approved supervisor(s), supervised practice level, workplace and any other requirements documented in a supervised practice plan (where necessary) **or** as stated in a condition or undertaking, or registration standard.

The framework does not establish the requirements for supervised practice. These are established in the National Law, as specified in a condition or undertaking, or registration standard.

To comply with a condition, undertaking or a requirement of a registration standard, supervisors and supervisees must comply with the framework. A failure to comply with the framework or to provide the necessary evidence of compliance with the framework could result in a finding by the National Board that a condition, undertaking or requirement of a registration standard has not been met and result in regulatory action being taken by the National Board under the National Law.

A note on terminology

The framework uses 'patient' to mean a person or persons accessing healthcare, which includes clients and healthcare consumers. These terms can also include families, carers, groups and/or communities. The meaning of patient for the purpose of this framework is set out in section *10. Definitions*.

2. Purpose and scope

When does this framework apply?

Supervised practice is used for three regulatory purposes across the National Scheme. Due to the profession-specific uses of supervised practice, the examples below may not be relevant for all professions.

The three regulatory purposes are:

1. As a registration requirement

For some National Boards, some types of registration require supervised practice such as limited registration and provisional registration (such as for overseas qualified practitioners).

2. To meet the National Board's eligibility or suitability requirements at application or renewal

This may be due to:

- returning to practice after an absence
- changing to a different field or scope of practice (where applicable)
- needing to meet the eligibility requirements for an application for registration or endorsement, or
- an inability to meet any other requirements of a registration standard for the profession.

Specific information on National Board standard requirements is provided in *Appendix 1 – Links to relevant National Board material*.

3. Because of a complaint (notification)

This will be in the form of a condition or undertaking imposed by a National Board, panel or tribunal as an outcome of a notification that requires the practitioner to complete a period of supervised practice.

If supervised practice is in place because of a complaint, a supervised practice plan is not needed.

The need for supervised practice is reflected by either one or a combination of the following a: registration requirement, notation, condition or undertaking recorded on a practitioner's registration. This information is available on the public register of practitioners.

The framework does not override or replace any requirements specified in a condition or undertaking or registration standard or any other supervised practice requirement.

When does this framework not apply?

This framework does **not** apply to:

- supervision of students undertaking clinical training (the meaning of student for the purpose of this framework is set out in section *10. Definitions*)
- supervision of unregistered health practitioners
- supervision for research purposes (unless the practitioner holds limited registration for teaching or research)
- provision of support to new graduates or less experienced practitioners, or
- performance review responsibilities of managers and employers.

This framework does **not** apply to the following registrant groups because of profession-specific uses of supervised practice:

National Board	Registrant group
Medical Board of Australia	• International medical graduates • practitioners completing their intern year, or • vocational trainees.
Paramedicine Board of Australia	• Practitioners with a Board-specific condition employed by and undertaking supervised practice with a body authorised by the National Board.[1]
Pharmacy Board of Australia	• Pharmacists.[2]
Podiatry Board of Australia	• Practitioners seeking their endorsement for scheduled medicines.
Psychology Board of Australia	• Psychologists.[2]

Profession-specific material relating to the framework

Some National Boards have extra requirements for supervised practice for a particular purpose (e.g. profession-specific registration standards, capabilities, competencies, thresholds or standards for practice). While the core components of this framework apply, there may also be extra profession-specific documents that need to be considered.

Supervisees and supervisors need to check if there are profession-specific requirements that apply to the supervised practice arrangement. A summary of these profession-specific requirements is at *Appendix 1 – Links to relevant National Board material*.

3. Who should use this supervised practice framework?

The framework should be used by:

- National Boards
- Ahpra
- co-regulators[3] (where applicable)
- health panels and performance and professional standards panels
- supervisees
- potential and approved supervisors, and
- employers of supervisees and/or supervisors.

Tribunals and panels considering matters arising from a notification about a registered health practitioner may decide to impose a period of supervised practice. A tribunal may refer to this framework in addition to the National Restrictions Library when drafting the supervised practice requirements.

[1] Aspects of the framework may still apply as agreed by the National Board.

[2] Due to other regulatory and/or profession-specific requirements the framework is not applicable to pharmacists or psychologists.

[3] Office of the Health Ombudsman, New South Wales Health Professional Councils.

4. Principles

This framework is underpinned by several principles that build on the Regulatory principles for the National Scheme and the guiding principles of the National Scheme set out under the National Law.

These principles are considered by National Boards when deciding the supervised practice arrangements and when ensuring monitoring and compliance with supervised practice. They also apply to the supervisees and supervisors, where relevant.

Patient safety

Patient care given during supervised practice must be safe and appropriate. This must be the overriding priority at all times.

The need for supervised practice is reflected by either one or a combination of the following a: registration requirement, notation, condition or undertaking recorded on a practitioner's registration. This information is available on the public register of practitioners.

Risk-based approach

The National Board will consider several factors when taking a risk-based approach to supervised practice.

The risk associated with a particular purpose for supervised practice will be influenced by:

- the setting and context in which the practitioner is being supervised
- the proximity to peers and other practitioners
- the supervisee's ability to show insight and/or reflection, where applicable
- the requirements of a relevant position description, and
- whether the supervised practice is required because of a condition or undertaking.

If the supervised practice is required in relation to an application or renewal of registration, the supervisee's qualifications, skills, competence, years of practice and clinical experience will also be considered.

This risk associated with the purpose of supervised practice will inform the:

- level of supervised practice required for a supervisee
- frequency of consultation between the supervisor and supervisee
- need for a supervised practice plan for some registration-related matters
- parameters for progression from one level of supervised practice to another
- number of years of experience required of the supervisor
- frequency of reporting, and
- detail of required reports.

As a general principle, if the purpose for supervised practice is to address an assessed higher risk, the supervision will be more direct and reports will be more frequent and detailed.

Accountability and transparency

Supervisees and supervisors must be accountable and transparent at all times in complying with their responsibilities for the supervised practice arrangement and in communication with Ahpra and the National Board. If the supervisee or supervisor does not act in good faith[4] in their role, a National Board may take regulatory action.

By providing the framework and supporting documentation National Boards are being transparent about the approach to supervised practice in the National Scheme.

Individual approach

National Boards make decisions about supervised practice arrangements in different ways depending on the purpose of the supervised practice.

For notification matters, the National Board will impose supervised practice requirements to manage the risk identified.

[4] 'Good faith' has its ordinary meaning of being well-intentioned or without malice.

For all other required supervised practice, the National Board will consider each proposed supervised practice arrangement on its individual merits and will only approve arrangements that it considers safe and fair. In these cases, supervised practice requirements need to be matched to the individual practitioner's experience, needs and capabilities as well as their employment arrangement and/or practice environment.

Culturally safe and respectful practice

Supervisors and supervisees have responsibilities to protect patient safety and improve healthcare quality for Aboriginal and Torres Strait Islander Peoples, contributing to improving their health wherever possible.

Supervisors and supervisees should recognise and consider the diverse and distinct needs of Aboriginal and Torres Strait Islander Peoples and their health and cultural safety, including the need to foster open and honest professional relationships. The National Scheme's definition of cultural safety for Aboriginal and Torres Strait Islander Peoples is set out in section *10. Definitions*.

