Dementia Australia™

Pathways and tertiary education in aged care

A submission to the Aged Services Industry Reference Committee

2 October 2020

About Dementia Australia

No matter how you are impacted by dementia or who you are, Dementia Australia is here for you.

We exist to support and empower the estimated half a million Australians living with dementia and almost 1.6 million people involved in their care. Dementia is the second leading cause of death in Australia, yet it remains one of the most challenging and misunderstood conditions.

Founded by carers more than 35 years ago, today we are the national peak body for people impacted by dementia in Australia.

We involve people impacted by dementia and their experiences in our activities and decision-making, to make sure we are representative of the diverse range of dementia experiences across Australia. We amplify the voices of people impacted by dementia through advocating and sharing stories to help inform and inspire others.

Dementia Australia is the source of trusted information, education and support services. We advocate for positive change for people living with dementia, their families and carers, and support vital research.

We are here to support people impacted by dementia, and to enable them to live as well as possible.

Introduction

Dementia Australia welcomes the opportunity to provide a submission to the Aged Services Industry Reference Committee (ASIRC) in response to the discussion paper *Pathways and tertiary education in aged care*.

Our submission addresses the gaps in dementia qualification pathways for aged care workers and identifies opportunities to improve the capacity and capability of the sector to deliver quality dementia care. In particular, Dementia Australia advocates for mandatory dementia education for all staff working in the aged care sector as well as for the development of dementia practice leaders.

Dementia in Australia

Dementia is the term used to describe the symptoms of a large group of neurocognitive conditions which cause progressive decline in a person's functioning. Dementia is not just memory loss - symptoms can also include changes in speech, reasoning, visuospatial abilities, emotional responses, social skills and physical functioning. There are many types of dementia, including Alzheimer's disease, vascular dementia, frontotemporal dementia and Lewy body disease.

Dementia is one of the largest health and social challenges facing Australia and the world. It is estimated that there are more than 459,000 Australians living with dementia in 2020[1] and around 1.6 million people[2] involved in their care. Without a significant medical breakthrough, there will be almost 1.1 million people living with dementia by 2058.[3]

Dementia is a terminal condition and there is currently no cure. It is the leading cause of death of women in Australia, the second leading cause of death in this country and it is predicted to become the leading cause of death within the next five years.[4]

It is generally not well understood that dementia is a progressive cognitive disability. Dementia is the single greatest cause of disability in older Australians (those aged 65 and over) and the third leading cause of disability overall.[5]

Although dementia is commonly perceived to be an age-related illness, it is not a normal part of ageing. Dementia is more common in older people but it can affect people in their 40s, 50s and even their 30s.[6]

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[1] Dementia Australia (2018) *Dementia Prevalence Data 2018-2058*, commissioned research undertaken by NATSEM, University of Canberra

[2] Based on Dementia Australia's analysis of the following publications – M.Kostas et al. (2017) *National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health; Dementia Australia (2018) *Dementia Prevalence Data 2018–2058*, commissioned research undertaken by NATSEM, University of Canberra; Alzheimer's Disease International and Karolinska Institute (2018), *Global estimates of informal care*, Alzheimer's Disease International; Access Economics (2010) *Caring Places: planning for aged care and dementia 2010–2050*

[3] Dementia Australia (2018) *Dementia Prevalence Data 2018-2058*, commissioned research undertaken by NATSEM, University of Canberra

[4] Australian Bureau of Statistics (2018) *Causes of Death, Australia, 2017* (cat. no. 3303.0)

[5] Australian Institute of Health and Welfare (2012) *Dementia in Australia*

Dementia and the aged care workforce

Aged care reforms over recent years have been increasingly based on the belief that supporting people impacted by dementia should be part of core business for service providers. Yet, as the Royal Commission into Aged Care Quality and Safety is demonstrating, dementia is not yet core business. There are still significant steps required for quality dementia care and support to become an intrinsic part of aged care services.

There have been multiple failings in the aged care system for people living with dementia, their families and carers – both at the individual provider and systemic level. The lack of a specific and consistent focus on dementia within legislative, regulatory, policy, funding and service delivery contexts means that the needs and preferences of people living with dementia, their families and carers are not now – and will not in the foreseeable future – be fully or adequately addressed. We need a strong and sustained focus on dementia in the aged care sector for the hundreds of thousands of Australians living with dementia and their families and carers.

