THE REIMAGINED
Personal Care Worker
DISCUSSION PAPER

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on behalf of the Aged Services Industry Reference Committee (ASIRC)
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Introduction

Purpose

This paper is one of a series of interlinking papers seeking to solicit input from aged care stakeholders to help the ASIRC and the industry reimagine what a Personal Care Worker ('PCW') could and should be - and do - from the perspective of the recipient.

It's not the answer to every challenge that we acknowledge needs to be addressed in aged care, given that many other issues such as wages, working conditions, staffing arrangements and other industrial relations matters are outside our remit. But it is part of the jigsaw in terms of the discussion about the **skills required to meet client needs**, focused on the entry-level PCW role.

We know, via feedback provided from the sector regarding the repackaging of the current *Certificate III in Individual Support,* that the content and structure of the qualification are not meeting the needs of care recipients in a consumer-directed environment. **However, we need to think beyond what is needed now**.

We want to challenge your thinking of what this role will look like well into the future as the dynamics of the sector continue to evolve.

We hope that by asking you what you think, you'll be able to critically and creatively consider the issues and stimulate the kind of constructive discussion that includes all key aged care stakeholders, from employers and service providers to workers and unions, to help reimagine the PCW together.

The questions we hope you will answer are framed around three key areas:

- The breadth of care recipients' needs
- The range and complexity of the skills and capabilities required to meet those needs
- The extent to which an individual worker can meet those needs versus the scope of the role as part of multi-disciplinary team.

Rather than drawing any particular conclusions or making any specific recommendations, we hope you'll not only find the answers and solutions we need to address these problems, but perhaps even explore other questions, start new conversations and discover other possibilities for the reimagined PCW and the recipients for whom they care, now and into the future.

1. The breadth of care recipients' needs

Key Considerations

As the Royal Commission into Aged Care Quality and Safety has recently found, most aged care stakeholders agree with the wider community that the needs, expectations and interests of recipients must come first in any discussion about how to reimagine aged care and the role of the PCW.

These needs, expectations and interests will change depending on the stage at which recipients may be in their ageing journey — from wanting customer choice to help support their independence, to re-enabling their independence, to assistance with acute care and medical intervention.

History of the Evolution of Recipient Needs

Although in the past many recipients of residential aged care may have entered it later in life and may have enjoyed a greater degree of independence prior to needing it,[1,2] the number of recipients receiving complex healthcare funding more than quadrupled between 2008 and 2019 from 12.7% to 53%.[3]

As a result, today these frail recipients present with more complex medical conditions and care needs, particularly around dementia care, palliative care, dysphagia and dysphasia,[4] and require increasing interfaces between healthcare and aged care,[5] with growing numbers of recipients being admitted to hospital from residential care and vice versa.[6]

But while much of the focus in aged care and the community has so far been on elderly recipients, with half of the historically large 'baby boomer' generation having already retired and the rest due to retire in the next 10–20 years,[7] expectations of care, support and service will change profoundly beyond existing concerns around dignity and respect.[8]

As baby boomers move into aged care, they aren't going to accept the basic services that have generally been provided in the past.[9] They tend to view retirement as more of a 'transition' than an 'event',[10] and want to live independently at home as long as possible.[11]

This reflects a growing consumer and policy trend towards home & community care since the 1980s via the Commonwealth's 'age in place' policy[12] in which home & community care not only enables recipients to stay out of residential care but keeps them well and out of hospital.[13]

More than 1.2 million people received aged care services during 2017–18, with most (77%) receiving support in their home or other community-based settings. Putting this in context, of Australians aged 65 and over in 2017–18:[14]

- 7% accessed residential aged care
- 22% accessed some form of support or care at home, and
- 71% lived at home without accessing government-subsidised aged care services.

Recipient Expectations: Support and Care

The Productivity Commission has described aged care as covering[15] a range of services provided to recipients which can include one or more of the following:

- **Assistance with everyday living activities — such as cleaning, laundry, shopping, meals and social participation**
- **Help with personal care—such as help with dressing, eating and toileting**
- **Health care—such as medical, nursing, physiotherapy, dietetics and dentistry**
- **Accommodation.**

These are consistent with international definitions of long-term care (LTC) which can be either LTC (social) or LTC (health).[16]

LTC (social) enables a recipient to live independently and involves help with shopping, laundry, cooking, performing housework, managing finances and using the telephone or other electronic communicative technologies.