Culturally safe and respectful practice requires supervisees and supervisors to have knowledge of how their own culture, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community and colleagues. It is expected that supervisees and supervisors will practise in a culturally safe and respectful way as set out in the relevant National Board code of conduct and other relevant standards, codes or guidelines.

Objectivity

Objectivity from the supervisor is essential for the supervised practice arrangement to be effectively delivered.

The supervisory relationship between supervisor(s) and the supervisee must be professional.

Conflicts of interest may prevent objectivity and/or interfere with the supervised practice arrangement. Supervisors and supervisees must disclose potential or actual conflicts of interest to the National Board. The National Board will decide whether any conflicts disclosed show a potential or actual conflict of interest. Conflicts of interest must be avoided if possible and managed if not avoidable.

When supervised practice relates to a registration type or to meet suitability or eligibility for registration a National Board may refer to an independent measure such as entry-level competencies or equivalent (refer to *Appendix 1 – Links to relevant National Board material*) for the profession to describe the level of competence expected of the supervisee.

For further information about conflict of interest refer to:

- *Appendix 2 – Information for supervisees*
- *Appendix 3 – Information for supervisors*

Flexibility

The National Board may approve more than one supervisor for supervised practice. This allows for flexibility if a supervisor is not available to carry out the supervised practice. It also allows for each National Board to approve a relevant and suitable supervised practice arrangement with more than one approved supervisor.

The supervisor will usually be from the same profession as the supervisee. A National Board may approve a practitioner from another profession as a supervisor in exceptional circumstances. This is at the discretion of the National Board.

Supervised practice arrangements may need to change over time, subject to National Board-approval. This may be because of progress towards the purpose of the supervised practice or because of a change of circumstances, such as change in supervisor or workplace.

Preparation and support

Supervised practice is most effective when supervisees and supervisors are prepared and supported. There needs to be a shared understanding of the supervised practice arrangements.

Supervisees should be given adequate orientation to any new supervised practice setting. Supervisors will need to meet any National Board-approved training requirements. This training may be counted as continuing professional development (CPD) if it meets the National Board's requirements set out in the registration standard for CPD.

5. Levels

Levels of supervised practice

The levels of supervised practice are designed to make sure that the supervisee practises safely. There are four levels of supervised practice described in this framework. Not all levels will be used by all National Boards.

The definition of 'consult' for this framework is set out in section *10. Definitions*.

More information about the supervised practice levels is available in *Appendix 4 – Supervised practice levels*.

Table 1 Levels of supervised practice

Level of supervised practice	Description of supervised practice level
Direct *Supervisor physically present at all times to observe the supervisee*	**Summary** The supervisor takes direct and principal responsibility for all individual patients receiving care from the supervisee. The supervisee must consult with and follow the directions of the supervisor about the management of each patient, including the process of assessment, before care is given. The care provided must be directly observed by the supervisor who is physically present with the supervisee at all times.
Indirect 1 (present) *Supervisor physically present at the workplace*	**Summary** The supervisee and the supervisor share responsibility for all individual patients receiving care from the supervisee. The supervisee must consult with the supervisor who is always physically present in the workplace or practice environment and available to observe and discuss at agreed intervals and as necessary the: • management of patients, including when care is being given, and/or • performance of the supervisee.
Indirect 2 (accessible) *Supervisor is accessible by phone or other means and available to physically attend the workplace*	**Summary** The supervisee takes primary responsibility for their practice and the management of all individual patients receiving care from the supervisee under the supervisor's general oversight. The supervisee must consult with the supervisor who is accessible by telephone, video conference or other means of telecommunication and available to attend the workplace or practice environment to observe and discuss at agreed intervals and as necessary the: • management of patients, and/or • performance of the supervisee. This may be after the care is given to the patient.
Remote *Supervisor is not present at the workplace*	**Summary** The supervisee takes primary responsibility for their practice including the management of all individual patients receiving care from the supervisee under the supervisor's general oversight. The supervisee must consult with the supervisor, who is accessible by telephone, video conference or other means of telecommunication at agreed intervals and as necessary about the: • management of patients, and/or • performance of the supervisee. This may be after the care is given to the patient.

Progression through levels

When supervised practice is required because of a notification, the supervised practice remains at the level outlined in the condition or undertaking.

Supervised practice may involve progression through levels when it is required for a registration type or to meet suitability or eligibility for registration. Progression can occur depending on the individual requirements of supervised practice as set out in the supervised practice arrangement, for example meeting the entry level competencies or equivalent.

For further information about the levels of supervised practice refer to:
- *Appendix 4 – Supervised practice levels*

6. National Board expectations of supervisees, supervisors, and employers

National Boards expect that supervisees and supervisors comply with the framework. If the supervisee fails to comply with the framework it could result in a decision by the National Board that a condition, undertaking or requirement of a registration standard has not been met and may result in regulatory action being taken by the National Board.

The National Boards also expect supervisees and supervisors to comply with all the relevant National Board standards, guidelines, code of conduct and other codes.

National Board expectations of supervisees

The supervisee must not start practice, or restart practice, until the National Board has approved the supervisor(s) and the supervised practice arrangement, unless otherwise agreed by the National Board.

If the supervisee knows that their, or their supervisor's, circumstances are going to change and they will not be able to comply with the approved supervised practice arrangement, they need to let Ahpra know as soon as possible and within seven (7) calendar days or as stated in the condition or undertaking.

The supervised practice approved by the relevant National Board will be documented in the supervised practice arrangement, which may also refer to a supervised practice plan. When supervised practice follows a notification, the requirements for supervised practice will be set out in the condition or undertaking in the supervised practice arrangement.

The supervisee must:
- practise within the approved supervised practice arrangement at all times
- discuss cases and ask questions of the supervisor and take account of the feedback given by the supervisor, and
- make sure that all reports are completed as needed.

For further information about expectations of the supervisee and the practical steps to prepare for a period of supervised practice refer to:
- *Appendix 2 – Information for supervisees*, which includes:
  - Nominating a supervisor
  - Who may act as a supervisor?
  - Costs
  - What must I do when I am practising under supervised practice?

National Board expectations of supervisors

A supervisor needs to have the qualifications, skills, knowledge, experience and availability needed for the role. These will vary according to the purpose of supervised practice and the risk associated with the role. The National Board will consider the supervisor's experience and circumstances (including their qualifications, responsibilities, relevant scope of practice) when deciding the requirements of the supervised practice. Information on the nomination process for a supervisor is available in *Appendix 2 – Information for supervisees*.

Supervisors must hold general registration and, where relevant the appropriate specialist registration or endorsement with a National Board.

The supervisor's registration must not be subject to any conditions or restrictions that could affect their effectiveness or suitability to successfully supervise another's practice.

A supervisor's required level of skills and the number of years of experience may vary according to the level of risk associated with the supervisee's individual circumstances.

