FAIR WORK COMMISSION

THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION
Applicant

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

AM2020/99

HEALTH SERVICES UNION
Applicant

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

AM2021/65

HEALTH SERVICES UNION
Applicant

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

CLOSING SUBMISSIONS OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

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A. Introduction

1. By Form F46 dated 17 May 2021, the Applicant ("**ANMF**") applies,[1] under section 158 item 1 of the *Fair Work Act 2009* (Cth) ("**FW Act**"), to vary terms in the *Aged Care Award 2010* ("**Aged Care Award**") and the *Nurses Award 2020* ("**Nurses Award**").[2]

2. In overview, two amendments are sought:

   (1) the amendment of the Nurses Award by inserting a new schedule, applicable to aged care workers only and expiring after four years, which increases rates of pay by 25 per cent; and

   (2) the amendment of the Aged Care Award by:

      (a) removing Personal Care Workers ("**PCWs**") from the main stream of "*aged care employee*" in Schedule B and creating a new classification structure for them; and

      (b) increasing PCW rates of pay by 25 per cent.

3. The two proposed variations that involve increases in modern award minimum rates of pay—*i.e.*, the variations described in [2(1)] and [2(2)(b)] above—will be called the "**Award Minimum Wages Variations**." The variation described in [2(2)(a)] above—will be called the "**PCW Classification Variation**".

A.1 Background to application

4. On 26 February 2021, the Royal Commission into Aged Care Quality and Safety ("**Royal Commission**") submitted its final report to the Governor-General.[3] The Final Report bluntly states as follows ([FR.2.214]):

> "*The bulk of the aged care workforce does not receive wages and enjoy terms and conditions of employment that adequately reflect the important caring role*

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1 The ANMF is an organisation that is entitled to represent the industrial interests of one or more of the employees that are covered by each of the awards.

2 The Application refers to the *Nurses Award 2010*, which is what the Award was called until the determination dated 29 July 2021 in matter AM2019/17 (4 yearly review of modern awards) took effect, on 9 September 2021.

3 The Final Report dated February 2021 will be called, "**Final Report**." The Final Report is in three volumes, the third having parts A and B. Inline references to pages of the Final Report will take the form **[FR.X.Y]**, where X is the volume number and Y the page number. The Interim Report submitted to the Governor-General on 31 October 2019, which is in three volumes, will be called the "**Interim Report**." Inline references will take the form **[IR.X.Y]**. So, [IR.1.25] is a reference to Vol 1, page 25 of the Interim Report. [FR.3A.100] is a reference to Vol 3A, page 100 of the Final Report.

they play."

5. That is the fact.

6. The problem of low wages is pronounced and has systemic consequences (see, *e.g.*, [FR.2.216]). It has been unresponsive to attempts to correct it (see, *e.g.*, [FR.3A.414]). In 2018, the Aged Care Workforce Strategy Taskforce recommended that industry develop a strategy to transition workers to higher wages. That did not work: "*there has been no discernible increase in aged care wage rates in the more than two and a half years since the Taskforce report was published*" ([FR 3A.414]).

7. As outlined below, enterprise bargaining has not (and will not) solve the low-wages problem. This shows the wisdom of Recommendation 84 in the Final Report ([FR.1.263]), so far as it is targeted at applications to vary wage rates to reflect the work value of aged-care employees under section 157 of the FW Act.

8. Recommendation 84 was that unions should collaborate with Government and employers and apply to vary wage rates in (*inter alia*) the Aged Care Award and the Nurses Award. The product of that "*collaboration*"—a consensus statement as between the various affected unions and employer organisations—strongly supports the ANMF's application. This, too, will be discussed below.

A.2 Overview of conclusions the Commission would reach

9. The Award Minimum Wages Variations are sought on the basis that a 25 per cent increase to minimum wages for aged care workers under the Nurses Award and the Aged Care Award is justified by work value reasons and is necessary to achieve the modern awards objective and minimum wages objective.

10. There are two planks in the ANMF's submission that such an increase is justified. These are cumulative, but if either of them is established then that would, the ANMF submits, found an increase in minimum award wages.

11. The *first* is that the nature of aged-care work has changed over about the last twenty years, including in that the work is now more complex and stressful than previously, it involves more skill and responsibility than previously, and is performed in conditions that are in many ways more demanding of employees than previously. These are all "*work value reasons*" within the meaning of the FW Act; yet wages have not increased in a way that accounts for these increases in work value.

12. The *second* is that, in any case, the wages of aged-care workers have historically been undervalued. The fact of aged-care workers being overwhelmingly women is at least a substantial explanation for this historical undervaluation.

13. Each of these two planks will be developed in considerable detail below. Here, though, an overview is provided of some (at least) of the conclusions the ANMF submits that the Commission would reach, in regard to each of the two planks.

A.2.1 The nature of aged-care work has changed over the last twenty or so years

14. It has been submitted that the work is more complex than previously, requires more skill, involves more responsibility, and involves (at least in many ways) more demanding or a worsening in conditions. The Commission would easily find that this is so, including because of the following matters:

(1) Recipients of aged care have more acute care needs than previously, and more complex treatment needs. Examples of this trend (selecting just a few out of many) include increased prevalence of dementia and other cognitive conditions, increased polypharmacy, increased wound care complexity, increased co-morbidity, decreased mobility, and decreased continence. Evidence supporting all of these propositions is summarised in Part E.1 below.

(2) There is a long-term trend of lower staffing levels in aged care, as well as a long-term change in skill mix in the sense that there are fewer RNs and ENs, and more AINs / PCWs. The latter of these points means both that the nursing workload (including supervisory workload) is spread between fewer nurses, and that AINs / PCWs are performing more-complex work than previously because nurses are not available to perform that work (see Part E.2).

(3) There has been a cultural transformation toward more person-centred, individualised, care, away from a more-regimented or task-based approach, historically taken towards aged care. Performance of person-centred care takes more time, and involves more skill and decision-making. The expectations of aged-care recipients and their families are commensurately higher than previously (see Part E.3).

(4) Aged care has always been a highly regulated industry, but the regulatory burden (which is acquitted, at least in large part, by the work of RNs, ENs, and

AINs / PCWs) has increased considerably over the last twenty or so years. This includes the work associated with the implementation of the "*Serious Incident Reporting Scheme*" (introduced April 2021), the work associated with procuring ACFI funding, the increased work as well as increased risk associated with limitations on the availability of chemical and physical restraints on residents (from July 2021), the increased burden of documentation, the increased complexity of care plans, and the increase in both the amount and complexity of interactions with residents' families (see Part E.4).

(5) There has been an increase in the need for particular kinds of skills associated with the provision of aged-care work, including in particular observational skills, interpersonal skills, making of clinical-type observations (blood pressure, *etc.*), dealing with falls, wound care, the use of catheters, and the administration of medication. In many cases, these increases are associated with the increase in acuity and the change in care models, but they have been separately addressed in Part E.5.

(6) There has been an increased need for workers to provide dementia care and palliative care, both of which are complex areas of care, requiring the bringing to bear of complex skills. Again, this is at least in large part a function of increased acuity, but it deserves (and has received) separate treatment in Part E.6.

(7) Because of the increased age and acuity of aged-care recipients on entry to residential care, death of residents is more frequent. Deaths themselves, and the interactions with family members thereafter, are distressing for aged-care workers, and take an emotional toll. It is not to be forgotten that, despite that aged-care work is work, it inevitably involves the making of personal connections with residents. To be confronted, constantly, with the deaths of persons with whom personal bonds have been formed is at least an unusual, if not a unique, burden shouldered by the aged-care worker (see Part E.7).

(8) For this reason and other reasons, the work is more mentally and emotionally demanding than it used to be. It is also more physically demanding (see Part E.8).

(9) Aged-care workers deal with more violence and aggression in the workplace than previously, including because of increased dementia, and because of decreased chemical and physical restraint (see Part E.9). Greater skill is required in de-escalating situations where violence and aggression is threatened.

(10) Including because of changed staffing profiles, the supervisory burden on RNs and ENs is spread between fewer of them, which increases the burden on each of them individually. The reverse side of the coin is that AINs / PCWs, while still subject to the supervision of nurses, are less-directly supervised, which enhances the responsibility they bear (Part E.10).

(11) While technology and changes in built form have made the work easier in some ways, they have made it more difficult in other ways. In any case, many of the technological changes that have been implemented are really responses which lessen, but do not entirely offset, the increased physical burden associated with changes in acuity. To exemplify this last point, aged-care workers are required to perform many more lifting manoeuvres than in the past, due to the decreased mobility of residents. This has dramatically increased work requirements. Because lifting machines are available, the dramatic increase in work is not as dramatic as it would be if lifting machines were <u>not</u> available; but this only lessens and does not eliminate the increase in work (Part E.11).

(12) The aged-care workforce is more-highly qualified, and receives more specialist training, than in the past (Part E.12).

(13) It has been increasingly difficult to attract and retain an aged-care workforce, meaning that workers are more-often working with newer workers (newer to the workforce as a whole, newer to a particular facility, or both). This lessens the ability of care teams to develop workflows and increase the efficiency of models of work and care, and hence increases the difficulty of the work (Part E.13)

(14) COVID-19 has increased the risk of the work, and the skill involved in doing it (not least because of training and changed protocols in regard to infection prevention and control). These changes are not short-term or transient—they will affect the nature of aged-care work into the future (Part E.16).

15. These conclusions would be enough for the Commission to be feel satisfied that reasons exist which justify a 25 per cent increase in award minimum wages.

A.2.2 Wages of aged-care workers have historically been undervalued

16. Further, however, the ANMF advances its *second* plank. This involves, in high overview, the following propositions.

(1) The aged-care workforce is, and has been, overwhelmingly female (upwards of 85 per cent across each of RNs, ENs, and AINs / PCWs (see Part E.14).

(2) There is and has been, economy-wide, a gender pay gap ("**GPG**") in Australia, whether or not one adopts a "*standard*" / "*orthodox*" approach or an "*institutional*," "*sociological*," or "*heterodox*" approach (see Part F.1 concerning the Smith/Lyons Report).

(3) The most-significant contributing component to the GPG is gender discrimination. This may include "*undervaluation of feminised work and skills*", which is "*influenced by social expectations and gendered assumptions about the role of women as workers*", and is including because of the "*invisibility*" of skills which have historically not been differentiated from "*social behaviour required to relate to other humans outside the workplace, especially children, or the ill, infirmed or aged*" (see, again, Part F.1 concerning the Smith/Lyons Report).

(4) These skills can, in fact, be identified—which is to say that, despite being "*invisible*," they can be made visible. The work of Hon Assoc Prof Junor aids in this task. Her tool (the Spotlight Tool) is designed to reduce unwitting gender bias, by measuring the content and level of skills that have been "*hidden*", "*under-defined*", "*under-specified*" or "*under-codified*" (see Part F.2 concerning the Junor Report).

(5) And, when the Spotlight Tool was turned onto descriptions given by aged-care workers of the work they perform, Dr Junor finds (as summarised in Part F.2), and the Commission may itself separately find (as summarised in Annexure 1 to these submissions), a very large number of countable instances of the kinds of skills that traditionally have not been recognised as such (and hence have been left out of account in the setting of rates of pay).

17. In short, the lay evidence, the evidence in the Smith/Lyons Report, and the evidence on the Junor Report, are mutually-reinforcing and entirely consistent. Each of the Smith/Lyons Report and the Junor Report contain conclusions that the current rates of pay in the Nurses Award and the Aged Care Award do not reflect underlying work value. Why is that? It is for reasons including that there are "*invisible*" skills that are in fact brought to bear by workers, but which have not traditionally been recognised as skills for various reasons.

18. How do we know that these skills are in fact being exercised? Because of Hon Assoc Prof Junor's analysis and separately because of the evidence of lay witnesses. And we know that there are and have been failures properly to value work in gendered industries (such as aged care) due to the existence of the GPG, which (the Smith/Lyons Report tells us) exists in largest part because of gender bias, including the non-recognition of "*invisible*" skills.

19. Submissions are made below about whether the Commission needs to make positive findings about why wages were not properly fixed in the past (it being uncontroversial between the parties that they were not properly fixed). But no matter which approach the Commission takes to that question, it will be relevant to the Commission's analysis to have an explanation as to why wages might be lower than work value warrants. Each of the two planks of the ANMF's argument provides such an explanation.

A.2.3 The Modern Awards Objective and Minimum Wages Objective

20. In summary, the Commission would be satisfied that the Modern Awards Objective and Minimum Wages Objective are met for the following reasons:

    (1) The current award minimum rates for all Nursing Assistants and Enrolled Nurse classifications under the Nurses Award and AIN / PCW classifications under the Aged Care Award are currently close to, or below the "*low paid*" threshold (see also the evidence in Part E.13 concerning the sufficiency of current wages).

    (2) Further, the current wage rates are neither fair nor relevant, including because the rates do not reflect workers' work value, are out of step with community, expectations, are inconsistent with rates applying in other sectors for equivalent work, and result in significant labour force deficiencies (see Part G.1 and G.2 below).

(3) Enterprise bargaining has not solved, and will not solve, this problem (see Part G.4 in particular).

(4) The Award Minimum Wages Variation would promote social inclusion through workforce participation by:

(a) a greater ability to attract and retain staff (as to which see, Part G.2 in particular);

(b) an incentive for career progression for workers in the industry;

(c) accordingly, higher-quality care and quality of life for aged-care residents.

This is especially so in circumstances where 86 per cent of the direct care workforce in aged care identify as female and where increased wages would promote further workforce participation and retention.

(5) A correction of the historical undervaluation of the work values of aged care employees would promote the principle of equal remuneration for work of equal or comparable value.

A.2.4 The PCW Classification Variation

21. As to the PCW Classification Variation, the simple point is that the work performed by AINs / PCWs differs qualitatively from the work done by general and administrative services and food services workers, so their rates of pay should be treated separately.

22. That is not to say that the ANMF supports a pay increase for AINs / PCWs and not for general and administrative services and food services workers (over whom the ANMF does not have coverage). Rather, even if the Commission is satisfied that those workers should have the same wage increase as AINs / PCWs, still it would be appropriate to separate out the latter in the classification structure. The existing classifications shoehorn together into a single classification varieties of worker who perform very different work. This carries with it the risk of stultification of development of particular terms and conditions (especially in relation to wages, but even otherwise) which take account of those qualitative differences between work.

A.3 Evidence and material available to the Full Bench in determining the ANMF's application

23. The Full Bench has before it a substantial body of material to assist in determining the ANMF's application. This material includes:

(1) Material establishing agreement between interested parties as to various factors;

(2) Evidence from frontline workers in the aged care industry;

(3) Evidence from union officials with particular knowledge of the aged care industry;

(4) Expert evidence;

(5) Evidence from employer representatives; and

(6) Evidence from numerous reviews, reports, and other source material, primary amongst which are the reports of the Royal Commission.