LTC (health) involves medical and personal care services which assist recipients with daily living, such as eating (support with food intake), bathing, washing, dressing, getting in and out of bed, getting to and from the toilet and managing incontinence.

In a home & community care setting, this means providing a combination of the two, and may mean a combination of service, support and care.

Despite Australians aged 65+ being among the most 'digitally excluded' citizens,[17] more and more of them are going online and using digital technology. Many recipients think that advances in remote medicine and Telehealth will allow them to live at home longer before needing to enter residential aged care, with the possibility of better health outcomes and greater independence.[18]

While the Aged Care Workforce Strategy Taskforce argued that the idea of a PCW had to widen beyond direct care to include all the 'touchpoints'* of a recipient's ageing journey, many recipients don't want an assortment of different strangers trooping through their homes, especially at the start of their ageing journey.[19]

They want someone they can trust to help them navigate a complex and confusing continuum,[20] who'll support their dignity, self-expression and choice,[21] and who's trained and empowered to provide appropriate service and care at every stage of their ageing journey, from supporting their independence and helping them to re-able themselves, to acute disability and palliative care.

Recipients' assessments of care quality in both home & community and residential care all emphasise the social and emotional dimensions of life and of care, including good relationships with care staff, staff having time to care, feeling at home and feeling valued, contact with family and friends, privacy, keeping active, going outside, and having choice over meals, entertainment activities and the timing of personal care, such as when to bathe.[22]

Recipient Expectations: Customer Service

Given the fact that **choice, dignity and flexibility** are now considered fundamental rights for recipients,[23] some recipients' representatives are now asking why choosing an aged care service can't be more like the way we choose other services, such as hotels or airlines, with the level of service, facilities and amenities determined by personal preferences or budgets.[24]

They also question why care is viewed from a deficit perspective, in which recipients' support and care needs are based on what they *can't* do, rather than a positive focus on what they *can* do, with many recipients expressing a desire for more independence in home & community care - and especially in residential care - with more input, information, collaboration and choice, and a reorientation from a 'treatment' or 'care' focus to a collaborative, goal-based relationship.[25]

But while there are some customer service principles in holistic healthcare, some PCW representatives maintain that often, by the time recipients enter residential care, they aren't doing so out of choice. Rather, they're doing so because they require health and medical care that's too complex for a home environment,[26] although studies have suggested that caring for recipients in a home-like setting can reduce hospital visits and acute medical interventions.[27]

This consumer-directed approach also reflects concerns about the ways this might commodify the care relationship, in which the quality of care is based on what users can afford to pay.[28] **It is critical that there be a benchmark standard of consistent care for all Australians who need it, regardless of the cost.**

* 'Touchpoints' include financial planning, primary health services, carers, in-home care, functional health care providers, specialist care providers, residential care, acute and subacute care, as well as system facilitators and navigators.

Recipient Expectations: Diversity and Inclusion

The question of inclusiveness of care and service extends to growing numbers of increasingly diverse or special-needs recipients, such as:[29]

- Aboriginal and Torres Strait Islander (ATSI) people[30]
- Culturally and linguistically diverse (CALD) people
- Lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI+) people and those of other sexualities and genders
- Those in regional, rural or remote areas (RRRAs)
- Veterans, and
- Other often under-represented and sometimes excluded communities.

These groups often find it difficult to access aged care information and services sensitive and appropriate to their needs, backgrounds and circumstances.[31]

Continuity Between Home Care and Residential Care

Many recipients would also like fluidity and continuity between home & community care and residential care, with many not only preferring to age in place at home, but concerned about the potential loss of autonomy and identity in moving permanently into residential care.[32]

Equally, although the most common reason for leaving residential aged care is death, some recipients may want to return home after receiving residential or respite aged care and being re-abled.[33]

QUESTIONS

1. While every person is an individual and at different stages of the life journey:

a. What are the core needs that cut across diversity and stages?

b. What are the core needs that address key elements of diversity?

c. What are the core needs specific to the three key life stages of healthy ageing, re-ablement and palliation?