A supervisor must:

- sign an approved form to act as a supervisor, subject to approval by the National Board
- complete the proposed supervised practice plan, if applicable, in consultation with the supervisee
- at all times supervise within the supervised practice arrangement approved by the National Board
- ensure the supervisee is practising within the terms of the supervised practice arrangement
- give clear direction and constructive feedback and work with the supervisee to address areas identified in the supervised practice arrangement and/or address identified problems
- fulfil any assessment as set out in the supervised practice arrangement
- only assign tasks that are within the scope of training, competence and capability of the supervisee, and appropriate to their role
- maintain adequate written records relating to the supervisee's practice
- be accountable to the relevant National Board and give honest, accurate, objective and responsible reports in the approved form at agreed intervals
- notify Ahpra immediately if they have concerns that the supervisee's health, conduct or clinical performance is placing the public at risk
- notify Ahpra as set out in this framework if any other circumstances arise that may affect the supervised practice arrangement, and
- check with their indemnity insurance provider and their employer/contracting body to make sure they have appropriate professional indemnity coverage in place to act as a supervisor under the framework.

For further information about the expectations of the supervisor refer to:

- *Appendix 3 – Information for supervisors*

The National Board's expectations of employers

An employer should think about the following factors in relation to supervised practice:

- potential and/or actual conflicts of interest
- if the employment arrangements, including the facilities and scope of practice of the relevant role can support a supervisee in carrying out supervised practice
- if supervisors or supervisees are covered by an employer's overall insurance arrangements and check that the professional indemnity insurance (PII) arrangements meet the National Board's minimum requirements and cover the proposed supervised practice arrangement, and
- immediately advise Ahpra of any concerns about the supervisee if they form an opinion that there is a risk to the public or if the supervisee is in breach of the supervised practice arrangement.

For further information about the expectations of the employer refer to:

- *Appendix 5 – Information for employers*

7. Compliance

It is important that the supervised practice arrangement manages the risk associated with the purpose of supervised practice.

Ahpra and National Boards monitor supervised practice. Monitoring will be proportional to the level of identified risk of harm and depending on the supervised practice purpose may include regular reporting, review of Medicare data, review of rosters or appointment diaries and/or employer reports.

If a supervisee does not practise in accordance with the supervised practice arrangement, this may pose a risk to the public and the National Board may take regulatory action under the National Law, including but not limited to investigation or immediate action for unprofessional conduct. A National Board may also take the necessary regulatory action required if a supervisee does not progress as expected.

If the supervisor does not, in good faith, supervise practice and carry out the role of the supervisor to the requirements outlined in the framework and appendices, the National Board may take regulatory action under the National Law, including but not limited to investigation or immediate action for unprofessional conduct.

Supervisees and supervisors are reminded to practise in accordance with the relevant National Board's registration standards, guidelines, code of conduct and other codes.

8. Completing supervised practice

The criteria for when supervised practice is successfully completed will depend on the purpose of supervised practice and profession specific uses of supervised practice. The criteria for successfully completing supervised practice will be set out in the supervised practice arrangement for each supervisee.

To meet a registration requirement or to meet suitability or eligibility for registration, the criteria for completing supervised practice includes when the supervisee has:

- shown competence against the relevant standards as assessed by the approved supervisor, and/or
- successfully transitioned through the supervised practice levels (if required), and/or
- successfully completed required training, assessment or examination approved by the National Board, and
- had the notations or conditions removed from their registration.

This information will be updated on the public register of practitioners.

Supervisees completing supervised practice as a requirement after a notification must apply for a review of the conditions or undertakings where they have successfully shown a period of competent and safe practice under supervised practice. Supervised practice will only be complete when the National Board decides the conditions or undertakings are no longer necessary.

9. Review

The framework was issued on 1 February 2022.

The framework was updated in April 2023 to reflect the Medical Radiation Practice Board of Australia adopting the framework from 1 April 2023.

It will be updated from time to time to support the implementation and understanding of supervised practice requirements across the National Scheme. This will generally be at least every five years.

Definitions

Consult in this framework means the supervisee and supervisor must engage and interact with each other in a way that is consistent with the level of supervised practice required and appropriate for the relevant supervised practice arrangement.

Cultural safety

The definition

Principles

The following principles inform the definition of cultural safety:

- Prioritising Council of Australian Governments (COAG)'s goal to achieve healthcare free of racism supported by the National Aboriginal and Torres Strait Islander Health Plan.
- Improved health service provision supported by the Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health.
- Provision of a rights-based approach to healthcare supported by the United Nations Declaration on the Rights of Indigenous Peoples.
- Ongoing commitment to learning, education and training.

Definition

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.

Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

How to

To ensure culturally safe and respectful practice, health practitioners must:

a. Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health;
b. Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism;
c. Recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community;
d. Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

National Scheme means the National Registration and Accreditation Scheme for registered health practitioners of 16 health professions:

- Aboriginal and Torres Strait Islander Health Practice
- Chinese medicine
- Chiropractic
- Dental
- Medical
- Medical radiation practice
- Nursing
- Midwifery
- Occupational therapy
- Optometry
- Osteopathy
- Paramedicine
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology

Patient in this framework means a person who has entered into a therapeutic and/or professional relationship with a registered health practitioner. The term 'patients' includes 'clients', 'consumers' and 'women'.[5] It can also extend to their families and carers, and to groups and/or communities as users of health services, depending on context.

[5] **Woman or women** is used to refer to those individuals who have entered into a therapeutic and/or professional relationship with a midwife. The word woman in midwifery is generally understood to be inclusive of the woman's baby, partner and family. Therefore, the words woman or women include all the women, babies, newborn, infants, children, families, carers, groups and/or communities, however named, that are within the midwife's scope and context of practice.

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in the profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge working in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of health services in the health profession.

Student in this framework means a student enrolled in a Board-approved program of study.

Supervised practice in this framework is a mechanism to give the National Board the assurance that the supervisee is practising safely, competently and ethically for a range of regulatory purposes. Supervised practice may be direct, indirect or remote according to the nature in which the practice is being supervised.

Supervisee is a registered health practitioner who is required to carry out a period of supervised practice. The supervisee practises under the supervision of a National Board-approved supervisor with a level of supervised practice outlined in the supervised practice arrangement or relevant condition or undertaking. Refer to *Appendix 2 – Information for supervisees* for further information.

Supervisor is a registered health practitioner who is approved by the relevant National Board to supervise another registered health practitioner for a specified period. The supervisor needs to have the qualifications, skills, knowledge, experience and availability required for this role. Refer to *Appendix 3 – Information for supervisors* for further information.

Supervised practice arrangement in this framework means all the elements of supervised practice approved by the National Board. This includes the approved supervisors(s), supervised practice level, objectives, workplace, and any other requirements documented in a supervised practice plan (where necessary) or as stated in a condition or undertaking or registration standard.

Supervised practice plan in this framework is the form approved by the National Board in which the supervisee and supervisor acknowledge and confirm they will carry out and comply with the requirements of supervised practice contained in the framework and reflected in the supervised practice arrangement.

Supporting documents in this framework includes the supervised practice plan, supervised practice report, correspondence from Ahpra, and National Board material set out in *Appendix 1 – Links to relevant National Board material* that form the framework and any documents relevant to the framework and updated by National Boards from time to time.

Appendix 1 – Links to relevant National Board material

National Boards have specific requirements for supervised practice for some regulatory purposes. It is important to check if there are profession-specific requirements that apply to the supervisee completing supervised practice. The National Board's entry-level competencies or equivalent may need to be referred to if a detailed supervised practice plan is needed.