24. The effect of the orders of 1 July 2021 is that the applications AM2020/99 and AM2021/65 by the Health Services Union ("**HSU**") and the application AM2021/63 by the ANMF are each to be dealt with jointly by one Full Bench and any evidence given in the matters will be admissible in relation to all of them. Evidence has been tendered by the ANMF, HSU, United Workers Union ("**UWU**") and employer interests represented by Aged & Community Services Australia ("**ACSA**"), Leading Age Services Australia ("**LASA**") and Australian Business Industrial ("**ABI**"). Some evidence will be of direct relevance to each of the applications currently before the FWC. Other evidence will be less directly relevant to the ANMF's application (such as evidence of from cooks of their work in an aged care facility). However, such evidence may still go to broader changes within aged care and the common issues and themes that reflect upon the work value of those covered by the ANMF's application.

Material establishing agreement

25. Material establishing agreement between interested parties as to various factors includes, first and foremost, the "*AGED CARE SECTOR STAKEHOLDER CONSENSUS STATEMENT*" ("**Consensus Statement**"). The parties to that Consensus Statement include ACSA, LASA, the ANMF, the Health Services Union, the United Workers Union, and a number of other aged-care stakeholder organisations.

26. By its own terms, the Consensus Statement "reflects the matters over which the parties have reached agreement…" (CS, page 1). It was made pursuant to recommendation 76(2)(e) of the Royal Commission in express contemplation of these proceedings. The parties to the Consensus Statement represent a broad cross-section of interests. The FWC would give very considerable weight to its content. Its content is supportive of the ANMF's application (and the other applications).

27. Further, many of the points of consensus are also the subject of agreement by other employers who were not parties to the Consensus Statement but who have filed material in respect of these proceedings (as outlined below).

28. ACSA and LASA together with ABI have filed joint submissions dated 4 March 2022 (the "**Joint Submission**"). Some of the content of the Joint Submission may be read as departing from the Consensus Statement despite ACSA and LASA being parties to the Consensus Statement. In opening submissions, Justice Ross questioned the representative of ACSA, LASA and ABI as to the status of assertions in the Joint Submission, seeking clarity around what the Full Bench should be guided by to the extent of any inconsistencies.[4] Despite that invitation, neither ACSA nor LASA have expressed an intention to abandon their status as parties to the Consensus Statement or renounce any part of the Consensus Statement. As such, the position of ACSA and LASA in these proceedings should be understood consistently with the Consensus Statement. Making inconsistent submissions would be akin to seeking to withdraw an admission. In the absence of clear evidence, parties to litigation and a Court or tribunal are entitled to assume that admissions were properly made, so that where leave to withdraw a submission is sought an explanation should be given.[5] No explanation has been given here.

Evidence from frontline workers in the aged care industry

29. There is a substantial body of evidence before the FWC from 72 frontline aged care workers as is relied upon by the ANMF, HSU and UWU. This evidence is summarised in the Report to the Full Bench by Commissioner O'Neill dated 20 June 2022 (**Lay Evidence Report**). The evidence from aged care workers in community care and

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4 Transcript, 26 April 2022, at [PN217] per Justice Ross.

5 See, e.g., *Celestino v Celestino* [1990] FCA 449 at page 8 (Spender, Miles and von Doussa JJ).

residential care spans each Australian State.[6] This evidence is addressed further below in these submissions.

Evidence from union officials

30. The ANMF also relies upon evidence from union officials filed by the parties. This includes the nine statements from the ANMF's eight officials and the oral evidence of seven of those witnesses. That evidence goes to (*inter alia*):

(1) The nature of the work performed in aged care;

(2) The nature of the aged care sector and the aged care workforce;

(3) The health status and characteristics of residents and clients in aged care;

(4) Enquiries and reviews into aged care;

(5) The regulation and registration of nurses;

(6) The education and training of employees in aged care;

(7) Regulation and funding in aged care;

(8) Occupational health and safety in aged care;

(9) Enterprise bargaining in the aged care sector; and

(10) The industrial history of wage fixation applicable to the aged care sector.

Expert evidence

31. The ANMF relies upon the Amended Report of Assoc Prof Smith and Dr Michael Lyons dated 2 May 2022 ("**Smith/Lyons Report**") as well as the oral evidence of Assoc Prof Smith, and the Amended Report of Hon Assoc Prof Anne Junor filed 5 May 2022 ("**Junor Report**") and her oral evidence.

32. This evidence is further addressed at Part F below.

33. The FWC also has the benefit of expert evidence adduced by the HSU from:

(1) Professor Sara Charlesworth;

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6 Lay Evidence Report at [7] and [8].

(2) Dr Gabrielle Meagher;

(3) Professor Kathy Eagar; and

(4) Dr Susan Kurrle.

Evidence from employer representatives

34. The Full Bench has also received evidence from nine employer representatives. Where relevant this evidence is identified below.

The findings of the Royal Commission, other reviews, reports, and source material

35. The FWC is entitled to inform itself in relation to any matter before it in such manner as it considers appropriate (FW Act, section 590(1)). And, it is not bound by the rules of evidence (FW Act, section 591).

36. The Royal Commission Interim Report and Final Report are likely to assist the FWC in deciding some of the issues raised by this application. The Royal Commission:

(1) attracted more than 10,000 public submissions ([FR.1.181]);

(2) surveyed more than 1,000 aged-care providers ([FR.1.182]), and visited providers ([FR.1.188]);

(3) received submissions from interested organisations including industry bodies and unions, and received expert evidence from (inter alia) academics, clinicians, service providers, and government agencies ([FR.1.183]);

(4) held 99 hearing days and heard from more than 600 witnesses ([FR.1.183]);

(5) was able to (and did) require the production of documents ([FR.1.185]);

(6) consulted with experts including officers of Australian Government agencies ([FR.1.187]);

(7) conducted and commissioned international and domestic research, yielding "a huge volume of data … from different parts of the aged care system that had previously been inaccessible to researchers" ([FR.1.189]).

37. The Commissioners were former judges (the Honourable Richard Tracey AM RFD QC; the Honourable Tony Pagone QC) and a former CEO of Medicare Australia and Australian Public Service Commissioner (Ms Lynelle Briggs AO).

38. The Australian Government has accepted the vast majority of the recommendations made by the Royal Commission, including Recommendation 85 which is targeted at improved remuneration for aged-care workers.[7]

39. Of course, the focus of the Royal Commission was different from the focus of these applications, and so much of the material set out in the Royal Commission reports is irrelevant, and equally many of the issues raised by this application were not addressed by the Royal Commission. Nevertheless, where there is overlap, the findings of the Royal Commission will generally be probative, and likely to assist the FWC. The FWC has taken this sort of material into account, in the past.[8]

40. The FWC has acknowledged and identified other key documents contained in the Research Reference List ("**RRL**") published 9 June 2022, noting that the Full Bench has indicated that it proposes to have regard to these materials in consideration of the applications.[9] It is submitted that the FWC can and should have regard to such materials in determining the ANMF's application.

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7 Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, May 2021.

8 See, *e.g., 4 yearly review of modern awards—Penalty rates* [2016] FWCFB 965 at [18] (Ross P, Catanzariti VP, Asbury DP, Hampton C, Lee C), citing *Equal Remuneration Test Case Decision* [2011] FWAFB 2700 at [225]; Re IEU [2014] FWC 7838 at [41], [42]; *Re SDA* [2014] FWCFB 1846 at [163]-[164]; *Annual Wage Review* 2012-2013 [2013] FWCFB 4000 at footnotes 111, 143, 144; *Redundancy Test Case Decision* [2004] AIRC 287; (2004) 129 IR 155 at [223]–[224].

9 See [2022] FWCFB 94 at [10].

B. Response to Background Documents and Provisional Views

41. On 09 June 2022, the Full Bench published "*Background Document 1—The Applications*." By its statement ([2022] FWCFB 94) also issued 09 June 2022, the Full Bench sought short written responses to the questions set out in that document. Where those questions are directed to the ANMF, the ANMF's responses are set out below.

B.1 Question 1 [of Background Document 1] for all parties: Are there any corrections or additions to section 1?

Footnotes 5–8

42. The wage increases sought by the ANMF's application dated 17 May 2021 are summarised in paragraphs [10] and [11] of Background Document 1. As noted in footnotes 5 and 7 to those paragraphs, the minimum wages in the Nurses Award and the Aged Care Award were increased since the application was made as the result of *Annual Wage Review 2020-21* (see [2021] FWCFB 3500, PR729289 and PR729273). Further, as noted in footnotes 6 and 8 to those paragraphs, in their submission dated 4 March 2022, the Joint Employers also calculate a 25 per cent increase on the minimum rates in the Nurses Award and the Aged Care Award and their calculations differ from the ANMF.

43. The ANMF's calculations were made before *Annual Wage Review 2020-21* whereas the Joint Employers' calculations were made after that review. The differences between the calculations appear to reflect the increase in minimum wages as the result of *Annual Wage Review 2020-21*. There have been two additional developments since the application was made which affect the variations sought by the ANMF.

44. *First*, the *Nurses Award 2020* came into operation on 9 September 2021. As noted in paragraphs [7]–[9] of Background Document 1, the ANMF proposes to insert a new Aged Care Employees Schedule into the Nurses Award which would apply to employees working in the aged care industry in all classifications except Occupational health nurses. Apart from the higher wages and the omission of the Occupational health nurse classifications, the proposed schedule reflected the structure of clause 14 of the *Nurses Award 2010* as it was in operation at the time the application was made. Clause 15 of the *Nurses Award 2020* differs from clause 14 of the *Nurses Award 2010* in two significant respects: it contains a minimum hourly rate for each classification and minimum entry rates for employees with a 4-year degree or a Masters degree.

45. *Second*, the minimum wages in the Nurses Award and the Aged Care Award have further increased as the result of *Annual Wage Review 2021–22* (see [2022] FWCFB 3500, PR740715 and PR740693).

46. The last two pages of these submissions (Annexure 2) are schedules. Part A of Annexure 2, relating to the *Nurses Award 2020*, reflects the results of *Annual Wage Review 2020–21* and *Annual Wage Review 2021–22*, and includes a minimum hourly rate for each classification and minimum entry rates for employees with a 4-year degree or a Masters degree. Part B of Annexure 2, relating to the *Aged Care Award 2010*, reflects the results of *Annual Wage Review 2020–21* and *Annual Wage Review 2021–22*.

Paragraph [15]

47. Paragraph [15] of Background Document 1 refers to the ANMF's proposal to remove PCWs from the main stream of "aged care employee" in Schedule B to the Aged Care Award and to create a new classification structure for them.

48. The two propositions set out in [15] were advanced by the ANMF in the context of the principles relevant to the proposed amendment. The PCW Classification Variation does not involve any variation to modern award minimum wages, so work value reasons are irrelevant, and so is the minimum wages objective. Section 157(1) provides that the FWC may make a determination varying a modern award <u>otherwise</u> than one varying minimum wages if the FWC is satisfied that making the determination is necessary to achieve the modern awards objective.

49. All of the modern awards objective considerations are either irrelevant and hence neutral (*i.e.*, sections 134(1)(f), (h)) or support the ANMF's proposed variation. Of those that support the variation, they are in two categories: considerations that would <u>immediately</u> be furthered by variation; and, considerations that would be advanced in future by making the variation today.

50. To exemplify the first category, section 134(g) is immediately furthered by the variation, because the award will be easier to understand if different work is treated differently. To exemplify the second category, section 134(d) and (da) would be advanced in future in the sense that dealing with PCWs differently would enable, in the future, changes to remuneration to address (say) unsocial hours worked by PCWs (but

not, say, gardening superintendents) more easily to be made. In the same way, dealing separately with PCWs would encourage the insertion of terms into the award (section 134(1)(d)), or in collective agreements (section 134(1)(b)), that address issues specific to PCWs.

51. It is appropriate for PCWs to have their own classification structure in light of the qualitative differences between their work and the work performed by other aged-care workers under the Aged Care Award. On the other hand, the commonality of work as between PCWs under the Aged Care Award and Nursing Assistants under the Nurses Award suggests the need for a separate PCW classification structure.

Paragraph [37]

52. Paragraph [37] of Background Document 1 states that, *"[a] Mention was held on 22 April 2022. The Commission proposed that in order to facilitate the efficient use of Commission resources, the Unions' employee lay witness evidence would be heard by a single member of the Full Bench, Commissioner O'Neill. The remaining witnesses (the union officials, experts and employer lay witnesses) would be heard by the Full Bench. The parties did not object to the course proposed*."

53. In a Statement of 24 April 2022 ([2022] FWCFB 58), the Full Bench determined that the evidence of the 81 Union lay witnesses would be heard by O'Neill C, who in turn would provide a Report to the Full Bench.

54. On 28 April 2022, the ANMF wrote to the Commission proposing that, for abundant caution, the President formalise the position determined by the Full Bench by way of a written direction, under section 616(3D)(b), section 582(2) and/or section 590, to the effect that O'Neill C hear the evidence of the Union lay witnesses and prepare a report for the Full Bench. The correspondence reflected a joint position of the HSU, UWU and the Joint Employers.

55. On 29 April 2022, the President issued a Direction that O'Neill C hear the evidence of the 81 Union lay witnesses and prepare a report for the Full Bench in respect of that evidence. The ANMF submits that, for completeness, reference should be made to the President's Direction in section 1 of Background Paper 1. And, given that some witnesses were added and some did not, in the end, give evidence, the Commission may wish to give consideration to whether a further direction is required.

B.2 Question 4 for all other parties: What do you say in response to the HSU submission?

56. The ANMF agrees with the summary of the HSU submission as set out in paragraph [58] of Background Document 1 and, further, refers to and repeats paragraphs [23]–[42] of its submissions dated 29 October 2021 and paragraphs [22]–[46] of its reply submissions dated 21 April 2022.

57. Further "*reasons related to … the nature of the work*" which are relevant to the assessment of work value under section 157(2A)(a) would include the following matters:

(1) the findings of the Royal Commission into Aged Care Quality and Safety;

(2) the vulnerability of the people who receive aged care services;

(3) that the work involves human beings not objects;

(4) that Commonwealth funding is 100 per cent (plus or minus a few percentage points) of labour costs, except in Government-operated facilities where it is around 66 per cent (plus or minus a few percentage points);

(5) that aged care services are for the benefit of the community broadly;

(6) that the industry is female-dominated;

(7) that the work is performed in a setting that involves a complex combination of providing residential accommodation, the provision of health and nursing care, the provision of social and emotional support, as well as palliative care to the aged and infirm.

58. The ANMF submits that each of the above are reasons related to the nature of the work which support the wage increases sought.

B.3 Question 5 for all parties: Are any of the propositions from the Pharmacy Decision contested?

59. No.

B.4 Question 7 for all parties: What is the relevance of the re-enactment presumption to the construction of ss.157(2) and (2A)?