A skilled workforce is critical to the quality of support and care provided by the aged care system. Building workforce capacity is critically important to consumers as documented in our communique *Our Solution: Quality care for people with dementia*.[7]

Dementia Australia is concerned, however, that the ability of the aged care workforce to meet the needs of people living with dementia, as well as its sustainability, is significantly limited.

How we value older people in our community has implications for the value and associated importance we place on the aged care workforce. The workforce is the foundation upon which the quality of aged care rests; and when this workforce lacks the necessary knowledge, skills and expertise, this can have a profound impact on people living with dementia, their families and carers. Aged care is one of the few sectors where there are no mandatory minimum education requirements to work in the area.

Mandatory dementia education for all staff working in the aged care sector as well as improved education and qualification pathways is critical to improving the quality of care provided to Australians living with dementia.

Having requirements around registration of the workforce are also critical to ensuring minimum and ongoing levels of knowledge and skill are maintained.

[6] There are also some rare forms of childhood dementia, including Sanfilippo Syndrome, Niemann Pick Type C Disease and others.

[7] Dementia Australia (2019) *Our Solution: Communique Care for people living with dementia* https://www.dementia.org.au/files/documents/DA-Consumer-Summit-Communique.pdf

Response to consultation questions

What do you know about existing qualification pathways in aged care?

1. In terms of current qualification pathways:

a. how can we make qualification pathways a reality in aged care?
b. what changes to qualifications pathways would support this?
c. how do we more clearly communicate information about the available qualification pathway options to workers, learners and potential recruits?

2. How can we support qualification pathways for entrant workers, ancillary staff and/or allied health professionals within the sector?

The key to the creation of qualifications pathways in aged care is clear support from aged care providers for qualifications in specific areas like dementia.

People with dementia, families and carers have identified the features of a successful aged care workforce, which include:

- education to communicate effectively with the person living with dementia, their families and carers, with a consistent focus on respect and empathy;
- gaining an understanding of the person's life to appropriately assess and respond to their personalised care needs;
- education to recognise triggers, verbal and non-verbal signs of pain/discomfort in the person living with dementia;
- providing holistic care involving families, carers, advocates and relevant health and clinical care professionals to assess and respond to ongoing care needs; and
- receiving and positively responding to feedback and complaints raised by the person living with dementia do not discount it because of their dementia.[8]

To enable the expectations of people with dementia, their families and carers to be met, the dementia knowledge of the aged care workforce must be significantly increased. Dementia Australia strongly recommends that all staff working in aged care receive a minimum level of mandated dementia education. This needs to form part of any vocational or tertiary education before being able to work in aged care.

To achieve this, there needs to be a cohesive, structured and integrated national approach to dementia education and training. This includes ensuring minimum standards for education and training for those working with people living with dementia. This approach should consist of a focus on leadership and cultural change at the organisational level to maximise opportunities to translate learning into improved practice. Dementia Training Australia is also currently working on developing standards for dementia education as well as learning pathways so that we can provide guidance on how to become dementia practice leaders.

Successive government reviews and regular censuses of the aged care workforce have consistently identified dementia as a critical competency gap for the aged care workforce. Despite the rising prevalence of dementia, current qualifications held by Personal Care

[8] Dementia Australia (2019) *Our Solution: Communique Care for people living with dementia* https://www.dementia.org.au/files/documents/DA-Consumer-Summit-Communique.pdf

Attendants and Community Care Workers do not include mandatory dementia education. Given the current packaging rules relating to the Cert. III in Individual Support it is only when the 'ageing specialisation' is selected that dementia becomes a mandated unit. With the packaging of the Cert. III qualification, then, dementia is only ever offered as an elective. Equally, given the exercise of judgement and decision making in support of people living with dementia, these skills are only taught at a Cert. IV and above level in the current structure, so this is also a compounding issue for the level at which any minimum qualification is set.