Links to registration standards and entry-level competencies or equivalent

National Boards	National Board material	Hyperlinks
Aboriginal and Torres Strait Islander Health Practice Board of Australia	Registration standard – recency of practice	www.atsihealthpracticeboard.gov.au/Registration-Standards
	Entry-level competencies	www.atsihealthpracticeboard.gov.au/Codes-Guidelines/Professional-capabilities
Chinese Medicine Board of Australia	Registration standard – recency of practice	www.chinesemedicineboard.gov.au/Registration-Standards
	Registration standard – standards for limited registration	www.chinesemedicineboard.gov.au/Registration-Standards
	Entry-level competencies	www.chinesemedicineboard.gov.au/Codes-Guidelines/Professional-capabilities-for-Chinese-medicine-practitioners
Chiropractic Board of Australia	Registration standard – recency of practice	www.chiropracticboard.gov.au/Registration-standards
	Registration standard – standards for limited registration	www.chiropracticboard.gov.au/Registration-standards
	Entry-level competencies	www.chiropracticboard.gov.au/Accreditation
Dental Board of Australia	Registration standard – recency of practice	www.dentalboard.gov.au/Registration-Standards
	Registration standard – standards for limited registration	www.dentalboard.gov.au/Registration-Standards
	Entry-level competencies	https://www.dentalboard.gov.au/Accreditation.aspx
Medical Board of Australia	Registration standard – recency of practice	www.medicalboard.gov.au/Registration-Standards
Medical Radiation Practice Board of Australia	Registration standard – recency of practice	www.medicalradiationpracticeboard.gov.au/Registration-Standards
	Entry-level competencies	www.medicalradiationpracticeboard.gov.au/registration/professional-capabilities
Nursing and Midwifery Board of Australia	Registration standard – recency of practice	www.nursingmidwiferyboard.gov.au/Registration-Standards/Recency-of-practice
	Standards for practice	www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards

National Boards	National Board material	Hyperlinks
Occupational Therapy Board of Australia	Registration standard – recency of practice	www.occupationaltherapyboard.gov.au/Registration-Standards/Recency-of-practice
	Entry-level competencies	www.occupationaltherapyboard.gov.au/codes-guidelines/competencies
Optometry Board of Australia	Registration standard – recency of practice	www.optometryboard.gov.au/Registration-Standards/Recency-of-practice
	Registration standard – standards for limited registration	www.optometryboard.gov.au/Registration-Standards/Limited-registration-for-postgraduate-training-or-supervised-practice www.optometryboard.gov.au/Registration-Standards/Limited-registration-for-teaching-or-research
	Entry-level competencies	www.optometryboard.gov.au/Policies-Codes-Guidelines.aspx#entry-level
Osteopathy Board of Australia	Registration standard – recency of practice	www.osteopathyboard.gov.au/Registration-Standards
	Entry-level competencies	www.osteopathyboard.gov.au/codes-guidelines/capabilities-for-osteopathic-practice
Paramedicine Board of Australia	Registration standard – recency of practice	www.paramedicineboard.gov.au/Professional-standards/Registration-standards/Recency-of-practice
	Entry-level competencies	www.paramedicineboard.gov.au/Professional-standards/Professional-capabilities-for-registered-paramedics
Physiotherapy Board of Australia	Registration standard – recency of practice	www.physiotherapyboard.gov.au/Registration-Standards
	Registration standard – standards for limited registration	www.physiotherapyboard.gov.au/Registration-Standards
	Entry-level competencies	www.physiotherapyboard.gov.au/accreditation
Podiatry Board of Australia	Registration standard – recency of practice	www.podiatryboard.gov.au/Registration-Standards
	Professional capabilities	www.podiatryboard.gov.au/Registration-Endorsement/Podiatry-professional-capabilities

Appendix 2 – Information for supervisees

This information applies to all registered health practitioners who are required by the National Board to complete a period of supervised practice. It informs and forms part of the *Supervised practice framework* (the framework) and should be read together with relevant supporting documents.

What is a supervised practice arrangement?

In this framework, a supervised practice arrangement means all the elements of supervised practice approved by the National Board. This includes the approved supervisor(s), supervised practice level, workplace and any other requirements documented in a supervised practice plan (where necessary) or as stated in a condition or undertaking or registration standard.

The need for supervised practice is reflected by either one or a combination of the following a: registration requirement, notation, condition or undertaking recorded on a practitioner's registration. This information is available on the public register of practitioners.

Why does the National Board require me to complete supervised practice?

There are three regulatory purposes that supervised practice is used for across the National Registration and Accreditation Scheme (National Scheme). Check section 2. *Purpose and scope* to see if the framework applies to you.

1. As a registration requirement

Some National Boards require supervised practice for some types of registration such as limited registration and provisional registration (such as for overseas qualified practitioners).

2. To meet the National Board's eligibility or suitability requirements at application or renewal

This may be because you:

- are returning to practice after an absence
- are changing to a different field or scope of practice
- need to meet the eligibility requirements for an application for registration or endorsement, or
- are unable to meet any other requirements of a registration standard for the profession.

3. Because of a complaint (notification)

This may be in the form of a condition or undertaking imposed by a National Board, panel or tribunal that requires you, the practitioner, to complete a period of supervised practice.

The reasons for your supervised practice will be given to you in writing by the Australian Health Practitioner Regulation Agency (Ahpra) on behalf of the National Board. Ahpra will be your contact point with the National Board.

When can I start supervised practice?

You must wait until the supervised practice arrangement is approved, including the approval of a supervisor by the National Board, before you start or restart practice.

> Any practice that occurs outside the approved supervised practice arrangement will be considered a breach of the supervised practice arrangement and may result in the National Board taking regulatory action.

Preparing for supervised practice

If you are carrying out supervised practice because of a registration type or eligibility/suitability requirement you will usually need to nominate a supervisor and prepare a proposed supervised practice arrangement including a plan. The details of the documentation you need to complete will be outlined in the application form, and/or in communication from Ahpra following your application.

If you are carrying out supervised practice because of a complaint (notification) the details of the supervised practice will be set out in the condition or undertaking. Ahpra will communicate with you about actions you need to take to prepare for supervised practice, which may include nominating a supervisor.

You must also give your employer or senior person at your workplace (for example a CEO, medical/clinical director or head of department) a copy of the supervised practice arrangement. If you are completing supervised practice because of a notification the senior person you must give a copy of the arrangement to will be stated in the condition/undertaking.

Nominating a supervisor

You may need to find and nominate your own supervisor depending on the purpose for the supervised practice. If nominating a supervisor, you need to consider the information in this appendix and the information in *Appendix 3 – Information for supervisors*.

If you are required to nominate a supervisor, it is recommended that you nominate more than one. Then, if the primary supervisor is no longer available, any other approved supervisor in the supervised arrangement can take on the role of supervisor and you can continue to practise. The National Board must approve all supervisors. They may approve someone other than your nominee(s).

If you are an employee, you need to make sure your employer agrees with your nominated supervisor(s).

Who may act as a supervisor?