60. The ANMF submits that the re-enactment presumption is relevant to the construction of section 157(2)-(2A) in two respects.

61. *First*, as stated in Background Document 1:

(1) at paragraph [59]: "*Section 157(2A) was inserted into the FW Act by the Fair Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Act 2018 (the 4 Yearly Review Amending Act)*."

(2) at paragraph [60]: "*The 4 Yearly Review Amending Act repealed s.156 of the FW Act, which required the Commission to conduct 4 yearly reviews of modern awards, effective from 1 January 2018 (subject to transitional arrangements). As s.156(4) was repealed, the definition of 'work value reasons' in s.156(4) was inserted into s.157 as s.157(2A). [footnote omitted]*"

(3) at paragraph [68]: "*The Pharmacy Decision was dealing with the meaning of 'work value reasons' in s.156(4) but the propositions set out above are applicable to the current proceedings because ss.156(3) and (4) 'are in terms relevantly identical to subsections 157(2) and (2A).' [footnote 43: Re IEU [2021] FWCFB 2051 [218]]*"

That is, in repealing section 156(4) and re-enacting the same words in section 157(2A), it can be presumed that the Parliament intended the words to bear the meaning already attributed to them in the *Pharmacy Decision*.

62. *Second*, as stated in Background Document 1 at paragraph [69], "*Propositions 4 and 5 above [from the Pharmacy Decision] are to the effect that while it would be open to the Commission to have regard to considerations taken into account in previous work value cases under differing past statutory regimes, in enacting s.156(4) the legislature chose to only import the fundamental criteria used to assess work value changes contained in earlier wage fixing principles, not the additional requirements contained in those principles*." It can be presumed that the Parliament intended:

(1) the fundamental criteria re-enacted in section 157(2A) to bear the meaning already attributed to them in previous work value cases; and

(2) that the additional requirements contained in earlier wage fixing principles no longer apply.

B.5 Question 8 for all parties:

As noted in the Pharmacy Decision, while not part of the Commission's statutory task [now under ss.157(2) and (2A)], it is likely the Commission would usually take into account whether any feature of the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done has previously been taken into account in a proper way.
It appears to be common ground between the HSU, ANMF and ABI that the minimum rates of pay in the Aged Care Award, the Nurses Award and the SCHCADS Award have not previously been properly set. [footnote omitted] In these circumstances, do parties agree that the Commission's statutory task under ss.157(2) and (2A) is to fix the amount that employees should be paid for doing a particular kind of work based on the value of the work as it is currently being done, and that to undertake that task it is not necessary to measure changes in work value from a fixed datum point or to identify any 'significant net addition' to work requirements?

63. Yes.

B.6 Question 9 for all parties: What do you say in response to the HSU submission?

64. The ANMF agrees with the extract of the HSU submission set out in [80] of Background Document 1, save that it is not an exhaustive statement of the meaning of the phrase "*fair and relevant*" in the context of minimum wages.

65. The terms "*Fair and relevant*", "*which are best approached as a composite phrase, are broad concepts to be evaluated by the FWC taking into account the s 134(1)(a)-(h) matters and such other facts, matters and circumstances as are within the subject matter, scope and purpose of the Fair Work Act*" (see *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368 at [65] and extracted in [79] of Background Document 1). Those concepts are not any narrower in the context of minimum wages.

66. The ANMF refers to and repeats [46] of its submissions dated 29 October 2021, and refers further to [838] below.

B.7 Question 10 for all parties: Are any of the observations about the modern awards objective (at [89] to [107] above) contested?

67. No.

B.8 Question 11 for all parties: Is it common ground that the consideration in section 134(1)(da) is not relevant in the context of the Applications?

68. The ANMF submits that the consideration in section 134(1)(da) is relevant to the PCW Classification Variation, as to which see [50] above.

B.9 Question 12 for all parties: Are any of the observations about the minimum wages objective (at [109] to [113]) contested?

69. No.

B.10 Question 13 for all parties: Are any of the considerations in section 284(1) not relevant in the context of the Applications?

70. The ANMF submits that the consideration in section 284(1)(e) is not relevant in the context of the Applications.

B.11 Question 14 for all parties: do the parties agree that the propositions above are uncontentious?

71. Yes.

B.12 Question 16 for the Unions and Joint Employers: Do the matters set out at [117]–[128] encapsulate the issues in contention, insofar as the work value claim is concerned?

72. Further to [125]–[126] of Background Document 1, the ANMF makes detailed submissions below concerning the work done by ENs and NPs, and work value reasons justifying the same increase in wages for them as for other workers. Otherwise, given the context of the paragraphs in relation to which question 16 is asked, the ANMF assumes that it is seeking identification of disputes in relation to the nature of the work performed by various kinds of workers. If the question is asking for identification of all disputes, then there may be several more than those identified at [117]–[128].[10]

B.13 Question 1 [of Background Document 2] for all parties: Are there any corrections or additions to Background Document 2? Is it common ground that the material set out in Background Document 2 is uncontentious?

73. The ANMF does not propose any corrections to Background Document 2, but continues to rely on the history of the *Nurses Award 2020* set out in the statement of Kristen

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[10] For example, in earlier submissions there were divergences between the parties in relation to matters including the "*significant net addition*" / "*evolutionary change*" issue, whether working conditions have been "*improved*", incremental increases, and the role of AINs / PCWs in clinical care. The ANMF maintains all of its submissions earlier made in writing; whether the employer parties modify any of their submissions in light of the evidence is as yet not known.

Wischer dated 14 September 2021. Ms Wischer was not required for cross-examination.

74. The ANMF does not propose any additions to Background Document 2, but it notes that gender bias is not the sole reason for the ANMF's submission that the fixture of rates in the *Nurses Award 2020* are not "*proper*" fixtures of rates (see [75] of Background Document 2). The ANMF submits that there has been a historical undervaluation of the nature of the work performed by aged care employees, of the skill or responsibility involved in that work, and of the conditions under which the work is done. Specifically, another reason that they were not "*proper*" fixtures of rates is that the "*invisible skills*" identified in the amended report of Hon Assoc Prof Junor have not been taken into account. While gender bias (or gender-based undervaluation) is one reason (and possibly the primary reason) for the invisibility of those skills, it is not the sole reason for invisibility (see [36] and also [201]–[212] of her amended report).

75. As to whether or not the material set out in Background Document 2 is uncontentious, while it is uncontentious that the submissions summarised in the document have in fact been made by the parties to which they are attributed, the subject matter of many of those submissions is contentious (and, where that is the case, it is addressed in these submissions).

76. For example, paragraph [76] of Background Document 2 states that "*The Joint Employers submit that the industrial history underpinning the Nurses Award reveals that the classifications and wage rates of RNs, ENs and AINs have been subject to extensive review. Notwithstanding that this history suggests that there may be a proper basis for finding the minimum rates in the Nurses Award are properly set, and in order to conclude that they are, ABI and others submit that reference must be made to a decision of a Full Bench that expressly assesses the minimum rates by reference to the C10 framework and the AQF. ABI and others submit that since the publication of the Nurses Award this has not occurred. ABI and others also submit that the exercise of properly setting minimum rates is a deliberate exercise and should be undertaken with respect to the existing classification structure in the Nurses Award. [footnote omitted]*" The Joint Employers' submissions summarised in this paragraph are contentious, most obviously the proposition that there may be a proper basis for finding the rates in the Nurses Award are properly set.

77. The ANMF's answer to Question 5 of Background Document 1 is that none of the propositions from the *Pharmacy Decision* are contested. As indicated in [63]–[65] of Background Document 1, the *Pharmacy Decision* "*traced the genesis and development of the concept of fixing wages based on 'work value'*" from 1921 to 1991 in paragraphs [131]– [162] of that decision. Then, as stated in [66] of Background Document 1, "*[a]gainst that historical background, the Pharmacy Decision Full Bench then stated 7 propositions in relation to the proper construction of ss.156(3) and (4) of the FW Act*" in paragraphs [163]–[169] of the decision.

78. As stated in paragraph [69] of Background Document 1, "*Propositions 4 and 5 above [from the Pharmacy Decision] are to the effect that while it would be open to the Commission to have regard to considerations taken into account in previous work value cases under differing past statutory regimes, in enacting s.156(4) the legislature chose to only import the fundamental criteria used to assess work value changes contained in earlier wage fixing principles, not the additional requirements contained in those principles.*"

79. In [159] of the *Pharmacy Decision*, as part of the "*historical background*", the Full Bench set out a three step process for the determination of properly fixed minimum rates from the *ACT Child Care Decision*:

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

In accordance with propositions 4 and 5, while it would be open to the Commission to have regard to that process in this case, it is no longer necessary to do so.

80. At the conclusion of the *Pharmacy Decision* in paragraphs [197]–[198], the Full Bench stated that:

> **"[197]** This outcome appears to be inconsistent with the principles stated and

> the approach taken concerning the proper fixation of award minimum rates in the *ACT Child Care Decision*, to which we have earlier made reference. However we note that the *ACT Child Care Decision* was made under a different statutory regime and pursuant to wage-fixing principles which no longer exist.
>
> **[198]** This matter may potentially constitute a work value consideration relevant to the 4 yearly review of the *Pharmacy Award*. In the conduct of the review, the Commission is required to discharge its functions under s 156(2) and is not confined to matters raised by interested parties. We will as a first step invite further submissions from interested parties concerning this matter. We will then consider what course, if any, should be taken. One possibility is that this aspect of the review may need to be referred back to the President of the Commission for consideration as to the procedural course to be taken pursuant to s 582, since the matter raised may have implications for other awards of the Commission, including but not limited to the *Professional Employees Award 2010*."

81. In a subsequent decision in [2019] FWCFB 3949 at [15], the Full Bench stated that it was persuaded that the issue should be referred to the President for consideration as to the procedural course to be taken pursuant to section 582 of the Act. Further, "*As we identified in the December decision, the issue has ramifications for other awards which contain classifications applying to employees who are required to hold undergraduate qualifications including, but not limited to, the Professional Employees Award 2010. As such, a broader review of the issue across a number of awards may be called for. We also note that a similar issue has been raised in connection with proceedings currently on foot concerning the Educational Services (Teachers) Award 2010. [footnote omitted]*."

82. On 27 August 2019, the President issued a Statement ([2019] FWC 5934) in which his Honour expressed a provisional view that awards with classifications requiring undergraduate degrees should be referred to a separate Full Bench. Further, the President stated at [15] that the Full Bench may take into consideration, among other things, "*whether the AQF alone is a satisfactory proxy for determining work value*."

83. The status of that proceeding had been on hold pending the outcome of the IEU's work value application in respect of the *Educational Services (Teachers) Award 2010*. A review of modern awards (including the Nurses Award) was scheduled to commence following the determination of the IEU's application to vary the *Educational Services (Teachers) Award 2010* which occurred on 11 October 2021.

84. In *Re IEU* [2021] FWCFB 2051, the Full Bench stated at [560] that "*In the Pharmacy Award decision, [footnote omitted] the Full Bench described in detail the development*

by the AIRC of an approach whereby the proper fixation of award minimum rates of pay required an alignment between key classifications in the relevant award and classifications with equivalent qualification and skill levels in the classification structure in what was originally the Metal Industry Award 1984–Part I and subsequently became the Metal, Engineering and Associated Industries Award, 1998 (Metal Industry classification structure). We endorse and adopt that analysis without repeating it." It then set out the three step process from the *ACT Child Care decision*.

85. In *Re IEU* at [653], the Full Bench stated that "*[w]e consider that the correct approach is to fix wages in accordance with the principles stated in the ACT Child Care decision. As earlier set out, this requires us to identify a key classification or classifications, align it with the appropriate classifications in the Metal Industry classification structure, and then set other rates for other classifications based on internal relativities that are assessed as appropriate.*"

86. The *ACT Child Care Decision* was made under a different statutory regime and pursuant to wage-fixing principles which no longer exist (see the *Pharmacy Decision* at [197]). It is no longer the correct approach to the Commission's statutory task under section 157(2)-(2A). In accordance with the propositions from the *Pharmacy Decision*, which are not contested, "*while it would be open to the Commission to have regard to considerations taken into account in previous work value cases under differing past statutory regimes, in enacting s.156(4) the legislature chose to only import the fundamental criteria used to assess work value changes contained in earlier wage fixing principles, not the additional requirements contained in those principles*" (see Background Document 1 at [69]). Those additional requirements include the three step process from the *ACT Child Care decision*.

87. The ANMF's answer to Question 8 of Background Document 1 is that it agrees that the Commission's statutory task under sections 157(2) and (2A) is to fix the amount that employees should be paid for doing a particular kind of work based on the value of the work as it is currently being done, and that to undertake that task it is not necessary to measure changes in work value from a fixed datum point or to identify any "*significant net addition*" to work requirements. The ANMF submits that it is also not necessary to apply the three step process from the *ACT Child Care decision*.

B.14 Document 3—Witness Overview

88. On 20 June 2022, the Full Bench published Background Document 3–Witness Overview. The ANMF has no further comments in relation to that document but relies on the specific submissions below with respect to witness evidence as set out below.

B.15 Document 4–Royal Commission into Aged Care Quality and Safety

89. On 20 June 2022, the Full Bench published Background Document 4—Royal Commission into Aged Care Quality and Safety. The ANMF has no further comments in relation to that document but relies on the specific submissions below with respect to the findings of the Royal Commission.

C. Response to Provisional Views

90. On 9 June 2022, the Full Bench in [2022] FWCFB 94, also expressed the following provisional views:

> "1. Based on the submissions of the Unions and the Joint Employers, the relevant wage rates in the *Aged Care Award 2010*, the *Nurses Award 2020* and the *Social, Community, Home Care and Disability Services Industry Award 2010* have not been properly fixed.
>
> 2. It is not necessary for us to form a view about why the rates have not been properly fixed.
>
> 3. Our task is to determine whether a variation of the relevant modern award rates of pay is justified by 'work value reasons' (and is necessary to achieve the modern awards objective), being reasons related to any of s.157(2A)(a)-(c) the nature of the employees' work, the level of skill or responsibility involved in doing the work and the conditions under which the work is done."

91. The Full Bench has invited the parties to address these provisional views in submissions to be filed by 22 July 2022. Accordingly, the response of the ANMF to these provisional views of the Full Bench is as follows:

(1) The ANMF agrees with the first provisional view.

(2) The ANMF agrees with the second provisional view, save that:

(a) The ANMF submits that the rates in the *Nurses Award 2020* and the *Aged Care Award 2010* have not been properly fixed for reasons including that there has been an historical undervaluation and that "*invisible skills*" have not been taken into account (in part because of gender bias).

