

7 April 2026

Via email: Vic_AgedCare@health.vic.gov.au

Catholic Health Australia Submission: Consultation on the Drugs, Poisons, and Controlled Substances Amendment (Medication Administration in Aged Care) Regulations 2026

Thank you for this opportunity to provide Catholic Health Australia (CHA)'s views on the Exposure Draft Regulations for medication administration in Victorian residential aged care. CHA appreciates the work of the Victorian Department of Health in consulting with the sector on these changes, and welcomes the Department's willingness to meet directly with CHA and its member organisations to discuss the reform and its implications.

Our submission outlines concerns with the evidence base, the scope of the exemption provisions, adequacy of the transition arrangements, and the disproportionate impact on the personal care workforce. Alongside this, the submission presents our key recommendations for mitigating the potential unintended consequences of these reforms.

CHA has also encouraged our members to complete their own submissions, and anticipates that several will submit their own feedback drawing on facility-level operational data. This submission should therefore be read alongside those individual responses.

We acknowledge that the legislation reflects the Victorian Government's intent to improve medication safety in residential aged care, something that CHA and our members align with in principle. However, we are concerned that the Exposure Draft Regulations, as currently drafted, do not adequately account for the operating realities of how medication is safely administered across the Catholic aged care sector in Victoria, and that the current transition arrangements are insufficient to avoid significant unintended consequences for residents, the aged care workforce, and provider viability.

We remain committed to working constructively with the Department on the design and implementation of these reforms, and welcome the opportunity to contribute further to the refinement of the Regulations. If you wish to discuss anything further, please contact Annabelle Wang, Policy Manager on 0468 467 831 or at annabellew@cha.org.au.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'Alex Lynch', written over a horizontal line.

Alex Lynch
**Director of Aged Care Catholic
Health Australia**



Catholic Health Australia – Medication Administration in Residential Aged Care (Victoria)

April 2026

Catholic Health Australia

www.cha.org.au

Catholic Health Australia (CHA) is Australia’s largest non-government grouping of health, community, and aged care services. CHA Members provide 12 per cent of all aged care facilities across Australia, in addition to 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Background

On 9 September 2025, the Victorian Parliament passed the Drugs, Poisons and Controlled Substances Amendment (Medication Administration in Residential Aged Care) Act 2025. The Act places a new requirement on registered aged care providers in Victoria to ensure that only registered nurses (RNs), enrolled nurses (ENs) who hold a Board-approved qualification in administration of medicines, and registered health practitioners administer prescribed and dispensed Drugs of Dependence and Schedules 4, 8 and 9 medications to residents who do not self-administer.¹

The requirement commences on 1 July 2026, with a 90-day grace period meaning no enforcement action will be taken until 29 September 2026. This transition window is among the most compressed applied to a comparable workforce regulation in Australian health or care sectors in recent years, an issue CHA addresses in detail below.

Victoria has been considering this reform for several years, first consulting on changes to medication administration in aged care in 2022. A second round of consultations took place in 2024, which included a sector-wide survey of medication administration practices.

The legislation was introduced and passed in September 2025, with \$7.6 million earmarked in the 2025-26 Victorian Budget to support the sector to implement the reforms. Included within this were the Exposure Draft Regulations which prescribe circumstances in which a person other than a nurse or registered health practitioner may administer medication. The exemptions are limited to unforeseen, time-bound events affecting nursing availability, and are explicitly not intended to replace workforce planning or to create a routine alternative to nurse-led medication administration.

CHA acknowledges that the legislation has been passed and that limited legislative change is anticipated at this stage. This submission therefore focuses on the actions that we believe should be prioritised within the Regulations and during the transition period to ensure that the reform achieves its stated objective of improving medication safety without creating unintended consequences for residents, the aged care workforce, and provider viability.

Overall comments

CHA welcomes the opportunity to engage with the Victorian Government on the Exposure Draft Regulations for medication administration in Victorian residential aged care. CHA and its members recognise that the administration of medication in residential aged care carries risks, and it is essential that models of care mitigate these risks in order to ensure the safety of older Australians in these settings.

CHA members ground their models of care in the Catholic mission, which views the dignity of every person as inviolable, and holds that care should be delivered with compassion, fairness, and respect for the individual as a whole person. These principles inform how CHA members design their clinical governance frameworks, support and train their workforce, and ensure that medication administration is conducted safely and monitored appropriately. They also align with the broader direction of national reform in residential aged care, particularly since the 2021 Royal Commission into Aged Care Quality and Safety (henceforth, 'the Commission').

¹ Personal care workers (PCWs) can continue to administer unscheduled and Schedules 2 and 3 medications, and the requirement does not apply when a resident is off the premises of the residential aged care home. Additionally, the requirement does not apply to clients receiving in-home aged care.