General requirements

When selecting and approaching potential supervisors, you should check they meet the following requirements:

- hold general registration and where relevant the appropriate specialist registration or endorsement
- have relevant experience (including their qualifications, responsibilities and relevant scope of practice)
- are not themselves subject to supervised practice, or do not hold registration subject to conditions or undertakings that would impact on their ability to effectively supervise you
- will sign an approved form to act as your supervisor, subject to being approved by the National Board
- agree to comply with the requirements of the approved supervised practice arrangement, and
- understand that supervised practice must be given according to the framework and the supervised practice arrangement approved by the National Board, and if not, the National Board may take regulatory action under the National Law.

While your supervisor will usually be from the same profession as you, a National Board may approve practitioners from another profession as your supervisor(s) in exceptional circumstances. This will be at the discretion of the National Board.

When identifying a potential supervisor, you may wish to seek advice from:

- prospective, current and past employers
- past supervisors
- education providers
- specialist colleges
- professional associations
- accreditation authorities (where relevant), and/or
- colleagues and mentors.

Conflict of interest

A supervisor must be able to give an independent report of supervised practice results and be willing to report to Ahpra if your practice places the public at risk or you are not compliant with the supervised practice arrangement.

You must declare any actual or perceived conflicts of interest that may undermine the supervisor's role. The National Board will decide whether any conflict declared shows a potential or actual conflict of interest. Disclosure of the actual or perceived conflicts of interest does not necessarily mean that the supervisory relationship will be prevented.

Some examples of situations that may result in a conflict of interest and that you must declare are:

- a personal relationship with the supervisor or their friend or relative
- a financial, business or other interest with the supervisor or your friends or relatives have a financial, business or other interest with the supervisor
- if you have been or are engaged in a therapeutic relationship with the supervisor, or
- the supervisor is your employer and your visa sponsor.

If a potential or actual conflict of interest arises during the supervised practice arrangement, you should contact Ahpra to notify them as soon as possible and within seven (7) calendar days.

Costs

As the supervisee, you are responsible for bearing any costs associated with the supervised practice arrangement.

Professional indemnity insurance

Before the supervised practice arrangement starts you need to make sure that you have the necessary professional indemnity insurance (PII) arrangements in place. You should refer to your National Board's PII registration standard and check with your insurance provider (or employer/other entity arranging cover) to make sure you meet the minimum requirements and to confirm that your supervised practice arrangement meets the requirements of your insurance cover.

You may need to seek advice from your employer if your PII is given under an organisational policy.

Documentation

You will need to complete some documentation before the supervised practice arrangement is approved.

What information do I need to give?

The purpose of the supervised practice will determine what information you need to give and when you need to give it.

For example, if the supervised practice relates to an application for registration or renewal of registration then you need to give information with your application.

If the supervised practice is because you do not meet recency of practice requirements, you may need to describe the learning you need to complete before you return to independent practice.

If the supervised practice is because of a complaint (notification) then the information will need to be given once the relevant conditions are imposed or undertakings are accepted.

What must I do when I am practising under supervised practice?

Patient safety

Patient care given during supervised practice must be safe and appropriate. This must be the overriding priority at all times.

While you are practising

The supervised practice arrangement approved by a National Board must be in place at all times when you are practising. You must not start practice until the supervised practice arrangement is approved by the National Board, unless otherwise agreed by the National Board.

As the supervisee you are responsible for ensuring that all reports are completed and submitted by the due dates.

You also need to:

- work together with your supervisor to develop and work within the approved supervised arrangement
- take joint responsibility for establishing a schedule of regular meetings with your supervisor and make all reasonable efforts to ensure that these meetings take place
- be prepared for meetings with your supervisor
- participate in assessments conducted by your supervisor to help determine your future supervised practice needs and progress

- recognise the limits of your professional competence and seek guidance and assistance, and follow directions and instructions from your supervisor as needed
- familiarise yourself and comply with legal, regulatory and professional responsibilities applicable to your practice
- advise and consult with your supervisor immediately if any issues, complaints or clinical incidents occur during the period of supervised practice
- reflect on and respond to feedback
- inform Ahpra as soon as possible and within seven (7) calendar days if: you cannot comply with the approved supervised practice arrangement; requirements of your supervised practice are not being met; or if the relationship with your supervisor breaks down
- inform the supervisor and Ahpra as soon as possible and within seven (7) calendar days of any leave or breaks in practice that may affect the requirements of supervised practice, and
- practise in accordance with all the relevant National Board's standards, guidelines, code of conduct and other codes.

What if I need to change my supervisor?

In the event you need to change your supervisor, you must:

- notify Ahpra in writing as soon as possible and within seven (7) calendar days or as stated in the condition or undertaking of any planned or unexpected supervisor changes (e.g. due to illness)
- submit a new proposed supervised practice arrangement to Ahpra for the National Board to consider, where applicable.

Each National Board has information on its website about how you can do this.

If you do not have an approved supervisor in place and you are not able to comply with the supervised practice arrangement, you must not practise.

What if I am not complying with the supervised practice arrangement or the framework?

If you cannot practise according to the approved supervised practice arrangement you must stop practising.

If you know your circumstances or your supervisor's circumstances are going to change and you will not be able to comply with the approved supervised practice arrangement, you need to let Ahpra know as soon as possible and within seven (7) calendar days or as stated in the condition or undertaking.

If you do not practise in accordance with the framework and the National Board-approved supervised practice arrangement, the National Board may take regulatory action against you under the National Law. The circumstances in which you practised outside of the supervised practice arrangement will be considered by the National Board when making this decision. Any provision of care, including in an emergency should be given in accordance with the relevant National Board's code of conduct.

Appendix 3 – Information for supervisors

This information applies to all National Board-approved supervisors of registered health practitioners required by the National Board to complete a period of supervised practice (supervisees). It outlines the National Board's expectations of an approved supervisor. This appendix informs and forms part of the *Supervised practice framework* (the framework) and should be read together with the relevant supporting documents.

The National Board relies on you, as the supervisor, to determine if the supervisee is practising safely, competently and ethically under the National Registration and Accreditation Scheme (National Scheme), and to monitor the supervised practice arrangement.

What is a supervised practice arrangement?

In this framework a supervised practice arrangement means all the elements of supervised practice approved by the National Board. This includes the approved supervisor(s), supervised practice level, workplace and any other requirements documented in a supervised practice plan (where necessary) or as stated in a condition or undertaking or registration standard.

The need for supervised practice is reflected by either one or a combination of the following a: registration requirement, notation, condition or undertaking recorded on a practitioner's registration. This information is available on the public register of practitioners.

Who can be a supervisor?

General requirements

When considering if you can be a supervisor, you should check if you meet the following requirements:

- hold general registration, or, where relevant, the appropriate specialist registration or endorsement
- have relevant experience (including your qualifications, responsibilities and relevant scope of practice)
- are not yourself subject to supervised practice, or do not hold registration subject to conditions or undertakings that would impact on your ability to effectively supervise
- will sign an approved form to act as a supervisor, subject to being approved by the National Board
- agree to comply with the requirements of the approved supervised practice arrangement, and
- understand that supervised practice must be provided to the requirements in the framework and the supervised practice arrangement approved by the National Board, and if not, the National Board may take regulatory action under the National Law.

While a supervisor will usually be from the same profession as the supervisee, a National Board may approve practitioners from another profession as the supervisor(s) in exceptional circumstances. This will be at the discretion of the National Board.