(b) As stated in the preamble to Question 8 of Background Document 1, "*As noted in the Pharmacy Decision, while not part of the Commission's statutory task [now under ss.157(2) and (2A)], it is likely the Commission would usually take into account whether any feature of the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done has previously been taken into account in a proper way.*"

(c) In taking into account whether any feature of the nature of work, the level of skill or responsibility involved in performing the work or the

conditions under which it is done has previously been taken into account in a proper way, it may be necessary for the Commission to form a view about:

(i) whether or not such features were taken into account in a way which was free of gender bias; and

(ii) whether or not the "*invisible skills*" were taken into account.

(3) The ANMF agrees with the third provisional view.

D. Overview of duties of various roles

92. This Part D sets out the duties of the roles relevant to the ANMF's application. This task is made substantially easier by the Lay Evidence Report. The submissions in this Part D will (relevantly) mirror the structure of Part C.2 of the Lay Evidence Report. In that part, O'Neill C set out under fourteen sub-headings overviews of the evidence of lay witnesses in various roles.

93. Not all of those roles are relevant to the ANMF's application. The approach taken by the ANMF in this Part D will be, under headings that refer to the relevant part of the Lay Evidence Report, to adopt such of the Lay Evidence Report as the ANMF relies upon in support of its case, and then to add <u>further</u> evidential references where necessary. In summary, therefore, this Part D should be read together with, and as supplementing, the Lay Evidence Report.

94. To assist in that connection, the below table sets out, from left to right, the heading number in the Lay Evidence Report, the title of the corresponding section, and the heading number in <u>these</u> submissions that relates to the same role.

C.2.1	Registered nurse in residential care	Part D.1
C.2.2	Enrolled nurse in residential care	Part D.2
C.2.3	Registered nurse in community care	Part D.3
C.2.4	Enrolled nurse in community care	Part D.4
C.2.5	Personal carers in residential care	Part D.5
C.2.6	Personal carers in community care	Part D.6
C.2.8	Nurse practitioners	Part D.7

95. In addition, Part D.8 relates to Nursing Teams, a topic not separately addressed in the Lay Witness Report.

96. The overview of the duties and roles is, indeed, an overview. The ANMF has set out in Part E further evidence going to duties and roles of the classifications under themes. For example there is evidence set out below in relation to:

(1) the role of RNs in respect of care plans (E.4.5) and dealing with families (E.4.6);

(2) the role of ENs in medication administration (E.5); and

(3) the role of AIN's and PCW in recording observations (E.4.4).

D.1 Registered nurse in residential care - Lay Evidence Report Part C.1

Agreement between interested parties

97. The parties to the Consensus Statement have recognised at [15] that:

> "… RNs are the clinical leaders in residential aged care and have experienced an increase in managerial duties (including co-ordinating and supervising and delegating) and/or administrative responsibilities."

The Lay Evidence Report

98. The Lay Evidence Report identifies a substantial list of typical duties of RNs in residential care arising from the lay evidence, including:

> "Leading a team, including enrolled nurses and care staff. This includes providing mentorship and supervision to ensure safe and effective care is delivered, as well as consulting, coordinating, and delegating in relation to workload."[11]

99. The ANMF adopt the contents of the Lay Evidence Report as it deals with the RN in residential care at [90]–[95].

Evidence of officials

100. The evidence of Annie Butler (ANMF Federal Secretary) is that the RN supervises the care team and is responsible for ensuring the care needs of each resident are met.[12] Decisions to delegate aspects of nursing care are made by the RN.[13] Registered nurses are educated to detect early signs and symptoms of changes in health status, make assessments of appropriate intervention strategies, and institute treatment measures in a timely manner. They are best placed to work with multidisciplinary teams of general

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11 Lay Evidence Report at [90], second dot point.
12 Amended Witness Statement of Annie Butler dated 2 May 2022 at [171].] (tab 181 page 9273).
13 Amended Witness Statement of Annie Butler dated 2 May 2022 at [169].] (tab 181 page 9273).

practitioners, geriatricians, palliative care specialists and other health professionals to deliver safe, effective care of the elderly with teams of qualified care workers.[14]

101. Andrew Venosta is a RN now employed as an Industrial Officer with the ANMF but with extensive experience in both acute hospital settings and in aged care. His evidence is that RNs working in acute hospital settings ordinarily work in areas or wards of specific clinical disciplines where patient care pathways have specific goal settings related to medical interventions and nursing interventions with the usual path being recovery leading to discharge. By contrast, he identifies that in the aged care setting, residents often have complex co-morbidities and there is no defined pathway leading to eventual recovery. Consequently, the RN in the aged care setting is required to apply a broad knowledge and skill base to deal with multiple clinical symptoms related to multiple co-morbidities.[15]

102. He identifies the broad skill base required of an RN in aged care now as typically including wound care, diabetes management, cardiac care, continence management, pain management, stoma care, nutrition and hydration, oral care, management of PEG (Percutaneous endoscopic gastrostomy) tubes, skin integrity and bariatric care. In addition, his evidence is that it is not uncommon to provide care for residents with various forms of cancer.[16]

Employer evidence

103. In her evidence, Kim Bradshaw (General Manager at Warrigal's Stirling Facility) describes a "*Day Shift/Afternoon Shift–RN*". She there identifies the ordinary daily tasks for an RN in residential care at Warrigal's Stirling Facility, including:

(1) Receiving handover and planning the day;[17]

(2) Meeting with AINs and allocating work for the day;[18]

(3) Blood glucose and insulin rounds before breakfast, lunch and dinner;[19]

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14 Amended Witness Statement of Annie Butler dated 2 May 2022 at [168].] (tab 181 page 9273).
15 Amended Witness statement of Andrew Venosta dated 3 May 2022 at [124]–[125] (tab 188 page 11145).
16 Amended Witness statement of Andrew Venosta dated 3 May 2022 at [126] (tab 188 page 11145).
17 Statement of Kim Bradshaw dated 4 March 2022 at [60] (tab 294 page 14945).
18 Statement of Kim Bradshaw dated 4 March 2022 at [61] (tab 294 page 14945).
19 Statement of Kim Bradshaw dated 4 March 2022 at [62] (tab 294 page 14945).

(4) A schedule 8 medication round (usually taking around two hours);[20]

(5) A wound management round;[21]

(6) Incident reporting, including taking any clinical assessments and notifying family/ next of kin of relevant information;[22]

(7) Attending residents with doctors if there is a doctor visit scheduled;[23]

(8) Spending time with new administrators, placing medication orders, making appointments for residents;[24]

(9) Attending to residents that are palliative and check of they are in pain and or agitated and give mediation;[25]

(10) Dispensing PRN (as required) medication;[26]

(11) Provide clinical updates to families of residents that are selected as "Resident of the Day"[27]

(12) Attending to buzzers with AINs;[28]

(13) Attend to phone calls, answer emails, supervise student RNs, mentor staff and supporting family members.[29]

104. In addition to this, Ms Bradshaw accepted under cross-examination that every shift is different,[30] and that every day, incidents can, and do, occur on shifts that throw any schedule out the window. Ms Bradshaw says that "*[e]very day there's an incident that changes the workload, or the plan that the registered nurse starts with usually is quite different by the time she gets to the end of her day*."[31] She agreed that this necessitates

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20 Statement of Kim Bradshaw dated 4 March 2022 at [63] (tab 294 page 14945).
21 Statement of Kim Bradshaw dated 4 March 2022 at [64] (tab 294 page 14945).
22 Statement of Kim Bradshaw dated 4 March 2022 at [65] (tab 294 page 14945).
23 Statement of Kim Bradshaw dated 4 March 2022 at [66] (tab 294 page 14946).
24 Statement of Kim Bradshaw dated 4 March 2022 at [67] (tab 294 page 14946).
25 Statement of Kim Bradshaw dated 4 March 2022 at [68] (tab 294 page 14946).
26 Statement of Kim Bradshaw dated 4 March 2022 at [69] (tab 294 page 14946).
27 Statement of Kim Bradshaw dated 4 March 2022 at [70] (tab 294 page 14946).
28 Statement of Kim Bradshaw dated 4 March 2022 at [71] (tab 294 page 14946).
29 Statement of Kim Bradshaw dated 4 March 2022 at [72] (tab 294 page 14946).
30 Cross-examination of Kim Bradshaw at PN12814.
31 Cross-examination of Kim Bradshaw at PN12815.

the RN balancing competing priorities and further that RNs "*have to be thinking all the time, problem-solve and de-escalate often.*"[32]

D.2 Enrolled nurse in residential care - Lay Evidence Report Part C.2

The Lay Evidence Report

105. The ANMF adopt the contents of Lay Evidence Report as it deals with the EN in residential care at [96]–[99].

Evidence of other Frontline Workers

106. Under cross-examination, Lisa Bayram (RN) was asked about the activities performed by the EN at her facility, that the PCW doesn't do. Her response was that:

> "the enrolled nurses work as a team leader, as the - in charge of the ward. They are responsible for the medication rounds. They're responsible for anything that we call clinical care or complex care needs. So, wounds, oxygen therapy, CPAP machines, blood glucose monitoring, anything that's got to do with the illnesses or comorbidities that the residents have. They're responsible for providing leadership for the PCAs.
>
> … And organising the workload for the shift.
>
> …And anything - and anything that the registered nurse asks them to do."[33]

Evidence of officials

107. The evidence of Annie Butler (ANMF Federal Secretary) is that an enrolled nurse is a person with appropriate educational preparation and competence for practice and has acquired the requisite qualification to be an enrolled nurse with the Nursing and Midwifery Board of Australia ("**NMBA**"). The enrolled nurse provides nursing care, working under the direction and supervision of the registered nurse.[34] The EN as a registered professional also has a level of responsibility for overseeing and delivering care.[35]

108. The evidence of Andrew Venosta (RN and Industrial Officer) is that the role of the EN in residential aged care has expanded to support the care planning and assessment

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32 Cross-examination of Kim Bradshaw at PN12816.
33 Cross-examination of Lisa Bayram at PN8072–PN8075.
34 Amended Witness Statement of Annie Butler dated 2 May 2022 at [173].] (tab 181 page 9274).
35 Amended Witness Statement of Annie Butler dated 2 May 2022 at [176].] (tab 181 page 9274).

processes related to resident care under the supervision of an RN. He says that ENs are also often required to take on a role of supervising PCWs.[36]

D.3 Registered nurse in community care - Lay Evidence Report Part C.3

The Lay Evidence Report

109. The ANMF adopt the contents of Lay Evidence Report as it deals with the RN in community care at [100]–[101].

Evidence of other Frontline Workers

110. Patricia McLean (EN) says that since about mid 2020 the initial care plan for her community care clients would be prepared by an RN.[37] She says that RNs act as team leaders and provide support to ENs.[38] Under cross-examination Ms McLean explained that because she was an EN she was always buddied up with the RN, so there would be an RN that she would consult with first and foremost but if she wasn't available then she would have to ring the office to speak with RNs in at the office.[39]

Evidence of employer witnesses

111. Johannes Brockhaus (Buckland CEO) says that when a client accesses home care services from Buckland, an RN undertakes an assessment of the client to help determine the level of care required.[40]

112. At KinCare, if a home care client has level 3 or level 4 funding, then a nurse may undertake a nursing assessment to determine their needs. The result of this, together with work by the customer care manager and the client or family member or next of kin is the development of a care plan that sets out the wants and needs of the client and when the work will be performed.[41]

113. Similarly, Sue Cudmore explains that in-home care work provided by Alliance Community Employees involves an initial assessment of the client's needs and goals which may be conducted by a RN and will become the care plan for the client. Where clients require higher levels of care, clinical care coordinators (RNs) would do the

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36 Amended Witness statement of Andrew Venosta, dated 3 May 2022 at [130] (tab 188 page 11146).
37 Amended witness statement of Patricia McLean, 9 May 2022 at [43] (tab 265 page 13309).
38 Amended witness statement of Patricia McLean, 9 May 2022 at [80]–[81] (tab 265 page 13315).
39 Cross-examination of Patricia McLean at PN9701.
40 Statement of Johannes Brockhaus 3 March 2022 at [149] (tab 293 page 14846).
41 Statement of Cheyne Woolsey dated 4 March 2022 at [33] to [38] (tab 297 page 15717 - 15718).

assessment and write the care plan. Depending on the needs of the client, the RN would either delegate to a care worker or do the work themselves. Where delegating tasks to a care worker, they would supervise that, and would be responsible for the training and the review process.[42]

D.4 Enrolled nurse in community care - Lay Evidence Report Part C.4

The Lay Evidence Report

114. The ANMF adopt the contents of Lay Evidence Report as it deals with the EN in community care at [102]–[103].

115. An enrolled nurse in community care (like the RN and AIN / PCW) works in the variable environment of client homes. In addition to her evidence summarised in the Lay Evidence Report, Patricia McLean (EN) also describes finding it daunting when she would enter a client's home for the first time and the client locked the door behind her.[43] She describes some clients as hoarders of paper, cardboard and other flammable material which is often stacked up between furniture in client's residences so as to restrict her movement through the house and often prevent entry to their toilet.[44] Ms McLean describes that some clients would not like her using their toilets and that some were so dirty or broken that she would not use them.[45]

116. Ms McLean says that until mid-2020 she would prepare care plans for community care clients.[46] She says that often a care plan would require her to make additional assessments and judgements of what treatment she needed to provide. She would also make assessments of the health of every client on every occasion when she had contact with them. She says that her work as an EN at Blue Care involved keeping care plans up to date by making changes as appropriate.[47]

Evidence of officials

117. The summary of the evidence of officials relating to the EN in residential care at [107] above is also applicable to the EN in community care.

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42 Cross-examination of Sue Cudmore at PN13546–PN13548 and Statement of Sue Cudmore dated 4 March 2022 at [32].] (tab 295 page 15071).
43 Amended witness statement of Patricia McLean dated 9 May 2022 at [100] (tab 265 page 13318).
44 Amended witness statement of Patricia McLean dated 9 May 2022 at [101] (tab 265 page 13318).
45 Amended witness statement of Patricia McLean dated 9 May 2022 at [102] (tab 265 page 13318).
46 Amended witness statement of Patricia McLean dated 9 May 2022 at [43] (tab 265 page 13309).
47 Amended witness statement of Patricia McLean dated 9 May 2022 at [44] (tab 265 page 13309).

D.5 Personal carers in residential care - Lay Evidence Report Part C.5

The Lay Evidence Report

118. The ANMF adopt the contents of Lay Evidence Report as it deals with personal carers in residential care at [104]–[127]. As identified in the Lay Evidence Report at [104], persons working as personal carers in residential aged care facilities have job titles including "*assistant in nursing*", "*personal care worker*", "*personal care assistant*", "*extended care assistant*", "*care services employee*" and "*home maker*". In these submissions, the terms "AINs and PCWs" are used interchangeably with "personal carers".