The Commission identified systemic concerns with medication management in residential aged care, including the inappropriate use of chemical restraint, and the need for strengthened clinical governance around medication administration processes. CHA and its members welcomed the Commission's findings and the reform agenda that followed, and our members – as mission-led, not-for-profit providers – have continued to strengthen their clinical governance frameworks and medication administration practices in response.

However, whilst the Commission made 148 recommendations covering a range of issues across aged care, none sought to exclude personal care workers (PCWs) from medication administration, or prohibit a particular category of worker from administering pre-packaged, pharmacist-verified medications under RN delegation.² Rather, the Commission's medication administration-related recommendations sought to address:

- prescribing practice (**Recommendation 17**);
- quality standards (**Recommendation 19**);
- quality indicators (**Recommendation 22**); and
- electronic management systems (**Recommendation 68**).

Moreover, the Commission recommended a mandatory minimum Certificate III for PCWs (**Recommendation 78**) and minimum staffing standards that explicitly include PCWs as part of the direct care team (**Recommendation 86**), which suggests that it envisaged this cohort to continue to participate in the direct delivery of care.

The Commission's silence on PCW exclusion from medication administration is itself instructive in that had it identified this as a patient safety concern, a recommendation to that effect would have been the expected response. Its absence weakens the policy foundation for a reform that departs from both the Commission's findings and the operational experience of CHA members.

Despite this, the Victorian Government has cited the Commission as a key driver for the recent medication administration reforms across the state.³ To support transparency and consistency across the sector, a clearer articulation from the Victorian Department of Health ('the Department') regarding the evidence base and policy rationale behind this reform would be welcomed by providers, residents, and their advocates, particularly as it departs from both the Commission's findings and the operational experience of CHA members.

In engaging with this consultation, CHA draws the Department's attention to several considerations that inform our detailed feedback. First, CHA is concerned that the evidence base underpinning this reform may not reflect the workforce composition and models of care of its members and the Victorian care economy more broadly.

Data cited during the parliamentary debate on the Bill found that nurses administer medications 91.2 per cent of the time in government-run facilities, compared with 81.2 per cent in non-government homes,⁴ the latter of which is more reflective of CHA members' models of care, who often rely on appropriately trained and supervised PCWs to perform routine medication rounds under RN delegation. CHA requests that the Department publish the disaggregated findings of its 2024 and 2025 surveys so the sector can assess whether the modelling underpinning this reform is representative of the providers it will regulate.

² Commonwealth of Australia (2021), Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity and Respect, Volume 1: Summary and Recommendations, tabled 1 March 2021. Available at: www.royalcommission.gov.au/aged-care/final-report.

³ Victorian Government, 'Protecting Older Victorians In Aged Care', media release, 31 July 2025, premier.vic.gov.au.

⁴ Victoria, Parliamentary Debates, Legislative Assembly, 26 August 2025 (Mathew Hilakari, ALP). Available at: <https://www.parliament.vic.gov.au/parliamentary-activity/hansard/hansard-details/HANSARD-2145855009-32015>.

Second, a comparable prohibition on PCW medication administration has not been introduced in other jurisdictions. New South Wales, Queensland, Tasmania and Western Australia all permit care worker involvement under governance and delegation frameworks, with Queensland's 2021 reforms going in the opposite direction to the approach adopted in Victoria.

Third, CHA acknowledges that the legislation has been passed and that limited legislative change is anticipated at this stage. Our recommendations, set out in section 4, therefore focus on the safeguards and transition mechanisms that should accompany the reform, including enabling PCW medication administration under structured clinical governance, extending the transition period with a funded upskilling pathway, and establishing an exemption framework for providers facing acute workforce constraints.

Other key concerns articulated in this submission include:

- That the Exposure Draft Regulations define exemptions too narrowly, limiting them to unforeseen, time-bound events and explicitly excluding the structural workforce constraints that will prevent many providers from achieving compliance within the transition period.
- That the 90-day grace period is incompatible with the 18 to 24 months required to train a nurse, and is one of the most compressed transition timelines applied to a comparable regulatory change in Australian health or care sectors in the past decade.
- That the reform – and potential PCW redundancies – falls disproportionately on a predominantly female workforce that the Fair Work Commission has found to be historically undervalued, and that the transition arrangements should be assessed through a gender equity lens.

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The Catholic Sector

The values, models and operating context of Catholic aged care providers in Victoria

CHA's aged care members are grounded in the Catholic tradition of providing service to the most vulnerable groups in society. Many were founded by religious orders and communities with a specific mission to care for those who are underserved by mainstream systems, and would otherwise be left behind, including older Australians in regional and remote communities, people with complex care needs, and those who cannot afford private care.