Conflict of interest

A supervisor must be able to give an independent report of supervised practice results and be willing to report to the Australian Health Practitioner Regulation Agency (Ahpra) if the supervisee's practice places the public at risk or is not compliant with the supervised practice arrangement.

You must declare any actual or perceived conflicts of interests that may undermine your role as a supervisor. The National Board will decide whether any conflict declared shows a potential or actual conflict of interest. Disclosure of the actual or perceived conflicts of interest does not necessarily mean that the supervisory relationship will be prevented.

Some examples of situations that may result in a conflict of interest and that you must declare are:

- a personal relationship with the supervisee or their friend or relative
- a financial, business or other interest with the supervisee or their friends or relatives have a financial, business or other interest with you
- if you have been or are engaged in a therapeutic relationship with the supervisee, or
- if you are the employer and visa sponsor of the supervisee.

If a potential or actual conflict of interest arises during the supervised practice arrangement, you should contact Ahpra to notify them as soon as possible and within seven (7) calendar days.

What must I do before agreeing to be a supervisor?

You need to read the framework and this appendix, so you understand the:

- National Board requirements to be a supervisor, and
- role and responsibilities of a supervisor.

If you are an employee, you need to make sure your employer agrees with you being a supervisor.

If you are not an employee, the setting within which you work (for example a hospital or practice) may still need to approve you being a supervisor.

Professional indemnity insurance

Before you start as a supervisor you need to make sure you have the necessary professional indemnity insurance (PII) arrangements in place. You should refer to your National Board's PII registration standard and check with your insurance provider (or employer/other entity arranging cover) to make sure you meet the minimum requirements and to confirm that your supervised practice arrangement meets the requirements of your insurance cover.

You may need to seek advice from your employer if your PII is given under an organisational policy.

How many practitioners can you supervise?

This depends on the purpose and level of supervised practice required for the supervisee(s). It is important that you have adequate time to carry out the role of supervisor.

Payment

It is the supervisee's responsibility to bear any costs associated with the supervised practice arrangement, such as payment to a supervisor, if applicable.

What must I do if I am approved as a supervisor?

You may need to carry out training developed by the National Board before you can start in your role as a supervisor.

Patient safety

Patient care given during supervised practice must be safe and appropriate. This must be the overriding priority at all times.

Clinical/non-clinical supervision

As a supervisor you will have responsibilities in relation to the clinical/non-clinical aspect of supervised practice which includes, to:

- supervise at all times within the approved supervised practice arrangement
- complete the proposed supervised practice plan, if applicable, in consultation with the supervisee
- give the supervisee your contact details so that, when they are practising they can contact you during working hours and after hours
- give clear direction and constructive feedback to the supervisee on their professional responsibilities and the constraints within which they must operate, the expectations of ethical conduct that apply to the profession, and the expectation that the supervisee will act in accordance with the directions of the supervisor and the consequences if they do not
- use measures appropriate to the level of supervised practice to ensure that the supervisee is practising safely (e.g. individual case reviews)
- work with the supervisee to address areas identified in the supervised practice arrangement and/or address identified problems
- understand the significance of supervised practice as a professional undertaking and commit to this role including regular, protected, scheduled time with the supervisee which is free from interruptions as needed by the supervised practice, and
- only assign tasks that are appropriate to the role of the supervisee and that are within the scope of training, competence and capability of the supervisee.

Reporting requirements

As a supervisor you will also have responsibilities in relation to the reporting aspect of supervised practice which includes:

- where applicable, understanding that the responsibility for determining the type and amount of supervised practice approved by the National Board may be informed by your assessment of the supervisee
- being accountable to the relevant National Board and giving honest, accurate, objective and responsible reports in the approved form as required by the approved supervised practice arrangement
- maintaining adequate written records about the supervisee's practice to help transition if there is an unexpected need to change supervisors and/or if more than one supervisor is approved
- being open to feedback from patients, staff and other registered health practitioners in the practice setting and discussing these concerns with the supervisee, and
- discussing the supervisee's work performance or details of the supervised practice with Ahpra at any time when required.

When should I contact Ahpra?

If you are approved as a supervisor, you will be contacted by Ahpra on behalf of the National Board. Ahpra will continue to be your contact point for the duration of the supervised practice arrangement.

Breach of supervised practice or risk to the public

During the period of supervised practice it is the responsibility of the supervisor to notify Ahpra immediately if:

- the relationship between the supervisor and the supervisee breaks down
- there are any concerns that the supervisee's conduct, performance or health is placing the public at risk
- the supervisee is not complying with the conditions or undertakings, or
- the supervisee is in breach of any requirements of the supervised practice arrangement.

Any practice that occurs outside the approved supervised practice arrangement will be considered a breach of supervised practice and may constitute behaviour for which the National Board may take regulatory action.

Mandatory reporting

As a registered health practitioner, you have an obligation under the National Law to make a mandatory notification to Ahpra in certain circumstances. Depending on the type of concern and risk of harm to the public you must notify Ahpra about another practitioner's impairment, intoxication, departure from accepted professional circumstances and sexual misconduct. Further information about mandatory reporting is available on the Ahpra website.

Changes to supervised practice

The supervisor needs to contact Ahpra as soon as possible and within seven (7) calendar days or as stated in the condition or undertaking if changes are necessary to the approved supervised practice arrangement. Examples of when this may occur include if there are changes to your or the supervisees' employment, the supervisee is absent or has ceased practice or you intend to withdraw from the supervisor role.

Changes to your registration

Supervisors should also notify Ahpra as soon as possible and within seven (7) calendar days, if during the period of supervised practice, following a complaint (notification) their practice is subject to a condition or undertaking.

What if I don't comply with the framework?

If you do not carry out your role according to the framework and supporting documents and in accordance with the approved supervised practice arrangement, the National Board may take regulatory action against you under the National Law.

This applies to supervisees and supervisors.

Primary and alternate supervisors

The National Board may approve more than one supervisor for the purpose of supervised practice.

When more than one supervisor is approved by a National Board, the alternate supervisor(s) is expected to take on the role of the primary supervisor when they are not available.

The alternate supervisor(s) is expected to give feedback to the primary supervisor about the supervisee's practice during the absence of the primary supervisor.

The alternate supervisor(s) may need to complete the supervised practice report in the absence of the primary supervisor. Alternate supervisors must follow the framework and other relevant supporting documents.

Appendix 4 – Supervised practice levels

This information supports and informs the *Supervised practice framework* (the framework) and gives further information about the levels of supervised practice.

The levels of supervised practice are designed to ensure the supervisee practises safely, competently and ethically.

Not all levels of supervised practice will be used when supervised practice is required, and progression from one level to the next level may also not be required. For example, some supervisees will stay at the same level of supervised practice for the whole period.

How are supervised practice levels decided?

There are four levels of supervised practice. The supervised practice level of the supervisee will be set out in the approved supervised practice arrangement. The decision about the starting level for a supervisee will depend on several factors that may include:

- the purpose for supervised practice (e.g. registration type, suitability or eligibility or a condition or undertaking following a notification)
- the level of risk associated with the purpose of supervised practice
- how closely the supervisee needs to be supervised, who is responsible for the care given and the proximity and availability of the supervisor.

Patient safety

Patient care given during supervised practice must be safe and appropriate. This must be the overriding priority at all times.