Evidence of officials

119. The evidence of Annie Butler (ANMF Federal Secretary) is that AINs and PCWs work under the supervision of RNs and also with direction from ENs. More experienced and qualified AINs and PCWs can provide "*on the ground*" supervision and direction to other AINs and PCWs.[48]

120. The evidence of Robert Bonner (Director, Operations and Strategy of the Australian Nursing and Midwifery Federation (SA Branch)) is that AINs / PCWs have roles that carry out non-complex components of personal care for residents that are within the scope of practice of a regulated health professional (RN or EN), and that were the province of these nurses in the aged care sector 20 years ago.[49] Under cross-examination, Mr Bonner further explained that the work that AINs / PCWs now do was in many cases undertaken by RNs or ENs 20 years ago.[50]

121. One of these functions commonly undertaken by AINs / PCWs in some jurisdictions is administering schedule 4 medications, which 20 years would have been the exclusive domain of the RN or EN.[51] Likewise, Mr Bonner identified that some of the wound care, some of the observation work of people in end of life care and some of the work in the dementia units undertaken by AINs / PCWs is work that would have been undertaken actively by ENs and RNs 20 years ago.[52]

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48 Amended Witness Statement of Annie Butler dated 2 May 2022 at [174].] (tab 181 page 9274).
49 Witness Statement of Robert Bonner dated 29 October 2021 at [86].] (tab 187 page 10812 - 10812).
50 Cross-examination of Robert Bonner dated 29 October 2021 at PN8991.
51 Cross-examination of Robert Bonner dated 29 October 2021 at PN8992–PN8993.
52 Cross-examination of Robert Bonner dated 29 October 2021 at PN8994.

D.6 Personal carers in community care - Lay Evidence Report Part C.6

The Lay Evidence Report

122. The ANMF's application to vary the Nurses Award applies to Nursing Assistants who provide "*nursing care*" and services for an aged person in a private residence.

123. . "*Nursing care*" is defined broadly under the Nurses Award at Schedule A.2 as meaning:

> "• giving assistance to a person who, because of disability, is unable to maintain their bodily needs without frequent assistance;
>
> • carrying out tasks which are directly related to the maintenance of a person's bodily needs where that person because of disability is unable to carry out those tasks for themselves; and/or
>
> • assisting a registered nurse to carry out the work described in clause A.5 [pertaining to the RN]."

124. The ANMF adopt the contents of the Lay Evidence Report as it deals with personal carers in community care at [128]–[149]. All of this evidence will be relevant to the ANMF's application with respect to the Aged Care Award. This evidence will also be relevant to the ANMF's Award Minimum Wages Variation with respect to the Nurses Award to the extent that this relates to the provision of "*nursing care*".

125. Relevant to the provision of nursing care, the Lay Evidence Report identifies evidence consistently given under cross-examination to the effect that where an in-home carer observed, for example, bruising on a resident, they would take a photo and report it to their manager or RN or case manager.[53] If the in-home carer required help with clinical care, they would report this to their team leader and this may lead to an RN attending to provide clinical assistance if this is funded in the client's package. Some in-home carers were able to contact a RN directly.[54]

Evidence of employer witnesses

126. Cheyne Woolsey (CEO of KinCare) identifies one of the biggest challenges faced by home care workers as being the environment and that they do not know what situation they are walking into.[55]

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53 Lay Evidence Report at [134].
54 Lay Evidence Report at [137].
55 Statement of Cheyne Woolsey dated 4 March 2022 at [42] (tab 297 page 15718).

127. Sue Cudmore (who has operational control of Alliance Community) expects that personal carers employed by Alliance Community, would be able to know what work can and can't be performed based upon what is a handbook[56] which is very detailed and at times complex and confusing.[57]

128. Johannes Brockhaus (Buckland CEO) says that home carers working for Buckland would be provided with the service plan/care plan for a client before going to clients.

D.7 Nurse Practitioners - Lay Evidence Report Part C.7

The Lay Evidence Report

129. The ANMF adopt the contents of Lay Evidence Report as it deals with Nurse Practitioners (**NPs**) at [170]–[172].

130. The Lay Evidence Report at [170] summarises the evidence of NPs Hazel Bucher and Stephen Voogt who describe their duties as including:

> "Managing most medical clinical needs for residents. Examples of the types of issues managed include chronic issues around dementia, cognition, mental health, chronic pain, falls, and infections. This involves monitoring medical issues and geriatric syndromes and usually requires assessment, investigations, and pharmacological intervention; …"

131. Further to the Lay Evidence Report Stephen Voogt (NP) was asked in cross-examination what it is that he can do that a registered nurse is not allowed to do. He answered, stating:

> "… So what it means is we have extended scope of practice. So we're allowed to do a lot of similar things as doctors. So we can order diagnostics and we can interpret those diagnostics, and we can then manage any illnesses through therapeutic medication. So we can prescribe, we can refer to specialists, we can order pathology and we can order radiology. So, yes, it's an extended scope of practice."[58]

D.8 Nursing Teams

132. In its opening Submissions, the ANMF pointed to the nursing team as the foundation for the delivery of care in accordance with the care plan. ANMF submitted that the nursing team comprised registered nurses, enrolled nurses and AINs/ PCWs working

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56 Cross-examination of Sue Cudmore at PN13587–PN13588.

57 Statement of Sue Cudmore of 4 March 2022 at "SC-05" (tab 295 page 15089 ff) and see generally cross-examination of Sue Cudmore at PN13593 –PN13693.

58 Cross-examination of Stephen Voogt at PN9295.

together.[59] Registered nurses, enrolled nurses and AINs/ PCWs working in aged care are hereafter collectively referred to as "direct care workers". The ANMF Submissions also pointed to the importance of the resident care plan in providing the foundation for the work and cooperative activity of the nursing team.[60]

133. As discussed further below at Part E.4.5, the Lay Evidence Report devotes a section to Care Plans. The material selected in the Lay Evidence Report in respect of Care Plans illustrates the relationships between the different members of the nursing team.

Evidence of officials

134. As described by Annie Butler (ANMF Federal Secretary) nursing care has shifted away from a task-based approach to nursing to a holistic approach. Nursing practice occurs along a spectrum; AINs and PCWs contribute to aspects of nursing care. There is crossover between AINs and PCWs and what ENs deliver, and then ENs and RNs, up to the NP as the highest level of that continuum.[61]

135. Under cross-examination, Ms Butler also gave evidence about the nursing team in relation to development of care plans. She responded to a question from Mr Ward as follows:[62]

> "Am I - we've had some evidence, I just want to see if it's consistent with your understanding, once the care plan is constructed, we've had a variety of evidence that says that the registered nurse will have the benefit of the progress notes on a particular resident and will from time to time review those and will make decisions as to whether or not the care plan should be amended. And that the registered nurse holds the authority to amend the care plan. Is that your understanding?---The registered nurse holds the - is the person responsible for developing and assessing and evaluating care and therefore amending the care plan. It can't be done in isolation, it just can't be. The contributors - everyone in that - what we would describe the nursing team and the care team has to contribute to any amendment and to changes that happen that then need to be changes made in the care plan so that care can be adjusted. In many times, you know, the personal care worker is the person making the observations.
>
> Yes?---And those observations have to be recorded and have to be–they form a vital part of how the care plan can actually operate effectively."

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59 Submissions of the Australian Nursing and Midwifery Federation dated 29 October 2021 (**ANMF Opening Submissions**) at [63], [77], [91], [89] and [210].

60 ANMF Opening Submissions at [63], [67] to [70], [73], [74] and [77].

61 Cross-examination of Annie Butler dated 2 May 2022 at PN3409.

62 Cross-examination of Annie Butler at PN3415 – –PN3416.

Evidence from frontline workers

136. Sheree Clarke an AIN at Opal Health Care at Morayfield Grove in her statement referred to her work as part of a nursing team including registered nurses at as follows:

> "I work as part of a nursing team. This means that I am never solely responsible for specific residents. As a team, we are together responsible for all residents. In a nursing team it is essential that I know other AINs have my back. I make sure that I have the back of my co-workers. For example, some residents are sometimes abusive or racist towards my co-workers. When this happens, I feel that I have a responsibility to assist the resident but also support my co-worker.
>
> RNs are an essential part of the nursing team. As an AIN, I keep abreast of what is happening and provide information to the RN. I also need the clinical skill of the RN to lead me. RNs have the education and training for clinical matters. Sometimes resident behaviour gets to the point that I cannot deal with it and I will require the assistance of the RN. If resident has a fall, I will need the RN to assess how to proceed before I can lift the resident off the floor."[63]

137. Jocelyn Hofman (RN at Bodington Aged Care) gave evidence of the role of the nursing team in delivering care in accordance with the care plan. She described the team as comprising registered nurses, enrolled nurses and AINs, PCWs, CSEs and gave evidence about the increased skills required of registered nurses to manage the nursing team.[64] At [19], [26] and [31] she said:

> "19. I work as part of a nursing team. I lead a team of Care Staff Employees (CSEs) Enrolled Nurses (EN) and if I'm delegated in charge of the facility, the other two Registered Nurses (RNs) from the other wings will consult and notify me of any issues of concern in their allocated areas.
>
> …
>
> 26. My role as a Registered Nurse is to also write the care plans. It is up to the Registered Nurse to be across the resident's needs and liaise with allied health and general practitioners. The care plan is the core document that informs the delivery of care in accordance with resident's needs. The plan provides the basis upon which the work of the nursing team of RNs, ENs and AINs/PCWs/ CSEs is directed. I remain accountable for the delivery of the care while on duty.
>
> …
>
> 31. The changes in the health status of the residents on admission and continuing post admission have an impact on the nature of the work of the registered nurses, enrolled nurses and CSEs at Bodington. In many respects, registered nurses are required to exercise the clinical skills and judgements found in a range of fields of nursing as diverse as mental health, oncology, diabetes, palliative care and gerontology. Also importantly are the nursing skills and attributes required to provide safe, respectful, dignified and high quality care. These are the skills required to deliver intimate and personal care;

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63 Witness Statement of Sheree Clarke dated 29 October 2021 at [47]–[48] (tab 268 page 13371).

64 Witness Statement of Jocelyn Hofman, dated 29 October 2021 at [39.] (tab 261 page 13156).

> the skills required to address aggressive or agitated behaviours; the skills whether personal, emotional or nursing skills required to attend in the process of dying and death for residents and to support and guide family members; the skills to manage the nursing team as a manager and as the accountable clinician; the skills to liaise with medical practitioners and allied health practitioners; the skills needed to act as a resident advocate. It is a specialised job requiring a diverse set of skills."

138. Linda Hardman (Nursing Assistant at Estia Health Figtree) referred to constant communication between members of the nursing team made up of AINs, RNs and ENs at [62] of her statement:

> "I work as part of a nursing team. It is made up of AINs, ENS, and RNs. I have described my tasks above, at paragraph 20. ENs are responsible for things like dispensing medication and wound dressings (which AlNs do not do), and of course for paperwork. RNs also dispense medication (including some that ENs do not), apply wound dressings, and attend to paperwork. There is constant communication between AINs, ENs, and RNs."

139. Ms Mashford an AIN at Regis Aged Care Wynnum referred to her work as part of a nursing team as receiving handover from other assistants in nursing and instructions from a registered nurse at [39]:

> "1 work as part of a nursing team. On shift I get a handover from other AINs as discussed above. Information from RNs is passed on to me via a printed information document for each wing. This is usually about 4-5 pages long. It deals when things that need to be done for each issue for and individual (for example, when a particular resident needs to be compression stockings put on). It identifies things like complex needs, pressure area."

140. Ms Bayram (RN in Charge and After-Hours Co-ordinator) referred to her role in her statement as a team leader of staff delivering care in a 22 bed wing:

> "In my role as AHC on PM shift I have overall responsibility for resident care in the whole facility and as the team leader for the 22-bed wing I am also responsible for direct patient care and overseeing the staff in that wing. If something happens in another part of the facility requiring my attention, I need to drop my usual routine and attend to it. For example, if a PCA found a new wound on a resident, I would need to assess this so that they could implement changes. This sort of event occurs very regularly."[65]

141. Ms Bayram's evidence during cross examination by Mr Ward (at PN8135 to PN8137) dealt with the respective roles of RNs and AINs / PCWs in the changing of care plans and the observations of AINs / PCWs:

> "If they observe something serious, we've already agreed that that would be referred to the EN or the RN such as bruising or a wound or something like that. I take it that those observations are reviewed by the RN on a regular basis

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65 Witness Statement of Lisa Bayram dated 29 October 2021 at [35].] (tab 262 page 13230).

> to determine if the care plan should be changed?---Yes.
>
> Is it the RN who has the authority to change the care plan?---There is some documentation that the PCAs are able to do but they wouldn't do that without discussing that with the RN first and with the sheer volume of documentation that needs to be done, we're trying to upskill the PCAs to be able to take on some more of that with the nursing staff oversight. So if they did something like if they thought that the continence care for a resident needed to be changed, they could discuss that with me. I would say yes or no, that's what we should do and then the continence assessment in the care plan, they would then be able to go in and make some changes to that, and then I could sign it off.
>
> Okay. So, you could listen to what they're suggesting based on their observations, you could make a decision to proceed. To save you time they could manually change to the care plan and then you would sign a new one off?---Yes."

142. In her statement Ms Bayram referred to her role is assisting the AIN / PCW team leaders[66] and in her oral evidence to nurses as the team leader in the context of the responsibility for talking to families about a skin tear or bruise.[67]

143. Part of the nursing team are the AIN / PCW team leaders. Numerous witnesses refer to the role of these team leaders. The evidence as to their responsibilities over and above that of other AINs / PCWs included:

(1) Ms Curry's Reply Statement (AIN Team Leader at Warrigal Mount Terry) referred to her role as a Team Leader in respect checking on inexperienced staff [26]; medication administration [58], [67]; referral to allied health staff and doctors [67]; and wound care [80].

(2) Ms Boxsell (Care Staff Team Leader at Evergreen in West Gosford) in her statement refers to her mentoring, performance management and supervision of her team [32], [69]; attending to resident falls [34]; liaising with external health professionals in respect of complex wounds and behaviour issues [63]; and reporting to the RN on resident mood change [65].

(3) Paul Jones (Care Services Employee at United Protestant Association NSW) refers to Team Leaders when rostered as co-ordinating work of staff [49], but that on evenings with no RN or Team leader rostered on site he is the most senior team member on site when administering medications [29].

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66 Witness Statement of Lisa Bayram dated 29 October 2021 at [38(d)].)] (tab 262 page 13231).

67 Cross-examination of Lisa Bayram at PN8146.

Evidence of employer witnesses

144. The evidence establishes the importance of the nursing team in the delivery of care and in framing the work of RNs, ENs and AINs / PCWs. The employer witnesses gave the following evidence about the teams:

(1) Ms Bradshaw (General Manager Stirling Residential Care) when asked about her reference to her team as including registered nurses and assistants in nursing or care service employees (CSE). She said:[68]

> "When I talk "team" on the floor, and it is very much a team and it has to be."