Aged care workers who participated in the 2019 Australian Nursing and Midwifery Federation National Aged Care Survey[9] rated 'the level of experience and qualifications' and 'standards of care for dementia care' as two key areas of concern across the aged care sector. Previous censuses of the aged care workforce have also consistently highlighted dementia as a priority to be addressed in education. Registered and enrolled nurses may be employed in aged care services with no specific aged care or dementia experience or education.

A first step in ensuring all providers can deliver appropriate dementia care is to have clearly defined criteria and expectations of staff, and a program of training that supports the delivery of that criteria. To support the needs of people with dementia, training must therefore include:

- knowledge of dementia including developing a real empathy for the person living with dementia;
- the delivery of person-centred care;
- strategies for communication and engagement;
- psychosocial approaches to addressing unmet needs (including alternative methods to physical and chemical restraint use);
- pain assessment and management (particularly as people with dementia may be unable to verbalise their needs);
- appropriate end-of-life and palliative care; and
- emotional intelligence and mindfulness.

Dementia education should include experiential learning (for example, Dementia Australia's EDIE) to enable aged care staff to develop empathy for people living with dementia. Immersive and experiential educational experiences have proven to be impactful and greatly contribute towards developing deeper insights into the world of living with dementia. Dementia Australia aims to incorporate immersive experiences into all of its education and inspire participants to alter their current practice and influence the practice of others.

> "(Dementia education has) reaffirmed and enhanced my passion at work, and to continue to find alternative ways to provide the quality of care expected." – Aged care worker

Knowledge of dementia must be a core requirement of a revised Cert. III in Individual support and the packaging requirements need to be changed in the short term to require the dementia unit of competency to be included regardless of the specialisation selected. A Cert.

[9] Australian Nursing and Midwifery Federation (2019) *National Aged Care Survey 2019 – Final Report* http://anmf.org.au/documents/reports/ANMF_Aged_Care_Survey_Report_2019.pdf

III in Individual Support (ageing) specialisation should be the minimum level as it is the only one which requires the dementia unit of competency.

Improved and mandated minimum levels and quality of dementia education alone will not lift the quality of care provided. Not only does the workforce need to be educated on the key concepts of quality dementia care, they also need to confidently understand how to translate that knowledge into practice.

> "For any worker coming into my home they need an understanding of what dementia is, we need real education not just the book work. People need to understand it (dementia)." – Person living with dementia

Recognising that 90% of learning occurs in the workplace means that knowledge translation activities are critical for dementia education to improve practice which results in enhanced quality of life and care outcomes for people with dementia. Programs that assist staff to apply the newly acquired knowledge and skills is critical if staff are going to be supported to work in a different way to what they may have done previously.

This highlights the importance of work placements as part of any vocational and tertiary education programs preparing workers to enter the aged care system. There needs to be stronger incentives to providers to offer such placements for students undertaking study in this area.

Having organisational cultures which actively promote the ongoing learning of their staff are critical to this application of knowledge into practice. Introducing buddy programs for new staff with more experienced staff, developing the coaching and mentoring skills of key staff can also assist with this learning.

Establishing dementia communities of practice can also help share the learning around practice change and improvement more widely across the sector as well as providing important support for the leaders at the coal face driving these changes in practice. Embedding practice improvements in dementia care takes time however being a part supportive professional community can make a significant difference to helping workers translate insights and knowledge gained through education into practice. This can also be critical to the sustainability of these changes to practice.

The current state of limited career progression opportunities for aged care staff must be addressed. It is incumbent on aged care service providers to develop structures and opportunities to appoint staff as dementia practice leaders to assist with embedding good practice to ensure that people with dementia receive quality dementia care. Currently, universities are producing graduates in Dementia practice at a Diploma, Degree and Masters levels and yet there are not the structures within the current aged care system that provide career opportunities for these graduates.

It is essential that dementia practice leaders are created through clearly articulated VET and tertiary education pathways. A core component of this is the development of a Cert. IV in Dementia Practice. Dementia Australia is currently developing a Cert. IV in Dementia Practice and is awaiting approval by Australian Skills Quality Authority.

The need for an advanced level of dementia-specific education to ensure that people living with dementia receive appropriate levels of support and care has never been greater. On 31 October 2019, the Royal Commission into the Aged Care Quality and Safety released its interim report, which highlighted the poor quality of care provided to many people living with dementia and that where there were examples of good practice; this was not consistent.