This mission orientation means that our members often operate in thin markets/areas where few other providers are willing or able to deliver services, and are committed to continue service provision when facing financial viability concerns. Nonetheless, our members – as not-for-profit providers – do not have unlimited capacity to absorb regulatory change without appropriate support, particularly as they have been navigating significant changes in the form of the new Aged Care Act, strengthened quality standards, and new care minute compliance requirements that were themselves expanded with effect from 1 April 2026.

The Catholic aged care sector collectively operates over 75 residential aged care homes across Victoria, with nearly 6,700 beds across metropolitan, regional, and rural settings (MMM 1-5). Our members deliver their care through a range of person-centred models of care, which is supported by robust clinical governance frameworks and supervisory controls that maintain oversight in situations where PCWs administer medications. For most Victorian-based members, a significant proportion of routine medication rounds involving Schedule 4, 8 and 9 medications are currently administered by PCWs under RN delegation. This model enables RNs to focus on higher-acuity clinical responsibilities, including assessments, care planning, and managing resident deterioration.

There is a further dimension to this model that the reform does not adequately account for: its contribution to genuinely person-centred care. Importantly, these models are supported by consistent monitoring, incident reporting and quality assurance processes, which have demonstrated that medication administration conducted within these frameworks does not result in increased medication errors and, in many services, has contributed to improved medication safety outcomes. This evidence from practice reinforces the effectiveness of contemporary, person-centred models that appropriately utilise PCWs while maintaining strong RN clinical oversight.

The model has emerged in response to broader Commonwealth care-minutes reforms and reflects contemporary, team-based approaches to care delivery. Importantly, it also supports more genuinely person-centred approaches to care: by increasing the number of PCWs engaged in routine medication administration, providers are better able to align medication delivery with resident preferences, routines and established relationships. In contrast, RNs' broader clinical scope and competing demands can limit their capacity to provide the same level of flexibility and continuity during routine medication rounds.

Several of CHA's Victorian aged care members also operate residential aged care services in other states and territories, each of which maintains its own regulatory framework for medication administration. These members currently manage workforce models, training requirements, and compliance records across multiple jurisdictions as part of their standard operations. The introduction of additional, Victoria-specific requirements in this context risks perpetuating

unnecessary operational and administrative burden for these providers, requiring the duplication of systems, policies and training without demonstrable improvements to resident safety or care quality. This burden is further amplified in the absence of clear transition arrangements or implementation support, particularly for providers already operating effectively under well-established clinical governance frameworks.

Further detail on workforce composition, medication incident rates, cost impacts, and geographic constraints can be found in the individual submissions of CHA's Victorian aged care members.

Consultation

Response to consultation questions

The Department's consultation paper poses three questions to guide submissions. CHA's responses to the Department's consultation questions are set out below. Further detail on each is provided in Sections 3 and 4.

To what extent do you agree that the Regulations reflect the policy intention?

CHA agrees that the Regulations reflect the policy intention of the Act in providing an exemption pathway for unforeseen, time-bound events where nursing staff are unavailable. However, CHA does not consider the Regulations to reflect the policy intention of improving medication safety in full, as the exemption provisions are too narrow to address the structural workforce constraints that will prevent many providers from achieving compliance within the transition period. This is a result of the structural workforce supply problem across the sector that the current exemption provisions do not address.

Is it clear when an exemption applies?

The exemption provisions are clear in their application to emergency-type situations, but CHA has concerns over their overall scope. The exemptions are designed for incidents such as floods, fires, or sudden staff illness, and explicitly exclude routine rostering gaps, ongoing vacancies, and foreseeable shortages.

This means that a provider who has taken all reasonable steps to recruit nursing staff but cannot fill vacancies due to labour market constraints has no legal pathway to continue medication administration by competent and appropriately governed PCWs whilst working towards compliance with the requirements of these exemption conditions. In practice, this is particularly challenging given that many CHA members already have well-resourced documentation processes, established supervisory arrangements and clear escalation pathways in place to manage both routine care delivery and unanticipated incidents, including emergencies.

Are there other operational scenarios, that cannot be reasonably planned for, where you feel an exemption should apply?

There are two additional categories of circumstance that the exemption framework does not currently address, namely in relation to facilities where:

- documented recruitment efforts over a sustained period have failed to attract sufficient nursing candidates despite the provider taking all reasonable steps, reflecting labour market conditions beyond the provider's control rather than a failure of workforce planning; and,
- PCWs who are enrolled in and making satisfactory progress towards an approved qualification, and where removing them from routine medication administration tasks during their study period would create an immediate and unmanageable workforce gap for aged care providers without the transition supports required to navigate these workforce challenges.

Key concerns

CHA and its members are concerned about the following aspects of the reform and the Exposure Draft Regulations.