(2) Ms Bradshaw's evidence about care for an unsettled resident was that:[69]

> "Registered nurses will mentor (audio mal-function) on the floor, especially if we have noted that we have an unsettled resident, that the whole team is aware of it and they will talk about what their strategies for that resident might be for that day, what has worked, what hasn't worked."

(3) Ms Bradshaw's evidence in speaking of the role of AIN's in the nursing team in response to a question in cross-examination was as follows:[70]

> "And I take it you would agree that it's undoubtedly a function of the role of an AIN to ensure that social and emotional wellbeing of residents?---Yes. They are part of the whole team that do that. We all do that, yes."

(4) Mr Sewell's (CEO Warrigal) evidence on the question of the development of care plans underscored the team approach. He agreed with the description from counsel for the HSU that the purpose of the process of developing a care plan is to have a team approach utilising the more clinical skills in a registered nurse, but the hands-on knowledge that the care worker has of the resident and their conduct and behaviour and desires.[71]

(5) Ms Brown (Warrigal Special Care Project Manager) gave evidence about the role of AINs in the nursing team when a resident doesn't seem their usual self

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68 Cross-examination of Kim Bradshaw at PN12826.
69 Cross-examination of Kim Bradshaw at PN12824.
70 Cross-examination of Kim Bradshaw at PN12767.
71 Cross-examination of Kim Bradshaw at PN13028.

she would rely upon the skills of observation of the AINs to identify that in the first place, saying:[72]

> "Yes, I'm relying on them as being part of a team to, yes, report up anything that's unusual."

[72] Cross examination of Emma Brown at PN13358.

E. Evidence of relevant to work value, separated into themes

145. In the same way as Part D mirrors relevant parts of Part C.2 of the Lay Evidence Report, this Part E mirrors Part D of the Lay Evidence Report. That is, this part has the same 15 subparts, in the same order, and with the same subdivisions as the Lay Evidence Report. There, they are sub-parts D.1–D.15; here, in the same order, those matters are addressed in sub-parts E.1–E.15 below.

146. As recognised in the Lay Evidence Report, there is a great deal of evidence about the impact of the COVID-19 pandemic on employees and their workplaces.[73] However, whereas the Lay Evidence Report did not identify such evidence this Part E also addresses COVID-19 at sub-part E.16 in addition to the subparts identified in Part D of the Lay Evidence Report.

147. Again, the approach will be, under headings that refer to the relevant part of the Lay Evidence Report, to adopt such of the Lay Evidence Report as the ANMF relies upon in support of its case, and then to add <u>further</u> evidential references where necessary. In summary, therefore, this Part E should be read together with, and as supplementing, the Lay Evidence Report.

E.1 Increased acuity and more complex needs in residential care - Lay Evidence Report Part D.1

Agreement between interested parties as to this factor

148. The ANMF relies upon the content of [1], [2], [7], and [8] of the Consensus Statement, which state as follows:

> "Australians are living longer. The proportion of Australians over the age of 65 is set to increase from 15 per cent to 23 per cent by 2066. With advanced age often comes increased frailty which is associated with increased morbidity, declining function and a concurrent need for supports. As a result, aged care consumers are entering aged care with more frailty, co-morbidities and acute care needs. Thus, the acuity of recipients of aged care services has increased and this trend is expected to continue.
>
> The proportion of people with dementia and dementia-associated conditions receiving aged care services has increased.
>
> …
>
> In each of the settings, consumers are increasingly requiring and receiving care to meet more complex needs including acute and sub-acute care. The need for

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73 Lay Evidence Report at [3].

> socio-emotional skills in addition to clinical and care skills is more apparent.
>
> There is an increase in the number and complexity of medications prescribed and administered."

149. Similarly, BaptistCare submits that acuity levels of residents in residential aged care have trended upwards over time (at [13]), and the work involved in providing care has increased in complexity over time (at [24]).[74]

150. IRT submits that the increased life expectancy of older Australians has resulted in residents presenting with more acute care needs, greater levels of frailty, and increased co-morbidities, as well as a significant increase in the incidence of dementia and other mental health issues.[75]

151. UnitingCare Australia submits (at page 2 of its submission) that aged care work is more complex than it used to be, in line with increased clinical support requirements, increased acuity, frailty, and dementia, declining function, a cultural transformation towards consumer-directed care, and management of more complex comorbidities.[76]

152. Evergreen Life Care submits that its staff are required to have a higher skill level to address the increased complexity of residents, particularly those living with dementia, which increased skill requirements have not been reflected in pay.[77]

153. The State of Victoria stated that approximately 48 per cent of residents in its aged care residential services had complex care needs, such as requiring tube feeding, complex wound care, disruptive behaviours, and chronic mental illness (at [11]).[78]

154. Background document 1 (at [116.2]) recognises the following as apparently uncontentious:

> "The acuity of residents and clients in aged care has increased. People are living longer and entering aged care later as they are choosing to stay at home for longer and receive in-home care. Residents and clients enter aged care with increased frailty, co-morbidities and acute care needs."

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74 Submissions of BaptistCare (tab 126 pages 876, 877).
75 Submissions of IRT at [5]–[6] (tab 128 page 1117).
76 Submissions of UnitingCare Australia (tab 129 page 1121).
77 Submissions of Evergreen Life Care (tab 132 page 3130).
78 Submissions of Victoria (tab 134 page 3136).

The Lay Evidence Report

155. The ANMF adopts Lay Evidence Report [258]–[275], which sets out extracts from the evidence of (*inter alia*) Jocelyn Hofman (RN) at [37], and Linda Hardman (AIN / PCW) at [26]–[31]. Also relevant in Ms Hardman's statement are [32]–[33]:[79]

> "There are also a lot more residents who have dementia or mental illness. I detail the effects of this, below.
>
> And, higher-acuity patients tend to have a greater need for wound care. For the AINs, that means a greater workload in terms of lifting and transferring so that ENs or RNs can attend to wounds."

156. As to dementia, Ms Hardman continued at [46]–[50] as follows:[80]

> "46. The number of residents with dementia or mental health issues has increased a lot over my time in aged care.
>
> 47. Dementia and mental illness cause difficult behaviours in residents, including aggression and violence.
>
> 48. So, much more than used to be the case, carers are faced with aggressive or violent residents. It is not unusual for residents to try to hit you.
>
> 49. There is also, I think for the same reasons, more verbal aggression than there used to be. Some residents are frustrated or in denial as to the need for them to be in care. They might be angry at their families, but because you are the person who is there, you get the abuse.
>
> 50. Another factor that leads to behaviours is that, especially after the Royal Commission, there has been a push to get residents off anti-psychotics or on reduced doses. In theory this is a good idea. In practice, my experience has been that when residents are taken off antipsychotics, often their behaviours get worse. As an AIN, I feed that back to the ENs and RNs, but even if doses are re-increased, in the meantime I am dealing with the behaviours."

Evidence of other Frontline Workers

157. In addition to those evidential references, the ANMF relies on the evidence of the following Frontline Workers:

158. Hazel Bucher (NP) says, at [39], as follows:[81]

> "The needs of the residents have increased in complexity since 2010. The prevalence of depression and dementia in RACF living is high, requires energy and insight from nursing staff to draw the resident into attending activities which once engaged, they will likely enjoy whilst also monitoring for increased risks of falls and choking episodes."

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79 Statement of Linda Hardman dated 29 October 2021 (tab 263, page 13269).
80 Statement of Linda Hardman dated 29 October 2021 (tab 263, page 13271).
81 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13125).

159. Ms Bucher draws attention to the fact that official data supports her own observations. The documents to which she refers state as follows:

(1) In 2019–2020, 54 per cent of people living in permanent residential aged care had dementia;[82]

(2) 81 per cent of people with dementia required high levels of care in the "*cognition and behaviour*" ACFI domain, 71 per cent in the "*activities of daily living*" domain, and 56 per cent in the "*complex health care*" domain;[83]

(3) The number of people with dementia is predicated to rise markedly in future—projected to more than double by the year 2046. As a leading cause of death and burden of disease, the demand that dementia places on health and aged care services is expected to increase considerably over time;[84]

(4) The proportion of people with a "*high*" care needs assessment has increased over time for every care domain over the period 2009–2017, except for a reduction in the complex health care domain in 2017;[85]

(5) Over the decade 2009–2019, cultural and linguistic diversity increased in that the percentage of residents from non-English speaking countries increased, from 16.7 per cent in high care and 12.6 per cent in low care to 19.8 per cent;[86]

(6) The care needs data collected through the Aged Care Funding Instrument show a substantial increase in the proportion of residents classified as having high care needs in each of the three care domains. By 2019, one in three residents was classified as "high care" on all three domains. The greatest increase in high care needs related to complex health care (from 13 per cent to 52 per cent);[87]

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82 Australian Institute of Health and Welfare, (2021) *Dementia in Australia 2021 Summary Report*, page 13 (tab 439 page 27911).

83 Australian Institute of Health and Welfare, (2021) *Dementia in Australia 2021 Summary Report*, page 13 (tab 439 page 27911).

84 Australian Institute of Health and Welfare, (2018) *Older Australia at a Glance* (tab 425, page 27193).

85 Australian Institute of Health and Welfare, (2018) *Older Australia at a Glance* (tab 425, page 27219).

86 Gibson D, (2020) *Who uses residential aged care now, how has it changed and what does it mean for the future?*, page 821 (tab 440, page 27926).

87 Gibson D, (2020) *Who uses residential aged care now, how has it changed and what does it mean for the future?*, page 823 (tab 440, page 27928).

(7) Just over half the people in residential aged care have a diagnosis of dementia (52 per cent), and 49 per cent have a diagnosis of depression;[88]

(8) Dependency levels and complex care needs are increasing;[89]

(9) Diagnoses of depression, use of anti-depressant medication, and polypharmacy all increased significantly between 2016/2017 and 2020/2021.[90] Polypharmacy, in particular, went from 44 per cent to 54 per cent in that period of four years.[91]

160. Ms Bucher also listed, at [42] and [43], changes in residential aged care over the last ten years, including:[92]

(1) increased wound care complexity ([42(a)]);

(2) more-challenging medication administration including polypharmacy ([42(b)]);

(3) dealing with increased co-morbidity and higher levels of acuity, substantially due to the ageing population and people staying at home as long as possible [42(l)];

(4) increased complexity and acuity at the time of admission, reflected in matters such as level of frailty, co-morbidities, poly-pharmacology, fall risks, and the number and severity of cognitive and dementia-related conditions ([43(b)]).

161. These matters, Ms Bucher said, resulted in an increase in the intensity and complexity of the work performed (at [44(b)]).[93]

162. Suzanne Hewson (EN) described (at [24]) increasing complexity of residents' care needs in the following domains: medication; nutrition and hydration; dementia care; social support; palliative care; co-morbidity and acuity.[94] Ms Hewson also noted,

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88 Gibson D, (2020) *Who uses residential aged care now, how has it changed and what does it mean for the future?*, page 823 (tab 440, page 27928).
89 Gibson D, (2020) *Who uses residential aged care now, how has it changed and what does it mean for the future?*, page 823–824 (tab 440, page 27928–27929).
90 Reierson F, (2021) *Trends in Medication Use 2016-2021*, page 2 (tab 441, page 27936).
91 Reierson F, (2021) *Trends in Medication Use 2016-2021*, page 2 (tab 441, page 27936).
92 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13126–13127).
93 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13128).
94 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13422).

at [27], that there had been a notable increase in violence from advanced dementia residents after a decrease in use of antipsychotics.[95]

163. Wendy Knights (EN) describes (at [12]–[13]) a change in the nature of aged-care residents which occurred, to her observation, in around 2008:[96]

> "… Based on my observations and speaking with incoming residents and their families at the time [2008], I understood that people were coming into nursing homes later than they used to, because there was funding for them to be in home care for longer. This meant that their care needs were much higher when they did enter nursing homes. I thought I needed to upskill to address those higher care needs.
>
> Before around 2008, there were clear differences between people entering aged care homes and needing low care, versus those who needed high care. After 2008 (and to the present day), nearly everyone is high care, or advanced care / hospice. I describe the differences this has meant in terms of my work, later."

164. Ms Knights continued at [19] as follows:[97]

> "The average age of residents (and, correspondingly, their care needs) has dramatically increased over my time in aged care. We have many residents in their 80s, 90s, and even 100s. We do classify about 56 residents as low care (in 7 units) because they are more mobile, but within that group there would only be 4 or 5 who are really low care. We have two 'advanced care' units–with 16 and 12 residents respectively, as well as a dementia unit of 18 residents. While there is a specific dementia unit, many people in other units have dementia but the dementia-specific unit is used for those with more significant behavioural issues."

165. Ms Knights set out at [34]–[38] her experience of increased acuity over the last decade or so. That evidence included the following: that the care needs of residents had increased dramatically over that time (at [34]); that the general physical capacity of residents is much reduced from the early 2000s (at [35]); that residents are less mobile and incontinence has increased (at [38]). Ms Knights listed activities of day-to-day living with which residents did not previously require assistance, but now do (at [36]–[37])—including showering, drying, dressing, making coffee, going to the dining room, transferring into wheelchairs, *etc*.[98]

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95 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13423).
96 Statement of Wendy Knights dated 29 October 2021 (tab 22 page 13439).
97 Statement of Wendy Knights dated 29 October 2021 (tab 22 page 13440).
98 Statement of Wendy Knights dated 29 October 2021 (tab 22 page 13443).

166. Ms Knights also describes (at [39]) that, "*things have changed significantly with medications*," including in that, "*[t]here are a lot more cancer drugs used*," and that "*[s]ome residents can be on up to 15 medications at a time*."[99]

167. As to dementia, Ms Knights identifies that there are far more residents with dementia than used to be the case (at [50]), which increases their care needs (at [50]), that there are fewer physical constraints which increase fall risks (at [51]), and that there has been a dramatic reduction in anti-psychotic medication after the Royal Commission (at [52]), which has led to "*atrocious*" behaviours (at [53]).[100]

168. Next, Ms Knights states that there are more residents, and more carers, from culturally and linguistically diverse backgrounds than was the case when she started at the Princes Court residential aged care facility (at [76]–[77]),[101] which was in around 2009.[102]

169. Finally, Ms Knights says that there is a far-greater number of residents who spend their end stage at the facility, and that that requires skills and an advanced level of emotional competence (at [82]).[103]

170. Christine Spangler (AIN / PCW) says as follows in regard to acuity, at [24(k)]:[104]

> "i. Acuity is higher than it used to be. People tend to stay at home for longer because of the home care packages. So by the time they get to us, their needs are a lot higher. Residents can be admitted straight from hospital, sometimes with not long left to live.
>
> ii. Residents generally have higher care needs now, compared to when I started at St Anne's. They need to call for assistance more frequently. Residents and their families generally have higher expectations than they used to about the standard of service."