The Royal Commission into Aged Care Quality and Safety, highlighted the following issues specifically related to the aged care workforce:

- The workforce is central to the quality of care and care outcomes.
- Aged care qualifications, particularly the Certificate III do not provide sufficient education to equip workers for their role, the tasks they need to perform or the environment they will work in – there needs to be specific education on palliative care and dementia.
- The crucial role of good governance and leadership in aged care providers to effectively respond to workforce challenges.
- The absence of minimum standards of dementia education and practices further add to the variable quality of care provided.

Currently, there is no advanced vocational qualification that comprehensively provides dementia-specific knowledge and skills in the areas listed above on the national register. Many providers see the current Certificate III in Individual Support as the minimum level of education required to work in aged care. However, as already referenced, there are many fundamental issues with this being considered the minimum:

- No dementia unit is mandated to be undertaken due to the current packaging rules unless the Ageing specialisation is selected.
- Providers are often unclear on whether the dementia unit has been undertaken due to the various ways the Cert III can be packaged.
- Qualifications at the Certificate III level are not designed to provide participants with the skills of problem-solving and exercising judgement which are often required when supporting someone living with dementia.
- When the dementia unit of competency is delivered, it often does not meet the expected standard due to the variable quality of vocational education provided.

In 2019, Dementia Australia's Centre for Dementia Learning consulted extensively with industry representatives nationally to discuss what they see as critical to improving the skills, knowledge and practice of staff working with people living with dementia. The feedback received highlighted the need for a greater understanding of dementia and in particular:

- the pathological and neurological features;
- how the progression of the disease changed the behaviour patterns of a person;
- end of life care for a person with dementia specifically;
- building leadership skills amongst teams to enhance and achieve best practice to support a person whether living in the community or within residential aged care; and
- developing empathy, communication and personal skills for staff who interact with families.

Dementia Australia has identified a clear need to develop a Certificate IV qualification in Dementia Practice in consultation with some of Australia's leading aged and community care providers as well as staff. This qualification will fulfil the significant education gap between the current Certificate III in Individual Support and the Diploma of Dementia Care at the University of Tasmania (UTAS) as well as other universities offering similar qualifications, which will also provide students with an opportunity to pursue a degree in dementia care. Dementia Australia is actively collaborating with UTAS to ensure that the proposed qualification offers a clear pathway for students seeking to extend their learning beyond vocational education. We are also working with their team to develop a formal learning pathway in which specific components of the Certificate IV credit directly into the Diploma.

3. How can we more effectively recognise skills, competency or prior experience (including 'lived experience'), regardless of where or by what means these were acquired, specifically

a. within qualifications themselves and by Registered Training Organisations (RTOs) in the VET sector and HE institutions?

b. when these skills or experience were acquired in other jurisdictions, particularly by migrant workers?

c. when these skills were obtained either in other sectors or within the aged care sector?

The current processes for recognising prior learning are vague and often extremely time consuming with often limited results at the end, creating real barriers to career pathways in aged care. Recognition of prior learning, minimum qualifications and ongoing professional development ought to be considered for current as well as new workers moving into the future. The existing workforce may also need additional support to transition to any new processes/policies put in place as a result of redesigned job roles. Consistency around approach will be important as allowing for local variation could mean inconsistent levels of quality, rather than achieving greater consistency in the quality of aged care nationally.

As such, consideration of the personal qualities displayed by aged care workers will become increasingly important; for example does the person demonstrate patience, compassion and empathy? These are skills that cannot easily be taught through a qualification, but they are key attributes to being a competent worker in the aged care sector, both now and in the future. Of course, the challenge of monitoring 'soft skills' is regulating and monitoring the consistent application of these attributes.

Clearer interfaces between vocational and tertiary education will provide an important way to address existing barriers to career progression and these need to be beyond the more traditional areas like nursing to other areas like occupational therapy, for example.

Given a significant number of the aged care workforce come from other countries they may potentially have skills, knowledge and qualifications which have relevance to their roles in aged care in Australia.

We would recommend that this area may warrant specific investigation into the current systems and processes for recognising education and experience obtained in other countries.