2. How critical is it that reimagined Personal Care Workers are able to interact with and respond to the needs of recipients and co-workers in a culturally familiar, safe and sensitive way?

3. How should a PCW meet both the social and health needs of care recipients?

4. What are the main differences between the needs of recipients living independently and those living in residential care?

5. How do you think service can or should combine both support and care needs?

6. How can we align health care imperatives and considerations with these customer service needs and expectations?

2. The range of skills required

Despite high levels of qualification in some areas of the aged care workforce, and the *Aged Care Quality Standards* calling for 'suitably qualified' workers, no specific qualification is stipulated,[34] and there's **no mandated minimum qualification for PCWs**[35]. Nor is there any requirement for ongoing continuous professional development (CPD), resulting in the widespread onboarding of unqualified staff.[36] The Australian Nursing and Midwifery Federation (ANMF) and the Australian College of Nursing (ACN) have called for PCWs to be regulated with nationally consistent nomenclature and titles, a code of conduct, professional standards and scope of practice, to ensure nationally consistent minimum educational and CPD requirements.[37] However, we cannot wait for regulation to ensure that PCWs have the skills that are demanded in a consumer-directed system.

Many senior representatives within the aged care sector, as well as the Aged Care Quality and Safety Commission (ACQSC),[38] have called for a greater customer service focus and consumer engagement beyond fundamental care, with a focus on quality, dignity, respect and choice.

Many PCWs and service providers have reported that they'd like more skills to be able to provide culturally appropriate care, especially at end of life, and a growing proportion of the aged care workforce, particularly PCWs, come from CALD backgrounds themselves.[39]

Given their desire for more social care in additional to 'basic' or 'fundamental' care tasks, recipients want people to treat them with respect and dignity and listen to them, and many PCWs would simply like more time to offer companionship, social and psychosocial care to those for whom they care.[40]

PCWs have also reported that they'd like to have the flexibility to move between home and residential care to gain a variety of experience in different contexts. Aged care providers of both services have also said they'd like PCWs to have the same opportunity to provide continuity in their relationships with their recipients.

In addition to many service providers now making residential care more 'home-like'[41] through initiatives such as the NANA (New Architecture for the New Aged) or American Green House Project design models,[42] many countries also employ a range of innovative, non-institutional care settings and services. These include:

- **Dedicated, small-scale 'dementia villages' in the Netherlands and Denmark,[43] (with a similar model in Tasmania opening in July 2020)[44]**
- **Community-based shared housing arrangements, such as those in Germany, in which both PCWs, healthcare professionals and family and community members collaborate in providing care,[45] or**
- **Intergenerational communities in the Netherlands, Japan, USA and Australia, in which recipients live among and interact with the general public, particularly children, adolescents and students.[46]**

These non-institutional settings blur the distinction between home & community care and residential care, and may offer greater fluidity between support services and more acute care and interventions, as well as increasing independence, reducing hospital visits, and even perhaps being more cost-effective than more traditional, existing models.[47] As a consequence, the concept of a PCW being trained to work exclusively in either a home & community setting or in residential care may no longer be appropriate.

Language, Literacy and Numeracy Skills

Questions of cultural literacy might also extend to issues of gaps in language, literacy and numeracy (LLN) skills, especially for increasing numbers of culturally and linguistically diverse (CALD) PCWs,[48] particularly in understanding recipients' wishes or recognising pain and other needs.[49] Regardless of the model of care, it appears clear that ability to communicate is an absolutely fundamental requirement for all PCWs in whatever setting they work.

Technology

There's no doubt that technology will play an increasing role in healthcare and aged care for both the aged care workforce and care recipients.[50] Many service providers would like PCWs to have stronger technological skills,[51] and many workers have said they'd like devices such as iPads or tablets[52] to help with some of the monitoring, reporting and administrative work they're required to do on the fly.[53]

Many PCWs would also like more modern assistive and diagnostic health information systems to help them, particularly with recipients who are immobile or have complex medical and co-morbidity conditions.[54]

As the number of recipients in the home care setting increases, the challenge of supporting PCWs in this environment without direct supervision is to ensure not only the safety and quality of care for recipients but also the safety of the PCWs themselves. While technology can help achieve this end, it cannot do so without an appropriate governance and supervisory framework.