Impact on medication safety and timeliness

Continuity of care as a medication safety factor

The reform assumes that ENs and RNs will automatically perform medication administration more safely than experienced PCWs. However, as some CHA members have reported, medication error rates amongst agency nursing staff are often higher than PCW cohorts, with our members employing experienced PCWs who have been performing this role safely for years under RN delegation with annual competency reassessment and other clinical governance mechanisms. This is corroborated by a 2023 paper which identified the use of agency staffing as a significant contributing factor to medication errors in Australian residential aged care, with 70.4 per cent of nurses surveyed identifying it as a cause, primarily due to unfamiliarity with residents and facility processes.⁵

This points to another issue, namely that the PCWs who currently administer medications have built relationships with residents over years of daily care, and understand their routines, preferences, and responses to medication in ways that an agency nurse rostered for a single shift cannot. Displacing these workers and replacing them with rotating agency staff who lack that continuity of knowledge would not represent an improvement in medication safety during the transition period.

Disruptions to existing models of care: scope, safety and service viability

Under the new amendments, all rounds involving prescribed and dispensed Drugs of Dependence and Schedules 4, 8 and 9 medications currently administered by PCWs will need to be performed by nurses or other registered health practitioners. As outlined above, many of our members' models of care are designed so that trained PCWs can perform these functions safely to allow ENs and RNs to focus on higher-acuity clinical work, including assessments, care planning, managing resident deterioration, and regulatory compliance.

Requiring ENs and RNs to absorb routine medication rounds currently performed by PCWs will draw them away from higher-acuity clinical work. CHA is concerned that concentrating medication tasks on a smaller nursing cohort elevates the risk of delayed or missed doses, rushed rounds, and burnout, with flow-on consequences for hospitalisation rates and overall resident safety. In practice, where providers face ongoing challenges in recruiting and sustaining appropriate nursing-to-resident

⁵ Kuppadaakkath, S.C., Bhowmik, J., Olasoji, M. and Garvey, L. (2023), 'Nurses' perspectives on medication errors and prevention strategies in residential aged care facilities through a national survey', *International Journal of Older People Nursing*, 18(6), e12567.

ratios, there is a growing likelihood that services will need to proactively reduce bed capacity in order to maintain acceptable standards of medication safety and timeliness.

These pressures are particularly acute for residential aged care homes in regional, rural and remote areas of Victoria, where workforce supply is limited and alternative local aged care options are often scarce or non-existent. As this legislative change alters providers' risk appetite - most notably in these settings - many will be confronted with the difficult decision to reduce available beds to ensure regulatory compliance and resident safety. For mission-driven providers, including CHA members, this decision extends beyond operational considerations and becomes a mission-level concern, as it directly affects their ability to continue serving marginalised, vulnerable and geographically isolated communities.

Additional costs

The reform will impose significant additional costs on CHA members operating in Victoria, including additional nursing hours to absorb medication rounds currently performed by PCWs, increased rostering costs, and the cost of backfilling PCW roles during any transition period.

Addressing workforce constraints – a reliance on agency staff

A particular pressure point is the sector's reliance on agency staff to fill RN and EN vacancies. Agency rates in aged care sector routinely sit above the Aged Care Award, and in some cases, may be significantly higher for overnight or weekend shifts. This introduces a concern that extends beyond cost to workforce sustainability more broadly. When providers are compelled to roster agency nurses to meet compliance requirements, they face a cascading set of consequences: reduced continuity of care for residents, diminished capacity to build stable, engaged care teams, and an effective subsidy of a labour hire market that is increasingly shaping - rather than supplementing - the aged care workforce supply. Over time, heavy agency reliance also erodes the conditions needed to attract and retain permanent staff.

It is the experience of CHA and its members that reliance on agency staff introduces heightened medication safety risks. Agency nurses, by the nature of their engagement, are less familiar with individual residents, their clinical histories, medication regimens, and the specific protocols of each facility. This unfamiliarity increases the likelihood of medication errors and near-miss events, which in turn impose additional burdens on providers – including incident reporting obligations, clinical review processes, and the resourcing of mitigation strategies to maintain safe medication management. These are real and recurring costs that do not appear in funding models but are borne directly by providers committed to maintaining the standard of care their residents deserve.

Addressing the unfunded impost on providers – the limitations of existing funding arrangements

These additional costs are not covered under current Commonwealth aged care funding arrangements. For example, the AN-ACC funding model does not include a mechanism that recovers the differential between the award and agency labour costs, meaning that providers bear this gap - as well as other costs as previously outlined - entirely.

This is compounding at a time when the sector is already navigating significant financial pressures: care minute compliance requirements, which were strengthened with effect from 1 April 2026; management of the operational and administrative burden of transitioning to the new Aged Care Act

2024, and sector-wide margin compression - driven by the intersection of wage growth, inflation, and funding indexation that has consistently lagged behind cost increases - which have left many providers with limited financial buffer to absorb further impact.