4. Given that the current RPL process is currently both cumbersome and expensive:

a. to what extent is it adversely affecting the aged care workforce in terms of both recruitment and progression?

b. is there room for improvement in the process, given the need to be mindful of the current AQF Qualifications Pathways Policy and the AQF Review's recommendations?

Dementia Australia's view is that the current RPL process does have an adverse impact and does not assist in developing career pathways and progression. Anecdotal reports suggest that many people decide that it is easier to not progress to further qualifications or alternatively undertake courses rather than have their prior learning recognised because the RPL process is complex and difficult. This can delay experienced staff being appropriately qualified and affecting their career progression. In addition, the lack of consistency and quality in courses adds to the complexity of applying for RPL.

5. How can we make it easier to transition between VET and HE:

a. in clinical pathways, non-clinical pathways and between the two?

b. horizontally, at the same AQF level—for example, in moving between aged care support services into administration, management or lifestyle?

c. vertically, to different AQF levels—for example, by moving from aged care support services to Enrolled Nurse (EN) or RN roles, or vice versa?

As previously mentioned there needs to be clearer interfaces between vocational and tertiary systems to enable direct care workers, in particular, to have clearer pathways to higher education in a range of areas that include allied health, nursing and management.

More work needs to be done to promote strong working relationships between VET and HE, which recognise the important pathway VET can be to HE.

6. What role can vocational providers or dual-sector universities play in strengthening pathways and transitions?

There is an opportunity for dual sector providers to model clearer interfaces between vocational and tertiary education that could demonstrate how such interfaces can aide career progression.

What do you see as barriers to these qualification pathways?

1. Would the inclusion of specific aged care focused skills or components in both VET and HE qualifications improve the articulation pathways between qualifications? If so, what specific areas should be included?

The inclusion of specific aged care focused components in both VET and HE is critical to creating qualifications pathways in aged care. As previously stated, introducing relevant dementia units at both VET and HE is an example of how such qualifications pathways could be facilitated. As previously described, Dementia Australia is advocating for mandatory dementia education for all aged care staff. This will ensure that people entering the aged care workforce have the necessarily skills and training to appropriately meet the needs of people living with dementia, their families and carers. Therefore dementia modules should be included in all health, disability and aged care VET and HE programs.

The work Dementia Training Australia is progressing to create standards and learning pathways is a good example of work currently underway to address current barriers to qualifications pathways. However, the success of this work is reliant upon both the VET and HE sectors embracing the application of both the standards and pathways to their work and needs to be supported by professional and registration bodies for different professional groups.

2. What other solutions could be considered to make pathways between qualifications within and between disciplines clearer?

As flagged in the *Matter of Care* report there is a need to review job architecture in aged care, including job design, job roles, progression and related competencies as well as modernising and realigning vocational training. This needs to be linked to higher education as well as additional support for on-the-job and non-formal learning. These new roles need to be based on integrated and living well models of care. The focus of this work needs to be on consumer needs, preferences and values driving the aged care industry.

3. How do we deal with pathways between unregulated and regulated parts of the workforce?

Whilst regulation certainly adds a level of complexity to the pathway the more significant barriers are those previously discussed. Approximately two-thirds of the aged care workforce consists of personal care workers (PCW), often retitled depending on where the person is working. For example, in Western Australia, a PCW is referred to as an Assistant in Nursing (AIN). In Victoria, they are referred to as Personal Care Assistants (PCA) which reflects a lack of consistency in the title despite the work role expectations being the same. The structure of the job role makes it virtually impossible to identify realistic opportunities for career progression, despite how long the person has been working.

An area of concern identified is fast-tracked minimalist courses that enrol students with no previous work experience or training in aged or community care. The key implication is that

students are often not properly skilled when entering the workforce, which will ultimately have a negative flow-on effect to the people they support.

Dementia Australia is supportive of a registration approach to regulate personal care workers. With regard to continuing professional development, Dementia Australia prefers a requirement for personal care workers to demonstrate they have met specified minimum CPD requirements as part of a registration process. This option does not just focus on a minimum requirement, but notes continuous improvements in skills, education, knowledge and training is required. This could be an hours' based system, with no higher bar than for nurses or allied health professionals. For example, personal care workers could complete an annual attestation that demonstrates what continuous professional development they have undertaken. Dementia should be a requirement for CPD each year to stay across contemporary practice for dementia care.