QUESTIONS

1. What should be the scope of the role of the ideal reimagined PCW?

2. What do you think is the range of skills a reimagined PCW will need to meet a recipient's individual or particular needs or requirements at every stage of the ageing journey?

a. How diverse do you think this range of skills should be?

b. What's the extent of expertise or proficiency a reimagined PCW should have in any particular area or skill set?

c. How broad do you think PCWs' knowledge of other skills and roles should be?

d. Are there any specific additional skills a PCW needs to work with a culturally diverse or other minority group?

3. In addition to skills, what aptitudes, traits and attitudes ('soft skills') should the ideal PCW possess, and should we screen to ensure candidates have these characteristics prior to assuming PCW roles?

4. What autonomy and responsibility do you think reimagined PCWs should have? Should this autonomy and responsibility be dependent on their level of experience?

5. How do you think we should build skills around continuity of care and the transition of care from one setting to another, regardless of the model of care, such as:

a. Metro versus regional, rural and remote areas (RRRAs)?

b. General duties versus more specific duties (such as palliative care, swallowing and meal assistance, disability services and dementia care)?

c. Home & community care versus residential care?

6. What technological skills are required by PCWs in their roles as carers?

a. Using a tablet or mobile phone to record clinical notes?

b. Enabling a recipient to use FaceTime or other communicative technologies?

c. Administering and operating an enterprise-wide software system in aged care?

d. Administering and operating remote monitoring or intelligent health information systems?

e. Operating robotic mobility, dexterity or socialisation devices?

f. Something else – and if so, what?

7. What skills, knowledge or capabilities would be required of a PCW in regard to assistive technology in supporting a recipient's daily living activities?

8. What do you think Telehealth and other remote communicative and diagnostic health technologies might play in aged care, particularly for chronic conditions or in the event of an epidemic?

3. Individual workers vs multidisciplinary teams

One of the key questions around providing this collaborative, contextual, individualised consumer-directed care and meeting the myriad needs of care recipients is whether it's better to have a **single PCW** assigned to an individual or to have PCWs working as part of a m**ultidisciplinary team**.

Hierarchical vs Matrix Management Models – Collaborative Breadth and Depth

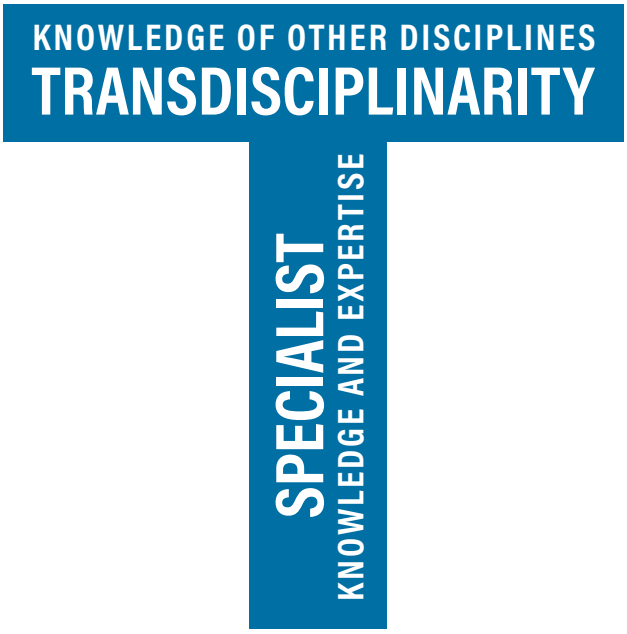
With recipients having increasing healthcare and support needs as they enter residential care — and increasing expectations by them and their families that high quality care should be provided — many service providers have adopted a hierarchical management model, which ranks speciality into a strict chain of command, limiting PCWs' decision-making authority and collaborative consumer-directed care relationships with recipients.[57]

While this command-and-control structure is useful in specific divisions of labour, delegations and clear lines of reporting and accountability,[58] it's problematic in home & community care, especially in regional, rural and remote areas (RRRAs), where RNs may be even more distanced from recipients and unable to make assessments, decisions or delegations, meaning increasing delays in being able to respond to recipients' needs or to work collaboratively with them.[59]