171. And, at [34], Ms Spangler says that a result of residents being in a more acute condition is that:

> "Problematic behaviours such as violence and verbal abuse are a lot more common than when I first started. I have personally had my shoulder dislocated by a violent resident, and I needed surgery to fix it. I have been scratched, pinched and bitten. Sometimes a resident will ram their walker into you on purpose. On one occasion on an afternoon shift, I put a resident to bed and she slapped me on the face. I then put her roommate to bed and she slapped me on

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99 Statement of Wendy Knights dated 29 October 2021 (tab 22 page 13443).
100 Statement of Wendy Knights dated 29 October 2021 (tab 22 page 13445).
101 Statement of Wendy Knights dated 29 October 2021 (tab 22 page 13449).
102 Statement of Wendy Knights dated 29 October 2021 at [3] (tab 22 page 13438).
103 Statement of Wendy Knights dated 29 October 2021 (tab 22 page 13450).
104 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13016).

the other side of my face."

172. The evidence of Irene McInerney (RN) is that needs of residents have become increasingly complex. In her witness statement at [39], Ms McInerney specifically identifies the following areas of increased complexity (also specifically describing in her witness statement how it is that complexities in each area have increased):

(1) Wound care;

(2) Medication;

(3) Pain management;

(4) Infection control and prevention;

(5) Food, nutrition, and hydration;

(6) Continence care;

(7) Dementia care;

(8) Mobility and falls;

(9) Social supports;

(10) Quality of life;

(11) End of life / palliative care;

(12) Greater and/or increased co-morbidity and acuity.

173. As for the last area, Ms McInerney describes an increase in comorbidities. She says that the focus on aging at home has meant that by the time people can no longer cope (with support in the community) they are really frail and in need of considerable care support. Residents often have multiple illnesses–heart disease, diabetes, peripheral vascular disease, arthritis etc. She describes her facility as sometimes feeling like a hospital but with a lot less staffing than in the public sector.[105]

174. Ms McInerney also describes the health setting of a residential facility as dynamic and lacking the stability and predictability there had been 10 years ago. She says that the existence of co-morbidities, greater psycho-social needs, poly pharmacology and

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105 Statement of Irene McInerney dated 10 May 2022 at [39] (tab 260 page 13144–13145).

complex disease processes demand increased complexity in nursing assessment and sophistication in identifying changes and illness.[106]

175. The evidence of Dianne Power (AIN) is that some of the more complex care tasks now completed by AINs were done by ENs when she first started working as an AIN in 2012.[107] Under cross-examination she explained that these more complex care tasks included medications such as ear, eye and nose drops, nebulizers, cleaning of suprapubic catheter sites and changing of catheter bags, all of which were RN and EN work when she first started.[108]

176. The increased acuity and more complex needs in residential care are magnified by difficulty accessing General Practitioner services within aged care clinics. Stephen Voogt (NP, Gerontology) gives evidence of his experience that some GPs are not providing adequate services into aged care facilities and that this has become worse over the years. He identifies that in Wangaratta there is one GP practice which is now refusing to provide care to residents in the aged care facilities and that a second practice may soon also withdraw from working in aged care facilities. As a consequence, he identifies that the GPs who continue to provide services to residential aged care facilities have less time to service residents in those facilities. Residents are more heavily reliant on NPs and RNs in the facility to try and monitor, observe and treat.[109]

177. Mr Voogt considers that residents of aged care facilities are the most complicated group of people to look after in our community. He considers that some GPs are not spending the necessary time to do this.[110] He says that the reduction in GP availability, the lack of support and changes to resident acuity means that the nurses on site must be more skilled, observant and responsible.[111]

178. Witnesses also identified the more complex needs of culturally and linguistically diverse residents and clients (*inter alia*):

    (1) Maree Bernoth (RN and Associate Professor) gives evidence of her research and supervision of other research dealing with cultural diversity and have also

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106 Statement of Irene McInerney dated 10 May 2022 at [40] (tab 260 page 13146 – 13147).
107 statementStatement of Dianne Power 29 October 2021 at [51] (tab 258 page 13109).
108 Cross-examination of Dianne Power at PN9516 [– [–PN9523.
109 Amended witness statement of Stephen Voogt dated 9 May 2022 at [28] (tab 269 page 13395).
110 Amended witness statement of Stephen Voogt dated 9 May 2022 at [31] (tab 269 page 13395–13396).
111 Amended witness statement of Stephen Voogt dated 9 May 2022 at [32] (tab 269 page 13396).

observed this in aged care facilities. She observes that there are now more residents in aged care facilities from culturally and linguistically diverse backgrounds and that the use of aged care facilities by first nations people is increasing. She identifies that this causes challenges in providing adequate care and takes extra time. With this diversity there is also requirement for the staff to be culturally aware and culturally safe.[112]

(2) Patricia McLean (EN) says that she has cared for aged care residents and community care clients from diverse cultural and linguistic backgrounds.[113] Ms McLean describes that where a client did not speak English, sometimes a family member would assist in translation but if no one was present to translate, she would communicate with them in very simple English and worked to understand their broken English.[114] She says that the need for her to respond to cultural, emotional, social, and psychological needs of residents and clients was always been part of her job, but has increased, especially in recent years.[115]

(3) Linda Hardman (AIN / PCW) at [24] observed that the diversity of residents has changed over time. She says that there is an increase in residents from various cultural backgrounds and it can make it more difficult to communicate with the residents. She relies on non-verbal cues and tries to learn some of their language to understand their needs;[116] and

(4) Stephen Voogt (NP) at [46] identifies residents from over ten nationalities at a facility where he was working, noting that there is a need to recognise each of the nationalities which is extremely difficult for staff.[117]

Evidence of officials

179. There is also evidence of union officials relevant to increased acuity of residents in residential aged care facilities.

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112 Witness Statement of Maree Bernoth dated 29 October 2021 at [54].] (tab 264 page 13284).
113 Amended witness statement of Patricia McLean dated 9 May 2022 at [65] (tab 265 page 13312).
114 Amended witness statement of Patricia McLean dated 9 May 2022 at [66] (tab 265 page 13313).
115 Amended witness statement of Patricia McLean dated 9 May 2022 at [67] [– [–[68] (tab 265 page 13313).
116 Statement of Linda Hardman dated 29 October 2021 (tab 263 pages 13268).
117 Amended witness statement of Stephen Voogt dated 9 May 2022 at [46] (tab 269 page 13399).

180. Kathryn Chrisfield (Occupational Health and Safety Team Manager, ANMF), draws attention to the increased occupational health and safety risk posed by:

(1) the increase in bariatric residents in aged care (as in the community) (at [30]);[118]

(2) increasing numbers of residents with dementia or other altered mental states becoming disoriented or defensive (or aggressive) (at [32]);[119]

(3) increases in acuity and care required in a general sense, leading to increased workload pressures (at [47]).[120]

181. Julianne Bryce (Senior Professional Officer, ANMF) also refers, at [50]–[51], to the impacts of increased acuity:[121]

> "50. The higher acuity of care required by residents, significant reduction in the number of nurses and substantial increase in the number of care workers has seriously impacted the nursing care required and the staffing and skill mix. There is a greatly increased burden of responsibility and accountability for registered nurses relating to both the provision of direct care and supervising and delegating nursing care provided by others.
>
> 51. Nurses have had to work in extremely difficult circumstances, due to these resident profile, workload, staffing and skill mix changes, in order to meet residents care needs, support their care worker colleagues and meet their professional regulatory requirements under the National Law. Nurses working in aged care are incredibly committed to providing safe, quality care for residents. Fatigue and burnout are major issues for the aged care workforce."

182. Increases in acuity in residential aged care are borne out by the Report on Government Services 2021 at Part f, section 14 relating to "Aged care services", addressed by Annie Butler her Amended Witness Statement (at [131]–[134]).[122] Table 14A.12 to that report records data collected by the Department of Health. The data provides statistics on three domains under which aged care residents are assessed under the Aged Care Funding Instrument (ACFI), namely:

(1) Activities of Daily Living (ADL),

(2) Behaviour and Cognition; and

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118 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10744).
119 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10745).
120 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10748).
121 Statement of Julianne Bryce dated 29 October 2021 (tab 189 page 13116).
122 "ANMF 15" – 14A.12 – Average annual Australian Government basic subsidy amount, including Conditional Adjustment Payment, per occupied place and the dependency level of aged care residents (a).

(3) Complex Health Care (CHC).

183. At annexure "AB 6" to her Amended Witness Statement, Annie Butler sets out data extracted from Table 14A.12 for the years 2010–11 to 2019–20.[123]

184. In summary form, the data in the spreadsheet shows in relation to ADLs that:

(1) The percentage of residents classified as needing high care increased from 41 per cent in 2010-11 to 63 per cent of residents in 2019–20; and

(2) The percentage of residents classified as having low care needs decreased from 26 per cent in 2010-11 to 8 per cent in 2019–20.

185. In relation to Behaviour and Cognition, the percentage of residents classified as needing high care has increased from 48 per cent in 2010–11 to 65 per cent in 2019–20.

186. In relation to Complex health care, in 2010–11 only 23 per cent of residents were assessed as having high care needs compared with 54 per cent in 2019–20.[124]

187. Based on this and additional data, the unchallenged opinion of Ms Butler is that there has been a significant increase in what can be described as resident acuity when entering residential aged care.[125]

188. By contrast to current levels of acuity, Robert Bonner (Director, Operations and Strategy of the Australian Nursing and Midwifery Federation (SA Branch) describes the type and acuity of residents in hostels and nursing homes in the 1990s as much less complex than it is today. His evidence is that often residents were "social" admissions or the people who were at the time referred to as the "worried well." They were widowed or single men and women who may have had few family contacts and apart from ageing and some minor medical complexity they needed some assistance with

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123 See Amended Witness Statement of Annie Butler dated 2 May 2022 at [131]–[135] and Annexure AB 6. (tab 181 page 9267–9268 and 9298).

124 With respect to the increase in the percentage of residents assessed as having complex health care needs, this increase is likely to be higher than reflected in the figures, due to the Commonwealth Government changing the questions and ratings used in assessing needs in the complex health care domain. The change is explained in the July 18 ACFA report, see Aged Care Financing Authority, Sixth Report on the Funding and Financing of the Aged Care Sector (Report, July 2018) 90.

125 Amended Witness Statement of Annie Butler dated 2 May 2022 at [153].] (tab 181 page 9271).

activities of daily living, medication self-administration and stand by assistance when mobilising.[126]

189. Likewise, the evidence of Paul Gilbert (Assistant Secretary of the Victorian Branch of the ANMF) is that in the late 1980s and through the 1990s there was a clear distinction in aged care between "hostels" and "nursing homes". He says that hostels were really supported accommodation, and even amongst nursing home residents there were people in their 70s (and even younger) entering aged care, not because they were desperately ill or unable to cope at home, but because they wanted company, security and did not want to live alone. Mr Gilbert identified that there was still a sense in the 1980s and 1990s that a significant part of the residential aged care sector was just a small step up from the retirement village. There were still concerts and trips out and some residents were still even able to take themselves out to the shops or bowls.[127]

190. The increasing incidence of co-morbidity and frailty in residential care was also identified in the evidence of Andrew Venosta. Mr Venosta is an RN, currently employed by the ANMF as an Industrial Officer, but who has extensive experience in the public and private acute hospital sector. For most of the last 20 years, Mr Venosta has worked extensively in aged care. Mr Venosta's evidence identifies the increasing needs of aged care residents arising from decreased mobility and dexterity, increased falls risk, and increased requirement for assistance with ADLs and hygiene. He describes residents having increasing clinical needs related to wound management, continence management, pain management, palliative care, medication management, nutrition and hydration, dementia, behavioural management, access to specialist medical services, and oral and dental health. He says that all of these increased needs contribute to a greater complexity in care planning generally.[128]

191. The evidence of Mr Venosta is that between 2000 - 2010, the aged care sector changed dramatically. The distinction between 'low care' and 'high care' disappeared rapidly with the distinction between 'hostels' and 'nursing homes 'being abolished by the Commonwealth in 2014. He describes 'Low care' residents during this period as becoming frailer with had more co-morbidities on entry, they were less ambulant and

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126 Witness Statement of Robert Bonner dated 29 October 2021 at [56].] (tab 187 page 10806).
127 Amended Witness Statement of Paul Gilbert dated 3 May 2022 at [8].] (tab 186 pages 10777).
128 Amended Witness statement of Andrew Venosta dated 3 May 2022 at [47] (tab 188 page 11134).

had a shorter average length of stay. He identifies that this trend has been accelerated by a focus, since about the mid-2000s, on older people being supported to stay at home for as long as they are able.[129]

192. As to culturally and linguistically diverse residents and clients, Ms Butler at [151] notes the findings of the Report on Government Services[130] that as at June 2020, almost 20% of people in residential aged care were people from culturally and linguistically diverse backgrounds. Ms Butler also summarises the findings of the Australian Institute of Health and Welfare as at 30 June 2020[131] as follows:

> "Compared with people born in Australia or other English-speaking countries, people born in non-English-speaking countries were assessed as having higher care needs in each domain. For example, in cognition and behaviour, high care needs were recorded for 72% of people born in non-English speaking countries, compared with 62% of people born in Australia and 66% of people born in other English-speaking countries.
>
> Similarly, care need ratings were highest among people who preferred to speak languages other than English—74%, 68% and 57% of people were assessed as having high care needs in cognition and behaviour, activities of daily living, and complex health care, respectively."

Evidence of employer witnesses

193. The evidence of Paul Sadler (CEO, ACSA) is strongly corroborative of the evidence advanced by the unions. He states that there has been a "*noticeable shift*" in the kinds of consumers accessing aged cares services (at [53]).[132] Generally, consumers in residential aged care now fall into three categories (at [54]):[133]

> "(a) consumers that no longer can live comfortably at home and need daily living assistance/have complex health care needs who will stay for between 6 and 18 months;
>
> (b) consumers with dementia/cognitive impairment who stay for between 2 and 5 years;
>
> (c) consumers who are considered palliative and will stay for anywhere from days to 12 months."

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129 Amended Witness statement of Andrew Venosta dated 3 May 2022 at [51]–[52] (tab 188 page 11134–11135).

130 Section 14 Aged Care Services of Productivity Commission, Report on Government Services 2021 (Released 20 January 2021) Table 14A.10 (ANMF 6).

131 Australian Institute of Health and Welfare (2020), People's care needs in aged care 2019-2020, Australian Government; Amended Witness Statement of Annie Butler dated 2 May 2022 at [152] (ANMF 21).) (tab 181 page 9271).

132 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13589).

133 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13589).