Individual CHA member submissions will provide facility-level cost estimates that illustrate the scale of this impact on each respective provider.

Workforce impact

CHA members report that a significant number of PCWs across their Victorian facilities face potential redundancy or significant role reduction as a direct result of this reform. Many of these workers have long tenure, demonstrated competency and relevant qualifications in medication administration, and strong relationships with the residents in their care. Their displacement will not only affect these residents they care for, but by disrupting continuity of care for residents it will also compound existing workforce pressures in a sector that is already struggling to recruit and retain experienced, qualified staff.

Understanding the human cost of displacement on the care relationship

Moreover, there is a clear and troubling human justice impact to these potential redundancies, as for many of these workers, medication administration is a core part of their role and engagement with the residents that they care for. CHA members have raised concerns regarding the equity impact of these redundancies too, as they report that their personal care workforce is overwhelmingly female, findings that are consistent with the 2023 Aged Care Provider Workforce Survey which found that 85.8 per cent of nursing and personal care staff identify as female.⁶

The workforce most directly affected by these changes is also one of the most vulnerable to their impact. According to the Aged Care Worker Survey 2024, many of the aged care workforce are from culturally and linguistically diverse backgrounds and many of whom entered aged care as a pathway to stable employment and community connection.⁷ A significant proportion are also older workers, for whom retraining and redeployment into alternative roles is neither straightforward nor guaranteed.

Any reduced demand for their skill sets from regulatory adjustments, has a profound human impact on their own ability to flourish, as well as on their families and communities. In the pursuit of good practice, the common good should not be abandoned and CHA remains committed to calling out these injustices even where they inadvertently emerge in the pursuit of a good aim. Policies that reduce hours and undermine workforce sustainability for some of the most vulnerable workforce participants are not merely economic concerns, they are ethical ones, striking at the heart of a just and compassionate society.

As such, CHA recommends that targeted transition support for displaced workers – including retraining assistance, recognition of prior learning, and where possible, supported pathways into

⁶ Australian Institute of Health and Welfare (2024), *2023 Aged Care Provider Workforce Survey*, published August 2024. Available at: <https://www.gen-agedcaredata.gov.au/resources/publications/2024/august/2023-aged-care-provider-workforce-survey>.

⁷ Refer to findings from the Aged Care Worker Survey 2024, whereby 40.4% of respondents were personal care workers or assistants. Australian Institute of Health and Welfare. (2025). *Aged Care Worker Survey 2024*. Available at: <https://www.health.gov.au/resources/publications/aged-care-worker-survey-2024-report>

enrolled nursing – should form part of the Department's implementation response to reflect an understanding of these human costs.

Ensuring pipeline stability and navigating competing reform agendas

There is also a real risk that displaced PCWs will choose to leave the aged care sector entirely, particularly given the already substantial administrative burden faced by the aged care workforce.⁸ Several CHA members have identified a cohort of workers who will need to be made redundant as a direct result of this reform, with no transition support in place to bridge the period between their departure and the recruitment of nurses to absorb the workload. This outcome would disproportionately affect a sector that is already experiencing acute workforce shortages.

Moreover, the loss of experienced PCWs – many of whom are already competent in medication administration and could otherwise be supported to upskill and obtain relevant qualifications – further diminishes the pipeline of skilled and experienced workers. Rather than strengthening medication safety, this reform risks undermining overall workforce sustainability and capability within residential aged care.

This points to contradictions between this reform and the broader workforce restructuring that has occurred across the sector in response to the Commonwealth's care minutes requirements. Many providers adjusted their models of care so that PCWs could take on a wider range of responsibilities, including medication administration, enabling RNs to meet the increased direct care minute targets through higher-acuity clinical work. This approach reflected a deliberate and clinically supervised model of task delegation, not an erosion of standards.

The tension is particularly difficult to reconcile in light of the Commonwealth Government's own consultation process on a national registration scheme for PCWs, conducted between February and April 2025. That process identified broad support for a clearer definition and scope of practice for PCWs, education and training pathways, and a phased approach to any new requirements.⁹ It signalled a clear trajectory towards professionalising and upskilling the PCW workforce over time – a direction the Victorian reform cut directly across.

Whilst CHA acknowledges that Victoria has been consulting on medication administration reform since 2022, the practical impact for providers is that these two separate reform agendas are pulling their workforce models in opposite directions, with knock-on effects for providers in terms of workforce planning, operational stability, and broader viability. Rather than building on the skills many PCWs have already demonstrated in practice, it removes those responsibilities without a transition framework, without workforce investment, and without acknowledgement of the capability that providers and their staff have developed under existing models of supervised clinical delegation. CHA's view is that meaningful coordination between Commonwealth and State reform agendas is essential - and that its absence imposes a foreseeable and avoidable burden on a sector that is already stretched.