What is a supervised practice arrangement?

In this framework a supervised practice arrangement means all the elements of supervised practice approved by the National Board. This includes the approved supervisor(s), supervised practice level, workplace and any other requirements documented in a supervised practice plan (where necessary) or as stated in a condition or undertaking or registration standard.

If supervised practice is required because of the registration type (e.g. provisional or limited registration) or eligibility and suitability requirements, then in most cases the supervised practice level, the frequency of reporting and any other specific requirements will be set out in the approved supervised practice arrangement. If the supervisee is required to submit a proposal for the supervised practice arrangement, the National Board may approve the proposed arrangement or an alternative arrangement, including a different level than proposed by a supervisee.

If supervised practice is required because of a condition or undertaking following a complaint (notification) the requirements for supervised practice, such as the level of supervised practice, the frequency of reporting, and any other specific requirements will be set out in the condition or undertaking.

The need for supervised practice is reflected by either one or a combination of the following a: registration requirement, notation, condition or undertaking recorded on a practitioner's registration. This information is available on the public register of practitioners.

The framework informs the supervised practice arrangement and the supervised practice plan (where available) and gives guidance on how to comply and outlines the National Board's expectations and what is necessary to effectively carry out supervised practice.

How does a supervisee progress through levels?

Some types of supervised practice involve progression through levels. In most cases, the National Board will need to approve the change in levels.

The purpose and underlying risk for supervised practice will sometimes allow for a progression through levels to be planned. It may also be appropriate at times for progression to be at the discretion of the supervisor if a National Board agrees to do so through the approved supervised practice arrangement.

A National Board will take the necessary regulatory action required if a supervisee does not progress as expected.

When supervised practice is required following a notification the supervised practice remains at the level outlined in the condition or undertaking.

What does each level of supervised practice mean in practice?

Further guidance on what is required in each supervised practice level is set out in the table below. The descriptions of each level aim to accommodate the different approaches including practice in clinical or non-clinical settings for the professions using this framework.

The supervised practice arrangement will specify the workplace(s) or practice environment(s) where the supervised practice is to take place.

The definition of 'consult' for the purposes of this framework is set out in section *10. Definitions*.

Detailed description of the levels of supervised practice

Level of supervised practice	Description of supervised practice level
Direct *Supervisor physically present at all times to observe the supervisee*	The supervisor takes direct and principal responsibility for all individual patients receiving care from the supervisee. The supervisee must consult with and follow the directions of the supervisor about the management of each patient, including the process of assessment, before care is given. The care provided must be directly observed by the supervisor who is physically present with the supervisee at all times. **What does this mean?** • The supervisor must be physically present to observe the provision of care by the supervisee. • The supervisor must be able to intervene in the giving of clinical care if needed. • Supervised practice via teleconference or other means of telecommunication is not permitted. • The supervisee must consult with the supervisor about the management of each patient before care is given.
Indirect 1 (present) *Supervisor physically present at the workplace*	The supervisee and the supervisor share responsibility for all individual patients receiving care from the supervisee. The supervisee must consult with the supervisor who is always physically present in the workplace or practice environment and available to observe and discuss at agreed intervals and as necessary the: • management of patients, including when care is being given, and/or • performance of the supervisee. **What does this mean?** • The supervisor must be physically present at the workplace when the supervisee is providing clinical care. • The supervisee must inform the supervisor when they have concerns, and at agreed intervals, about the management of each patient. This may be after the care has been given. • The supervisor, or someone nominated by the supervisor, needs to be able to intervene in the giving of clinical care if required.

<table>
<tr><th>Level of supervised practice</th><th>Description of supervised practice level</th></tr>
<tr><td>Indirect 2 (accessible)
Supervisor is accessible by phone or other means and available to physically attend the workplace</td><td>The supervisee takes primary responsibility for their practice and the management of all individual patients receiving care from the supervisee under the supervisor's general oversight.
The supervisee must consult with the supervisor who is accessible by telephone, video conference or other means of telecommunication and available to attend the workplace or practice environment to observe and discuss at agreed intervals and as necessary the:
management of patients, and/or
performance of the supervisee.
This may be after the care is given to the patient.
What does this mean?
If not physically present at the workplace, the supervisor needs to be available by phone or other means of telecommunication at all times.
The supervisor must be able to attend the supervisee's workplace if needed.
The supervisor must be able to monitor if the supervisee is practising safely including in instances when the supervisee is working after-hours or on call.
The supervisee and supervisor must conduct regular case reviews.
The supervisee is permitted to work independently, provided the supervisor is readily contactable by telephone or other means of telecommunication such as videoconference.</td></tr>
<tr><td>Remote
Supervisor is not present at the workplace</td><td>The supervisee takes primary responsibility for their practice including the management of all individual patients receiving care from the supervisee under the supervisor's general oversight.
The supervisee must consult with the supervisor, who is accessible by telephone, video conference or other means of telecommunication at agreed intervals and as necessary about the:
management of patients, and/or
performance of the supervisee.
This may be after the care is given to the patient.
What does this mean?
The supervisor must be available by phone or other means of telecommunication for case review or consultation if the supervisee requires assistance.
The supervisor and supervisee must conduct regular case reviews.</td></tr>
</table>

Appendix 5 – Information for employers

This appendix is to help employers understand information about the *Supervised practice framework* (the framework) that applies to supervisees and supervisors. This appendix should be read together with the framework and relevant supporting documentation.

Employers make an important contribution to the risk-based approach of the National Registration and Accreditation Scheme (National Scheme) supervised practice process by giving supervisees an opportunity to practise while under supervised practice and/or allowing a supervisor to supervise another health practitioner at a health service or private practice.

What is a supervised practice arrangement?

In this framework, a supervised practice arrangement means all the elements of supervised practice approved by the National Board. This includes the approved supervisor(s), supervised practice level, workplace and any other requirements documented in a supervised practice plan (where necessary) or as stated in a condition or undertaking or registration standard.

Why does the National Board require health practitioners to complete supervised practice?

Supervised practice is used for three regulatory purposes across the National Scheme. Employers can check section *2. Purpose and scope* to see when the framework applies to their employees.

1. As a registration requirement

Some types of registration require supervised practice such as limited registration and provisional registration for some National Boards (such as for overseas qualified practitioners).

2. To meet the National Board's eligibility or suitability requirements on renewal or application

This may be the result of:

- returning to practice after an absence
- changing to a different field or scope of practice (where applicable)
- needing to meet the eligibility requirements for an application for registration or endorsement, or
- inability to meet any other requirements of a registration standard for the profession.

3. As an outcome of a complaint (notification)

This may be in the form of a condition or undertaking imposed by a National Board, panel or tribunal that requires the practitioner to complete a period of supervised practice.

Preparing for supervised practice

Requirements of supervised practice

Before any supervised practice can take place, the supervisee must:

- hold the relevant registration e.g. general registration, provisional registration, limited registration, specialist registration, and
- have the supervised practice arrangement approved by the National Board.

A supervisee must stop practising if they cannot practise in accordance with the approved supervised practice arrangement.

A supervisee and supervisor must comply with the requirements and responsibilities specified in the framework and *Appendix 2 – Information for supervisees*, and *Appendix 3 – Information for supervisors*.