Everyone in the aged care workforce along the continuum of recipients' ageing journeys will need to have specific aged care competencies and knowledge to understand recipients' specific needs and expectations.[60]

These workers and professionals may increasingly work collaboratively in 'matrix-style' multidisciplinary teams such as those being adopted by many organisations, both in health care and the wider industry, which increase mobility, expertise, knowledge and communication to solve problems flexibly, creatively and collaboratively.[61]

Many secondary and higher education curricula are seeking to help create 'T-shaped people',[62] meaning those who, whilst having significant **depth** in a particular area of specialty or expertise, also have a **broad** general knowledge and capabilities in a range of other areas, enabling them to work in collaborative, cross-disciplinary teams.



This T-shape enables workers to do the following:

- Contribute their own expertise
- Understand how it can connect and engage with others' expertise, and
- Understand how others' expertise can help them and their team to solve any particular problem.

Benefits and Disadvantages of Individual PCWs vs Mixed-Skills Teams

Recognising that recipients' different needs and expectations will change depending on where they are on their ageing journeys and what the context and setting of their care is, PCWs need a wide range of skills to address their needs, from environmental support and re-ablement to acute medical intervention and end-of-life care.

Individual Personal Care Workers

Individual PCWs in a long-standing relationship with individual recipients can ensure more collaborative work in their support and care, as well as continuity for recipients as they progress on their ageing journeys and their needs change.[63]

However, in each case this is heavily dependent on one individual PCW, which means that in the event that person falls ill, dies or leaves, it may well have a negative effect on their recipient.

It also means that in a home or community care context, the PCW will need a greater range of skills and a higher level of authority and autonomy to be able to perform these different tasks, especially in RRRAs. And in the event of referring medical decisions upwards, especially in RRRAs, it means that responsible RNs, doctors and other health professionals may not be able to provide timely assessments and advice, resulting in potentially harmful delays.[64]

Mixed-Skills Teams

A mixed-skills team can offer a greater range of skills, knowledge and expertise, as well as offering the same benefits of collaborative work in recipients' support and care in a home or community care context.

An example of a collaborative multi-disciplinary team is the **US Community Aging in Place, Advancing Better Living for Elders (CAPABLE)** model, developed by the Johns Hopkins University School of Nursing, in which RNs, occupational therapists (OTs) and tradespeople work together to enable recipients to live at home longer by emphasising autonomy and resilience, as well as improving recipients' mobility, functional ability, and overall capacity to age in place by addressing personal, physical and environmental factors.[65]

For example, if a recipient is having trouble bathing safely or confidently, the CAPABLE team would examine what barriers exist, and how to address them.

- **The OT would work on re-ablement and safe ways to enter the bathtub or shower**
- **The RN would look at underlying medical issues, such as pain, balance or muscle tone**
- **The tradesperson might address physical structural issues, such as installing grab bars or ensuring safe and adequate entry,**

with the solution based on the recipient's needs and wishes from a positive enablement perspective, rather than a deficit risk-based one.[66]

Early trials and studies suggest that in addition to ensuring recipients stay at home longer, with a decrease in hospitalisation and residential care admissions and a 50% reduction in functional, mobility and disability issues, this model also offers potential savings of up to ten times the investment and may also be effective in RRRA settings.[67]

Another example of multidisciplinary teams is the **Dutch Buurtzorg ('neighbourhood')** model, in which mixed teams of up to 12 Registered Nurses (RNs) and Enrolled Nurses (ENs), PCWs and allied health workers involve family, other primary carers and the community to support and care for 'neighbourhoods' of up to 60 recipients.[68]

Reports suggest that this not only increases recipients' independence and families' involvement, but frees teams from restrictive management, empowering them to be

creative, flexible, responsive and autonomous,[69] as well as potentially reducing burnout.[70]

These self-governing teams not only maintain or regain recipients' independence, but also train recipients, their families, carers and communities in proactive self-care techniques, as well as creating networks of neighbourhood resources, similar to the 'aged care community hub' concept proposed by Professor Ian Maddocks.[71]

These Buurtzorg-type teams could be effectively deployed in smaller group homes or 'dementia villages' similar to those in the Netherlands or Denmark, which research suggests can not only offer better quality of life and health outcomes, but also be more cost-effective than 'traditional' residential care models.[72]