The scale and difficulties of the transition expected in Victoria is illustrated through the example of a CHA member who - despite proactively preparing for this reform well in advance of the legislation

⁸ Refer to CHA's submission on a national approach to care worker screening. Available at: <https://cha.org.au/catholic-health-australia-submission-on-a-national-approach-to-care-and-support-worker-screening-2/>

⁹ Department of Health, Disability and Ageing. (2025). Consultation summary report on a national registration scheme to support personal care workers in aged care. Accessed at: <https://www.health.gov.au/resources/publications/consultation-summary-report-on-a-national-registration-scheme-to-support-personal-care-workers-in-aged-care>

commencing - reports significant difficulties with transitioning to the new rules. Specifically, they note that transitioning from a PCW-led to an RN-led medication administration model has taken approximately 18 months across five of its 15 homes, with six, including two in regional settings, remain in a state of transition. This experience demonstrates that even for well-resourced and willing providers, the transition is neither rapid nor linear. Against this backdrop, CHA and its members are concerned that the proposed 90-day grace period is unlikely to be sufficient for providers that have not yet commenced workforce transition planning, particularly in the absence of clear guidance, transitional arrangements or supporting measures.

Regulatory Inconsistencies

Addressing the emergency-only delegation

CHA notes that the Exposure Draft Regulations contain inconsistencies that are difficult to reconcile with the stated policy intent of improving medication safety. Under Regulation 149Q(1), a PCW may be delegated to administer medications during an unforeseen event where no nurse is available and the RN determines the medication cannot wait, yet the same worker is prohibited from performing the same task during a routine medication round where conditions are controlled and clinical oversight is readily available, and clear escalation pathways are in place.

If the PCW is deemed competent to administer during an emergency, when conditions are less controlled and clinical oversight is more constrained, it is not clear why they are prohibited from doing so during a routine round where the opposite conditions apply.

Separately, the requirement does not apply when a resident is off the premises, meaning a PCW can administer medication to a resident on an outing or at a medical appointment under standard NMBA delegation, but cannot do so once the resident returns to the facility. This creates a dual framework for the same workers, residents, and medications, with the distinction based solely on location rather than clinical risk.

Ensuring a consistent approach to medication safety in home-based aged care settings

Additionally, the Regulations apply only to residential aged care settings, despite these environments having continuous access to a qualified, multidisciplinary care team and established on-site escalation pathways. This contrasts with in-home aged care settings, where workers are often operating alone in an older person's home, clinical oversight is remote rather than proximate, and escalation relies on external communication channels rather than immediate team-based support. It is difficult to reconcile the application of stricter limitations in residential care — where clinical governance, supervision and support structures are strongest — while permitting broader delegation in home-based settings where the clinical risk profile may be higher due to workforce isolation and delayed escalation.

Misalignment with other Australian jurisdictions

No other Australian jurisdiction has introduced a comparable prohibition on care worker medication administration. CHA has undertaken a comparative analysis of medication administration frameworks across all Australian states and territories, which shows that every other jurisdiction permits trained PCWs to administer medications under governance and delegation frameworks, and none has found it necessary to introduce a blanket prohibition:

- **New South Wales:** aged care workers who hold the HLTHPS006 competency unit and have completed an annual reassessment may administer from dose administration aids under RN delegation as routine practice.¹⁰
- **Queensland:** the Medicines and Poisons Act 2019 provides a statutory defence for workers administering from pre-prepared dose forms, representing a deliberate and recent policy choice in the opposite direction to Victoria's reform.¹¹
- **Tasmania:** Department of Health guidelines (February 2020) explicitly permit aged care workers to administer oral and topical medications including buprenorphine patches (Schedule 8) under RN delegation.¹²
- **Western Australia:** WA Country Health Service policy permits trained support workers to administer from dose administration aids, including oral Schedule 4 restricted and Schedule 8 medications.¹³
- **South Australia, the Northern Territory, and the Australian Capital Territory:** none of these three impose specific prohibitions, with delegation operating under the NMBA's Decision-making Framework.

At the national level, the Aged Care Quality and Safety Commission's guidance on safe and quality use of medicines acknowledges that, depending on state and territory law, appropriately trained and competent care workers can perform some medication administration tasks under the supervision of a registered health practitioner.

For CHA members who operate across multiple states and territories, this reform creates an additional layer of regulatory and operational complexity, requiring separate workforce models, training frameworks, and compliance regimes for their Victorian facilities that differ from those operating safely and lawfully in every other jurisdiction in which they deliver care. This fragmentation further impedes workforce mobility within the aged care sector, as workers may be required to alter their scope of day-to-day practice depending on the state or territory in which they are employed. Such inconsistencies complicate recruitment, onboarding and deployment of staff across jurisdictions, and risk deterring experienced workers from remaining in – or moving within – the aged care sector at a time of sustained workforce shortages.