Nomination of a supervisor

A supervisee may be required to nominate a supervisor to carry out the supervised practice. It is recommended that a supervisee nominate more than one supervisor so that if the primary supervisor is not available the alternate supervisor can carry out the supervised practice. The National Board must approve the supervisor(s). They may approve someone other than the practitioners nominated by the supervisee.

A supervisee may contact you for advice about identifying potential supervisor(s) at the workplace.

Alternatively, an employee may contact you for advice about being nominated as a potential supervisor at the workplace. A supervisor should make sure you, as the employer, agree with any proposed supervised practice arrangement.

Documentation

The supervisee must give their employer or senior person at their workplace(s) (for example a CEO, medical/clinical director or head of department) a copy of the supervised practice arrangement. If the supervisee is completing supervised practice because of a notification the senior person they must give a copy of the arrangement to will be stated in the condition or undertaking.

Who can be a supervisor?

A supervisor needs to have the qualifications, skills, knowledge, availability and experience required for the role. These will vary according to the purpose for supervised practice and the risk associated with this role.

This will generally mean that the supervisor will have enough experience in the relevant clinical area and relevant qualifications, responsibilities and scope of practice. The requirements to be a supervisor include that they:

- hold general registration, or where relevant, appropriate specialist registration or endorsement
- have relevant experience (including their qualifications, responsibilities and relevant scope of practice)
- are not themselves subject to supervised practice, or do not hold registration subject to conditions or undertakings that would impact their ability to effectively supervise the supervisee
- will sign a form to act as the supervisor, subject to being approved by the National Board
- agree to comply with the requirements of the approved supervised practice arrangement, and
- understand that supervised practice must be provided to the requirements in the framework and the supervised practice arrangement approved by the National Board, and if not, the National Board may take disciplinary action under the National Law.

While the supervisor will usually be from the same profession as the supervisee, a National Board may consider approving a practitioner from another profession as a supervisor in exceptional circumstances. This will be at the discretion of the National Board.

The supervisor will also need to meet any National Board-approved training requirements.

Conflicts of interest

A supervisor must be able to give an independent report of supervised practice outcomes and be willing to report to Ahpra if a supervisee's practice places the public at risk or if they are not compliant with the supervised practice arrangement.

The supervisee and supervisor must declare any actual or perceived conflicts of interest that may undermine the supervisor's report. The National Board will decide whether any perceived conflict declared shows a potential or actual conflict of interest. Disclosure of the actual or perceived conflicts of interest does not necessarily mean that the supervisory relationship will be prevented.

Some examples of situations that may result in a conflict of interest and that supervisees and supervisor must declare are:

- a personal relationship with the supervisor or their friend or relative
- a shared financial, business or other interest with the supervisor or their friends or relative have such an interest
- if the supervisee has been or is engaged in a therapeutic relationship with the supervisor, and/or
- if the supervisor is the supervisees employer and visa sponsor.

Health service

Employers in a health service, public or private, will need to think about the following possible conflicts of interest about supervised practice arrangements between two employees:

- Whether the supervisor also oversees the employment of a supervisee as a staff member.
- If there are processes in place should employment issues interfere with the progress of the supervised practice arrangements.

Private practice

Employers in a private practice will need to think about the following possible conflicts of interest about a supervised practice arrangement if the employer is also the supervisor:

- Whether the supervisor in a dual role as an employer and supervisor can exercise objective and unbiased judgement in relation to the supervisee.
- Whether the supervised practice arrangement which is based on trust and confidence is possible if there is an unequal distribution of power or authority in the supervisor's favour.
- How possible employment issues such as pay decisions, leave and job performance evaluations are managed.
- How possible disagreements between the supervisee (employee) and supervisor (employer) in their supervisee/supervisor roles are managed as this could affect the supervisee's employment role.

Responsibilities of the employer

Employers have an obligation to make sure that the employment arrangements support a supervisee to complete their period of supervised practice. This can include facilities, scope of practice and supervised practice arrangements.

Employers also have a responsibility to advise Ahpra as soon as possible and within seven (7) calendar days, of any concerns about the supervisee if they form the opinion that there is a risk to the public.

Employers may also have responsibilities in relation to professional indemnity insurance (PII) as set out below.

Mandatory notifications

Employers have mandatory notification responsibilities under the National Law. If an employer forms a reasonable belief that a registered health practitioner has behaved in a way that meets the threshold for notifiable conduct, they must notify Ahpra. Further information about mandatory notifications is available on the Ahpra website.

Professional indemnity insurance

It is the responsibility of the supervisor and supervisee to check they have the required PII arrangements in place before the supervised practice arrangement starts.

The National Board's PII registration standard sets out the requirements for registered health practitioners to have appropriate PII arrangements in place.

Supervisees and/or supervisors may be covered by either individual or third party PII arrangements, such as via a health service and/or employer's overall insurance arrangement. Employers should check with the insurance provider to make sure the supervisor and supervisee, if covered by a third party PII arrangement, meet the minimum requirements and to see if the supervised practice arrangement affects their coverage.

How many practitioners can a supervisor supervise?

This depends on the purpose and level of supervised practice required for the supervisee(s). It is important that the supervisor has enough time to carry out the role of supervisor and that the supervisee receives the level of support as detailed in the supervised practice arrangement.

Does the supervisor get paid to be a supervisor?

It is the supervisees responsibility to bear any costs associated with the supervised practice arrangement.

Patient safety

Patient care given during supervised practice must be safe and appropriate. This must be the overriding priority at all times.

The need for supervised practice is reflected by either one or a combination of the following a: registration requirement, notation, condition or undertaking recorded on a practitioner's registration. This information is available on the public register.

When should I contact Ahpra?

An employer needs to contact Ahpra as soon as possible and within seven (7) calendar days if the:

- relationship between the supervisor and the supervisee breaks down
- employer has concerns that the supervisee's health, conduct or performance is placing the public at risk
- supervisee is not complying with the conditions or undertakings accepted
- supervisee is in breach of any requirements of the supervised practice arrangement, or
- supervisor is not carrying out their role to the requirements of the framework and supporting documents and in accordance with the approved supervised practice arrangement.

What if the supervisor cannot perform their role?

If circumstances change and the supervisor is not able to comply with the approved supervised practice arrangement the supervisor should let Ahpra know as soon as possible and within seven (7) calendar days or as stated in the condition/undertaking.

A supervisee cannot practise without the approved supervised practice arrangement in place at all times.

What if the supervisor or supervisee does not comply with the framework?

If the supervisor or supervisee does not, in good faith,[6] practise in accordance with the supervised practice arrangement or in accordance with the requirements contained in the framework and appendices, the National Board may take disciplinary action under the National Law, including but not limited to immediate action and/or investigation for unprofessional conduct.

Primary and alternate supervisors

The National Board may approve more than one supervisor for the purpose of supervised practice.

When more than one supervisor is approved by a National Board, the alternate supervisor(s) is expected to take on the role of the primary supervisor when they are not available.

The alternate supervisor(s) is expected to give feedback to the primary supervisor about the supervisee's practice during the absence of the primary supervisor.

The alternate supervisor(s) may need to complete the supervised report in the absence of the primary supervisor.

[6] 'Good faith' has its ordinary meaning of being well-intentioned or without malice.