4. What approaches could be established to ensure that previously acquired qualifications and/ or the experience of migrant workers or those with CALD backgrounds are able to be recognised, while ensuring those workers are proficient in LLN and digital literacy skills?

When it comes to dementia care education, most other countries are even less advanced than Australia. In addition, in some cultures there is significant stigma and misunderstanding surrounding dementia. Dementia Australia therefore has concerns about prior dementia qualifications and/or experience acquired from other countries being recognised without considerable examination of the quality and source of qualifications and application of experience.

Dementia Australia recommends that there be support for migrant workers or people from CALD backgrounds built within the structure of dementia education delivered in Australia. This does not necessarily mean the translation of education resources, as we require aged care staff to be proficient in English. Experiential learning through programs like Dementia Australia's EDIE has been found to be important for people from CALD backgrounds who may have limited English proficiency.

Dementia Australia's preferred approach to strengthening English proficiency in aged care for personal care workers is for them to demonstrate their proficiency in English as part of a registration process, with the caveat of needing to provide clearer guidance for providers. There needs to be accessibility for workers with no unintended consequences to the workforce in terms of cost to qualify or demonstrate English proficiency. Additionally, it should not act as a barrier to the existing workforce in the sector and in developing this option such barriers need to be minimised.

There are touch points where English proficiency in aged care is important, such as reading and understanding client case notes, so there is a need for care workers to have a level of comprehension. English language might not be a barrier to communicating with a person face to face, but in other contexts it can pose a real issue.

It may be useful to consider governments' role in subsidising English language programs which help to provide workers with the necessary English proficiency to work in aged care. This could include context specific language classes like understanding medical terminology.

5. What recommendations should be made to the National Skills Commission in relation to funding the cost of upskilling workers in the aged care sector?

This is a complex issue to navigate. Significant consideration must be given to the funding the cost of upskilling workers in the aged care sector. The question of who pays is important. How much is government going to pay? How much are providers going to pay? How much are individual workers going to pay? And how much cost is potentially going to be passed onto the consumer? These questions need to give consideration and clarity provided around how much consumers ought to pay to receive higher quality care, because it is doubtful that both the sector and government would be able to meet the increased costs.

How might these pathways be facilitated?

1. What mechanism could be used to address transition between qualifications (e.g. nesting) and transition more broadly across the sector?

The nesting of lower qualifications within courses leading to a higher qualification is an important way of approaching the issue, which can help to overcome some of the issues associated with RPL.

Whilst we support the findings of the AQF review outlined on p, 10 of the discussion paper there will need to be further consideration of the guidelines and standards that would need to be developed relating to CPD and less formal qualifications.

Within the standards set by ASQA organisations who are specialists in the area could be responsible for developing the specific standards relating to that area. For example the current work of Dementia Training Australia in developing national standards for dementia education.

2. What other mechanisms should be considered for upskilling workers across the sector, both in VET and HE (e.g. micro-credentials, short courses, digital 'badges', etc.)?
a. How should these mechanisms be valued?
b. Should they have an Equal Value of Learning (EVL) or be aligned to AQF levels?

3. Would CPD be a more appropriate approach?
a. If so, how and when would this CPD be delivered, and by whom?
b. Should there be one body that develops, accredits and tracks aged care-specific CPD?

Micro-credentialing, short courses and CPD could be useful for upskilling workers. Although such approaches can make upskilling and education more accessible, it can potentially slow down the process of obtaining full qualifications and is an incremental way of upskilling. This can ultimately lead to it taking longer for staff to be in a position to deliver the quality care that is desperately needed for people living with dementia.

There are also concerns about who determines and regulates the quality of these upskilling mechanisms. Previous investigations dating back to the Productivity Commission Inquiry into Caring for Older Australians have consistently raised concerns about the consistency in the quality of dementia education. With regard to mandatory dementia education, Dementia Australia recommends that national standards be developed by a body like Dementia Training Australia to ensure a consistent quality of dementia education is delivered. These standards should map out key content requirements at the different levels. This should form clear learning pathways to assist staff to continue to build their dementia knowledge and progress to become dementia practice leaders.