Transition period

Providers cannot make sound operational and workforce decisions without clarity on what non-compliance means in practice and what pathways exist to remedy it - yet neither has been articulated for this reform. It is the experience of CHA and its members that there remains a lack of clarity around what enforcement action may follow where a provider is unable to meet the new medication administration requirements by the commencement date, whether due to workforce shortages, rostering constraints, or the practical realities of rural and regional service delivery. Equally, there is currently no articulated remediation pathway — that is, a structured process by

¹⁰ The framework operates under the Poisons and Therapeutic Goods Act 1966 (NSW) and Regulation 2008.

¹¹ Medicines and Poisons Act 2019 (Qld), Part 2. Commenced 27 September 2021.

¹² Tasmanian Department of Health, Guidelines for the Administration of Certain Substances by Aged-Care Workers in Residential Aged Care Services, February 2020.

¹³ WA Country Health Service operates a medication assistance policy under the Medicines and Poisons Act 2014 (WA), which replaced earlier poisons legislation without introducing a prohibition on care worker involvement.

which a provider identified as non-compliant can demonstrate good faith effort, access support, and work towards full compliance within a defined and reasonable timeframe.

CHA welcomes the Department's commitment to supporting providers through this reform and notes that early, clear guidance on consequence and remediation frameworks will be essential to a successful transition. Providers are genuinely committed to meeting the intent of the legislation, and many are already taking steps to prepare.

However, without a shared understanding of what non-compliance means in practice and how it can be addressed, providers are left to make significant operational and workforce decisions without the regulatory certainty they need to do so effectively. CHA looks forward to working with the Department to develop this guidance and would welcome early engagement on the design of a remediation framework that supports providers to achieve compliance in a manner that is both practicable and consistent with the Department's implementation objectives.

Supporting PCW upskilling through recognised qualification pathways

CHA asks that the Department consider a more sustainable and clinically sound approach to workforce transition: one that supports experienced PCWs to administer medications as part of a recognised learning pathway, such as the Diploma of Nursing, rather than displacing them entirely from a function they have been performing competently under supervised delegation. This approach would serve the dual purpose of meeting the legislative intent – ensuring medication administration is performed by appropriately qualified staff – while simultaneously building a stable pipeline of qualified, experienced workers from within the existing workforce.

This change would reflect a straightforward workforce planning reality. The Diploma of Nursing takes 18 to 24 months to complete on a full-time basis, and longer for those undertaking study part-time whilst continuing work which is common across the PCW cohort. The current 90-day grace period is fundamentally incompatible with this timeframe.

Without a bridging mechanism that allows PCWs who are actively enrolled in and progressing through a recognised qualification pathway to continue performing medication administration under appropriate clinical supervision, the reform risks displacing experienced PCWs before any upskilling investment can take effect. This outcome would undermine both the workforce sustainability objectives that underpin the Commonwealth's broader aged care reform agenda and the Department's own interest in a transition that strengthens, rather than diminishes, the capability of Victoria's residential aged care workforce.

Addressing existing challenges with labour market

The 90-day grace period also fails to account for the current labour market for RNs and ENs. CHA members report sustained difficulty recruiting nursing staff, with vacancies remaining open for months despite active and well-resourced recruitment efforts. The reform assumes that providers can recruit sufficient additional nursing staff to absorb the medication administration workload currently performed by PCWs within the transition period. Such an assumption fails to reflect the reality of the current market, however, particularly outside metropolitan Melbourne, where nursing workforce availability is particularly scarce, recruitment pipelines are thin, and the cost and complexity of attracting staff to regional and rural settings adds a further layer of difficulty that metropolitan-focused policy design does not adequately capture.

Where providers cannot recruit RNs or ENs within the transition period, they face two unworkable options: rely on agency staff at significant cost and with the medication safety risks outlined above, or cease medication administration services entirely, with direct implications for resident care. Neither outcome is consistent with the Department's objectives, and neither should be the foreseeable result of a reform designed to improve safety.

CHA calls for the proposed exemption framework to be designed with sufficient flexibility to respond directly to these workforce realities, and that regional and rural providers be explicitly recognised within that framework.

Specifically, CHA requests that the exemptions provide for circumstances where a provider can demonstrate, through documented evidence, that it has made genuine and sustained efforts to recruit appropriately qualified nursing staff but has been unable to do so due to local labour market conditions. In such circumstances, an exemption should permit appropriately trained and supervised PCWs to continue performing medication administration for a defined extended period, subject to clear conditions including clinical oversight, incident reporting, and a provider-level workforce transition plan approved by the Department.