However, while the cost per intervention is almost double, care costs are comparable to other aged care models, as interventions are less than half in number versus other conventional home & community care models.[73]

Additionally, because Buurtzorg utilises a flat, matrix-style, autonomous management structure, it means that hierarchies and specialties are disregarded, with a team member (usually a nurse) not only providing medical interventions and care, but also personal care, such as washing, grooming or dressing.[74]

However, one of the key bottlenecks in current skills mixes and staffing is the shortage of RNs in aged care, resulting in fewer RNs forced to manage more ENs, PCWs and other staff, and thus being unable to directly care for recipients,[75] which potentially leads to burnout.[76]

As is widely recognised, these recruitment and retention issues are systemic across the aged care workforce. Despite rapidly growing demand for aged care, with projections of up to one million aged care workers — at least three times the number we have now — needed in the next 20 years,[77] service providers are struggling to recruit and retain workers.

Already, there's a shortfall of at least between a quarter and over a third of both residential and home care workers, with almost 84,000 individuals reporting that they're planning to leave the sector in the next 5 years, just as demand ramps up.[78]

While many stakeholders have argued for mixed-skills staff ratios, others have questioned this approach, instead calling for innovation, given the funding and staffing concerns.[79]

Regardless of the model, involving the community in joint training to enable independence and collaborative care relationships can also offer potential benefits. A 2009 French study tested the value of workshops attended by health professionals, PCWs and other non-professional staff, patient representatives, members of local authorities and other community stakeholders, and found that such joint training helped develop mutual recognition of roles and barriers, foster understanding of the system and set realistic expectations by all stakeholders of each other.[80]

QUESTIONS

1. What is realistic in terms of the expectation of skills, capabilities and responsibilities of a PCW if the current context of the role is that of an entry-level worker paid minimum wage and with at best an entry-level qualification or none at all?

2. In what way could an individual have all the knowledge, skills and capabilities to provide the emotional, social and physical care needs of recipients[81] when many PCWs are already concerned about not having enough time to perform even basic care tasks?

3. If it is not an individual PCW meeting all these needs, how should we aggregate and provide all these different support services and care requirements?

4. How would these skills, services and care be provided by individuals or teams in home care, especially in RRRAs?

5. How would authority and responsibility be delegated or referred in these flat, matrix-style teams?

6. What specialist knowledge and expertise would a T-shaped PCW need to bring to a team of mixed skills?

7. What broad knowledge of these other disciplines would PCWs need to have to be able to

a. Work with these other skills groups
b. Be more aware of identifying needs, issues or problems
c. Refer their recipients towards to the right professionals
d. Make the right decision in the moment?

8. If we reduce the specialist vertical axis and make the broad knowledge horizontal axis greater, how will this impact on service delivery and care quality in relatively unsupervised setting or contexts like home & community care or RRRAs?

a. And how much
   i. specific expertise
   ii. general knowledge and
   iii. overall capacity and autonomy would they need in these settings or contexts?

9. If entry-level PCWs have little or no authority or responsibility, and the Taskforce has called for more supervision of them,[82] how can we ensure that supervision is able to be provided, especially in home & community care?

10. How much responsibility and autonomy is it reasonable to give to an unregulated, entry-level worker, especially as recipients' medical needs and conditions become more acute and complex?

Conclusion

If we put recipients and consumer-directed care at the centre of any workplace model, then all the workflows and services that recipients need end up circling them, like a prism that refracts their needs through their primary carers, the PCWs.

If, as a result of the discussion we hope this paper stimulates, and thanks to your input and insights, we can radically and profoundly reimagine PCWs and shift the architecture of the job and role design to meet the needs of recipients now and into the future, new jobs and roles can and will be created to not only meet growing demand for aged care across the continuum but also to be able to meet the needs of recipients as those needs and expectations change.

In our forthcoming linked discussion paper for the Pathways and Tertiary Education Special Interest Advisory Committee (PATESIAC), we'll look at how aged care workforce organisation and roles, education and training, skills progressions and pathways can enable reimagined PCWs to have viable, flexible and mobile long-term careers in aged care — and the knowledge and capabilities, skills and proficiency they'll need to provide the quality of service, care and support recipients want and deserve.

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