4. Do you see online training delivery as being able to facilitate pathways in the aged care sector? Are there any risks that you consider to be associated with this approach?

Although online training delivery can certainly make education more accessible to a more diverse range of people, there are risks associated with this approach. Issues to be considered include:

- Limited access to technology and varying levels of digital literacy can be barriers to online training.
- Online training can be difficult for experiential learners who learn by doing, which can also include some workers from a CALD background.
- Making online training engaging and interactive can be challenging.
- Who pays for online training – organisations or individual staff?
- When is online training undertaken – during work hours or in the workers own time?

Dementia Australia's experience in moving to online education delivery through our Virtual Classroom demonstrates that overall there is still a preference for face to face delivery by both providers and participants. Anecdotally, the quality of assessment work is lower from virtual classroom approach however this has not been formally analysed or evaluated. This may change as facilitators and learners adapt to online learning techniques.

This learning is also best suited where participants are already working or have placements in aged care so they are able to apply the learning.

5. Do we need a pathways framework such as New Zealand's Kaiawhina Health and Disability Workforce Pathway? Can we connect all skills and roles to more clearly show vertical and horizontal pathways between them, as well as how skills might transfer or be accredited between them?

The *Matter of Care* report has already outlined the need to develop a clear approach to workforce planning and capacity building. Without knowing more about the Kaiawhina Plan our concern is that this appears to cover aged care, health care and disability support. This broad focus, which was applied to the creation of the Cert.III in Individual support a number of years ago, resulted in areas like dementia not getting the level of focus they should do for anyone working in aged care or indeed disability support.

As previously stated a sound knowledge of dementia needs to form part of any minimum levels of qualification required to work in aged care. Given the varying quality of VET and other education provided to the aged care workforce identified through previous reviews there needs to be clear standards developed for determining the quality of dementia education provided nationally.

To appropriately provide care to people living with dementia, there is a need to include dementia-specific education in national standards. The dementia training standards framework in the United Kingdom is a useful benchmark to consider. It details the essential skills and knowledge necessary across the health and social care spectrum and has three tiers:

awareness, which everyone should have
basic skills which are relevant to all staff in settings where people with dementia are likely to appear and
leadership

Australia needs standards around these areas to lift the bar in education for quality care, not just in dementia, but more broadly across aged care. Dementia Training Australia is currently seeking to develop such standards with the support of the Department of Health.

6. What new aged care job roles do you envisage being required in the next five years that will need to be addressed?

Qualification pathways and career prospects in dementia care are limited. Even for those who have a diploma or degree qualification in dementia, the career pathways do not exist in residential or home/community care settings. The lack of specialist dementia roles means that there are limited career opportunities for staff to specialise in this area and be employed in roles which maximise this knowledge and skills. Although a small number of organisations have a dementia consultant role at a more senior strategic level, there is a lack of on the ground roles.

The programs provided by the Centre for Dementia Learning perform a crucial role in raising the quality of care. However, at an organisational level the ability to apply the knowledge is often limited. Seven years ago, we developed a consultancy service which works with aged

care providers to achieve sustainable improvements in practice. This is achieved through taking a tailored approach that builds the capacity of the leadership team. What has become evident through both this work and our education work more broadly, is the need for advanced dementia-specific education that enables an aged care worker to become a dementia practice leader who champions sustainable and effective changes in practice through mentoring and coaching other staff to have a positive impact on people living with dementia.

Dementia Australia believes that dementia practice leaders are needed, and that without them we will not see a significant improvement in the quality of dementia care that is so desperately needed in aged care. With the increasing acuity of aged care consumers who have complex needs, both in residential and home care, we need dementia practice leaders who can deliver quality dementia care and mentor their colleagues to do the same.

Conclusion

It is imperative that we improve the capability and capacity of the aged care workforce to support people living with dementia, their families and carers. It is therefore essential that dementia is covered to a certain standard both in aged care qualifications and dementia specific qualifications. Dementia Australia looks forward to working with the Aged Services Industry Reference Committee to progress this important work.