Embedding flexibility as a core component of the transition

By comparison, other Australian regulatory changes that have imposed new workforce requirements have provided significantly longer and more flexible transition pathways. The early childhood education sector introduced mandatory minimum qualifications under the Education and Care Services National Regulations, with Regulations 126 and 127 permitting educators who are enrolled in and making satisfactory progress towards an approved qualification to continue in their roles under 'actively working towards' provisions that remain in effect today, more than a decade after their introduction.

The Commonwealth's 24/7 registered nurse requirement, introduced from 1 July 2023, was accompanied by renewable 12-month exemptions for eligible facilities that could demonstrate alternative clinical care arrangements and evidence of reasonable steps towards compliance. A 90-day grace period is, to CHA's knowledge, one of the most compressed transition timelines applied to a comparable regulatory change in Australian health or care sectors in the past decade, and the workforce bearing the cost of that compression is one that the Fair Work Commission has found to be historically undervalued on gender-based grounds.

Recommendations

CHA makes the following recommendations to the Department.

Recommendation 1: Amend the Regulations to enable personal care workers to administer medications in routine, documented, and clinically governed circumstances

CHA recommends that the Regulations be amended to allow PCWs who have been assessed as competent under a structured clinical governance framework to continue administering medications in routine practice. This would occur under RN delegation, where the provider operates a documented governance framework that includes mandatory competency training with annual reassessment, RN delegation documented in the care plan, defined scope boundaries, and incident reporting.

This approach would be consistent with how medication administration is managed in every other Australian jurisdiction, and would achieve the policy objective of improved medication safety through targeted governance rather than blanket prohibition. Moreover, it would preserve existing workforce arrangements that have been operating safely within CHA members' facilities, avoid the displacement of experienced PCWs, and allow RNs to focus on higher-acuity clinical work that most directly depends on their qualifications.

Recommendation 2: Extend the transition period to at least 18 months with a funded upskilling pathway

The experience of CHA's own members confirms that transitioning from a PCW-led to an RN-led medication administration model takes at least 18 months, even for providers that commenced preparation well in advance of the legislation. We therefore recommend that the Department extend the transition period to at least 18 months from commencement, aligned with the time required for eligible PCWs to complete the Diploma of Nursing, with milestone-based compliance reporting at regular intervals.

Alongside this, CHA recommends the adoption of an 'actively working towards' provision, consistent with the approach used in the early childhood education sector under the Commonwealth Education and Care Services National Regulations. Applied to residential aged care, this would mean that PCWs who were performing medication administration at the commencement of the legislation and who are enrolled in and making satisfactory progress towards an approved qualification may continue to administer under existing delegation arrangements for the duration of the transition period.

This specific 'actively working towards' provision would apply only to existing PCWs with demonstrated competency,¹⁴ and is not a pathway for new entrants. Nonetheless, given that the personal care workforce is majority female, and the Fair Work Commission has found this cohort to be historically undervalued on gender-based grounds, such a provision is essential to ensure that the transition does not fall disproportionately on those least able to absorb its impact.

¹⁴ An example could be the completion of a Certificate IV - Individual Support (Ageing) and relevant modules or units aligned with the provision of routine medication administration for clients that are unable to self-administer. This is typically the case for PCWs who are in a team leader position.

We also recommend that the Department provide dedicated implementation funding to support providers through the transition. This would include providing support for backfilling arrangements to enable PCWs to attend training whilst maintaining service delivery, and recognition of prior learning for experienced workers who should not be required to complete a qualification from the outset. For PCWs pursuing the Diploma of Nursing, which is already funded through free TAFE, the primary barrier is not tuition but the cost to providers of releasing workers to study whilst maintaining safe staffing levels. Dedicated funding for backfilling during study periods would address this directly.

Recommendation 3: Establish a structured exemption framework for providers facing acute workforce constraints

CHA recommends that the Department introduce within the Regulations a structured exemption pathway modelled on the Commonwealth's 24/7 registered nurse exemption framework. Under this framework, providers who can demonstrate genuine workforce constraints alongside reasonable steps towards compliance may apply for a time-limited, renewable exemption from the restriction on PCW medication administration.

The exemption would be conditional on the provider maintaining a structured clinical governance framework for medication administration and actively supporting affected PCWs to enrol in approved qualification pathways. This would preserve the policy direction of the reform whilst providing a managed pathway to compliance for facilities where the nursing labour market cannot deliver the workforce the legislation requires within the prescribed timeframe. This should be viewed not as a permanent carve-out, but as the same level of transitional flexibility that the Commonwealth has already acknowledged is necessary when a new workforce requirement outpaces the labour market's ability to respond.