194. Similarly, in home care, there has been a shift in more consumers accessing the highest funding package (at [56]), noting that this is reflective of such consumers having the highest level of need for assistance.[134]

195. As union witnesses said, this has been (in part) the result of consumers staying in their homes longer, meaning that they access aged care later (at [57]).[135] And, Australia's population is aging (at [59]). So, "*consumers accessing aged care are less mobile, have more than one comorbidity and are increasingly experiencing incontinence*" (at [58]).[136]

196. The evidence of Mark Sewell (CEO, Warrigal) is to the same effect. As the federal government tightened access requirements for residential aged care, fewer people moved into facilities for low care support, and the home care sector grew (at [48]).[137] So, the elderly are only approved for residential care "*if they have high care needs and are towards the end of their life*" (at [49]).[138] Residents are now "*older, clinically frailer, less mobile, and wit more complicated health conditions than two decades ago*"; a large portion have "*dementia, cognitive conditions or mental health issues*" (at [50]–[51]).[139] Accordingly, more physical support work is required of front-line workers (at [52]), and workers need to be able to "*diffuse emotional situations*" (at [53]).[140]

197. Mr Sewell agreed in cross-examination that residents are now entering residential care when they are unable to be cared for, or care for themselves, at home, and require 24/7 supervision at least (PN12963). Warrigal's experience has been that people in home care are also older, frailer, and with more complex needs than used to be the case (PN12967). A greater proportion of home care consumers have difficulty not only looking after themselves, but looking after their homes as well (PN12976). This requires home care workers to be alive in dealing with the home care environment in which the resident lives (PN12978).

198. Mr Sewell also accepted that the demographics of home care recipients were such that the potential for emergency situations to arise would be greater now than when he

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134 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13589).
135 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13589).
136 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13589).
137 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14601).
138 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14601).
139 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14601).
140 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14602).

started at Warrigal (PN13123), that there has been an increase in the number of home care recipients with dementia or other cognitive issues (PN13125), which might lead to unpredictable or challenging behaviour (PN13126). That might create an emergency situation (PN13127), and that is more the case now than it was 20 years ago (PN13128).

199. Craig Smith (Executive Leader Service Integrated Communities, Warrigal) gives similar evidence. He says that, "*[t]he persons coming in RACF are generally coming in with higher needs and are frailer than they were previously*" (at [61]).[141] This means that consumers are likely to require two-person assists or the use of mechanical aids, as they are less mobile (at [63]).[142] He said in cross-examination that the age and frailty of residents now entering aged care, and entering over the previous five–ten years, had substantially increased (PN13295).

200. The evidence of Emma Brown (Special Care Project Manager at Warrigal) is that over the past 10 years she has observed a progressive shift in the profile of consumers accessing care, being:

(1) An increase in consumers with complex health needs (such as dementia, less mobility, or presenting with more than one co-morbidity);

(2) An increase in the number of consumers coming in that are more frail or weaker;

(3) There are fewer long-standing consumers (that is consumers who stay for more then two years);

(4) An increase in consumers who need palliative care; and

(5) An increase in the number of consumers that are overweight and may have diabetes or be on dialysis.[143]

201. The evidence of Johannes Brockhaus (Buckland CEO) is that there has been a material change in the type of persons accessing residential aged care since he joined the industry.[144] This material change related to an increase in the age, frailty and levels of acuity and health needs of the residents.[145] He describes "social admissions"

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141 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14129).
142 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14129).
143 Statement of Emma Brown dated 2 March 2022 at [44] (tab 290 page 13987).
144 Statement of Johannes Brockhaus dated 3 March 2022 at [30] (tab 293 page 14831).
145 Cross-examination of Johannes Brockhaus at PN13787.

(*i.e.*, residents entering aged care to be around people of the same age who did not require high levels of care) in residential aged care as very common until around 2018.[146] By contrast, he says that Buckland is now seeing frailer residents with more comorbidities and conative impairments coming to Buckland because they can no longer care for themselves at their home. He describes these residents now frequently coming to Buckland palliative to receive end of life care.[147] He identifies a consequence of this being that the higher care needs of the residents has produced greater clinical and physical care needs to be dealt with by the care workers and the nursing staff.[148] This includes greater needs with mobility, showering, toileting, feeding and the like, consequent upon the higher care needs of the residents you're now experiencing.[149]

202. Higher resident acuity is also borne out by the reduction in the duration of stay of Buckland residents, down from 3.5 years in the 12 months preceding January 2021 to 2.59 years in the 12 months preceding January 2022.[150] Mr Brockhaus attributes this change in stay to more home packages being released, meaning that the elderly are remaining in their own homes longer and entering aged care with high needs or towards the end of their life.[151]

203. Under cross-examination, Mr Brockhaus agreed with the proposition that significant changes in the demographics, that is the age, frailty and care needs of residents has an impact upon the work that the carers perform.[152]

204. Cheyne Woolsey (Chief Human Resources Officer at KinCare, a home care provider) identifies that since he started at Kincare (around 5 years ago) customers are staying in their homes longer. There is now a higher portion of KinCare customers presenting with dementia or experiencing cognitive decline and with multiple health issues.[153] Further, he says that this has impacted on the time being spent by home care workers

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146 Statement of Johannes Brockhaus dated 3 March 2022 at [31] (tab 293 page 14831).
147 Statement of Johannes Brockhaus dated 3 March 2022 at [32]–[33] (tab 293 page 14832).
148 Cross-examination of Johannes Brockhaus at PN13798.
149 Cross-examination of Johannes Brockhaus at PN13798.
150 Statement of Johannes Brockhaus dated 3 March 2022 at [35] (tab 293 page 14832). At [36] Mr Brockhaus also clarifies that this reduction in the average stay was not attributable to the impact of COVID 19 (tab 293 page 14832).
151 Statement of Johannes Brockhaus dated 3 March 2022 at [37] (tab 293 page 14832).
152 Cross-examination of Johannes Brockhaus at PN13871–PN13872.
153 Statement of Cheyne Woolsey dated 4 March 2022 at [25] to [26] (tab 297 page 15716).

with each customer, and additional complexities and challenges in the personal care tasks being performed by home care workers compared with 5 years ago.[154]

205. Kim Bradshaw (General Manager at Warrigal's Stirling Facility) describes around 70 per cent of residents in her facility with some residents in the memory support unit exhibiting difficult behaviours, maybe once per day.[155] She says that the difficult behaviours have increased over the last 10 years because of the change in resident acuity.[156] Under cross-examination she accepted that "difficult behaviours" could sometimes manifest as violence and aggression.[157] Her evidence is that due to the increase in home care packages, these residents are at their most acute for the needs required by the time these residents access Warrigal's services, otherwise they would remain at home with a home care package.[158]

Findings of the Royal Commission

206. Further, all of this is supported by findings of the Royal Commission. Relevant findings are below.

207. At [IR.1.45]: the early 2000s saw a "*renewed focus by all levels of government on home and community care*," there was an "*increasing demand for home-based services*," and all this in the context of a "*growing proportion of the population aged over 65 years*";

208. At [IR.1.94]: the ageing population will "*cause the number of people in the above 65 years bracket—people who consume aged care—to increase*";

209. At [FR.3A.177] the Royal Commission found *"The residential aged care setting has changed over the years. People now enter residential facilities later in their lives. Consequently, many more are frail or have chronic or complex health conditions. Increasingly, new entrants to residential aged care have neurological conditions that result in such things as disorders of memory, understanding, behaviour, motor and sensory function, mobility and balance."* (footnotes omitted).

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154 Statement of Cheyne Woolsey dated 4 March 2022 at [27] (tab 297 page 15717 - 15716).
155 Statement of Kim Bradshaw dated 4 March 2022 at [13] (tab 294 page 14938).
156 Statement of Kim Bradshaw dated 4 March 2022 at [14] (tab 294 page 14938).
157 Cross-examination of Kim Bradshaw at PN12819.
158 Statement of Kim Bradshaw dated 4 March 2022 at [14] (tab 294 page 14938).

210. [FR.3B.801] and [FR.3B.805] show projections of the number of residential care recipients, and the costs of such care, increasing steadily to 2049 (see also [FR.3A.374–375] and [FR.3A.377]);

211. At [IR.1.96]: the number of people aged 70 year and over is expected to triple over the next forty years.

212. At [IR.1.217], a reference to the increasing likelihood in aged persons of chronic health conditions including, "*cardiovascular disease, arthritis, brittle bones …, macular degeneration, and hearing loss*," as well as an "*increase in neurological conditions that affect thinking, behaviour, motor and sensory function, mobility, and balance*."

213. At [IR.1.85]: the Royal Commission referred to an increased incidence of dementia in older ages, increasing the need for disability support;

214. In figure 3.1 on [IR.1.86], showing an estimate of Australians with dementia having increased markedly between 2010 and the present day, and continuing to increase through to 2030;

215. At [FR.3A.104]: the number of older people living with dementia is expected to increase in line with ageing population, and that in 2019 just over half of the people living in permanent residential aged care had dementia, but it could be as high as 70 per cent.

216. There are also findings as to the prevalence of mental health conditions in aged care, including that up to 50 per cent of older people in residential aged care have symptoms of depression and anxiety ([FR.2.103]).

217. References to the prevalence of assaults between residents, and by residents against aged-care workers, appear at [FR.3B.522]. [IR.1.6] refers to a "*major quality and safety issue[]*" being "*a high incidence of assaults by staff on residents and by residents on other residents and on staff*."

218. At [IR.1.92], the Royal Commission found that "*obesity rates have continued to rise*," and that in June 2019 it was found that "*two-third of Australian adults were overweight or obese*." This increases "*risks of high blood pressure and diabetes, which contribute to cardiac and kidney disease*." It also leads to mobility decreasing, and difficulty in

preforming routine tasks. Of course, all of these matters increase the workload of direct care workers.

Relevance of this evidence to work value

219. This evidence is relevant to each of the matters set out in section 157(2A) of the *Fair Work Act 2009* (Cth).

220. As to the nature of the work, the evidence clearly establishes that the nature of the job, and the task requirements imposed on workers, have changed considerably over the last twenty or so years. It is more or less agreed between all interested parties and witnesses on all sides, and it is supported by the Royal Commission's findings, that:

(1) residents in residential aged care present with more acute care needs than used to be the case;

(2) this includes, but is decidedly not limited to, an increase in dementia or other cognitive condition (and the consequences of that increase), and an increased frequency in the need for palliative care (see a fuller list at [172]);

(3) this enhances the complexity and difficulty (mental, emotional, and, especially for AINs / PCWs, physical) of the work of aged-care workers at every classification;

(4) it also increases the risk to aged-care workers in every classification (*e.g.*, of injury due to increased physicality of the role; of workplace violence; of work-related stress).

221. Likewise, Background Document 1 (at [116.1]) recognises as apparently uncontentious that "*[t]he workload of nurses and personal care employees in aged care has increased, as has the intensity and complexity of the work [footnote omitted]*".

222. Increased acuity is also relevant to conditions under which the work is done, in the sense that the conditions of work that might have been suitable (or might have presented a particular degree of difficulty) for a less-acute resident cohort, become less suitable (or present a higher degree of difficulty) for a more-acute resident cohort. There have, of course, been changes in the environment in which the work is done (*e.g.*, built form).

223. The level of skill and responsibility required of all members of the nursing team has been substantially increased as a result of the changes in the health status of the resident and client population identified in the evidence in this sub-part. In short, the evidence set out above relates to each of the matters set out in section 157(2A) of the *Fair Work Act 2009* (Cth), and amply justify a considerable increase in the amount that employees should be paid for doing the work that they do, across all classifications.

E.2 Changes to staffing levels and skill mix- Lay Evidence Report Part D.2

Agreement between interested parties as to this factor

224. The Consensus Statement at [14]–[16] says as follows:

> "14. Changes in staffing levels, skills mix and, consequently, workloads, have a significant impact on the changing nature of the work and therefore work value.
>
> 15. Since 2003, there has been a decrease in the number of nurses, both Registered Nurses (RNs) and Enrolled Nurses (ENs), as a proportion of the total workforce employed in aged care. [footnote omitted] RNs are the clinical leaders in residential aged care and have experienced an increase in managerial duties (including co-ordinating and supervising and delegating) and/or administrative responsibilities. Expectations of RNs have increased markedly (along with a shift from residents with lower to higher social and clinical needs). Nurses are required to detect changes in resident health status, identify elder abuse and anticipate medical decision-making. Overall, there are more demands upon nurses due to workforce structures and meeting governance requirements. They develop care plans and oversee their implementation and review.
>
> 16. Again since 2003, there has been an increase in the proportion of PCWs and AINs (care workers) in aged care with less direct supervision. PCWs are being required to perform duties that were traditionally undertaken by nurses (such as peg feeding and catheter support) after receiving relevant training and/or instruction. Care workers in both residential care and home care are performing increasingly complex work along with the increasing complexity of the needs of residents entering care. There are more expectations of care workers to detect changes in resident or client condition, identify elder abuse and assist with medications and other treatments."

225. BaptistCare's submission at [17]–[18] is also relevant:[159]

> "17. Over time, the role of frontline care staff has required requires [sic] more assessment, care documentation and practices that assist the clinical staff. This includes assisting with medication, simple wound dressing, assisting with the implementation of continence programs, attend to regular checks including urinalysis, blood pressure, temperature and pulse checks, blood sugar level checks and assist and support diabetic clients in the management of their

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159 Submissions of BaptistCare (tab 126 page 876–877).

> insulin and diet.
>
> 18. The roles for other frontline staff have changed over time also. Adherence to the Aged Care Quality Standards rightly requires a significant and increased focus on the wellbeing of residents. This has meant that staff in lifestyle streams are required to be cognisant of providing activities and programs that are tailored to the care needs of residents. What was previously 'Diversional Therapy' is now a targeted, person-centred program that meets the social and spiritual needs of residents."

226. Additionally, Background Document 1 (at [116.6] and [116.8]) recognises the following as apparently uncontentious:

> "6. Since 2003, there has been a decrease in the number of Registered Nurses (RN) and Enrolled Nurses (EN) as a proportion of the total aged care workforce. Conversely, there has been an increase in the proportion of Personal Care Workers (PCW) and Assistants in Nursing (AIN).
>
> …
>
> 8. PCWs and AINs operate with less direct supervision. PCWs and AINs perform increasingly complex work with greater expectations. [footnotes omitted]"

The Lay Evidence Report

227. The ANMF adopts Lay Evidence Report [276]–[290]. As stated at [277], several witnesses gave evidence that "*there are fewer RNs, which puts greater demands on them, and on ENs and personal carers*." The Lay Evidence Report quotes from the statement of Hazel Bucher (NP) at [43]–[44], and Pauline Breen (RN) at [23].

Evidence of other Frontline Workers

228. In addition to this evidence, Linda Hardman (AIN / PCW) said at [63] of her statement as follows:

> "When I started working in aged care twenty years ago, there would have been at least four RNs on each shift. On most normal shifts now, there is often only two RNs on a shift. The consequence is that their workload is high. They are also often in charge of the facility and have to deal with staffing issues on top of their clinical workload."[160]

229. Jocelyn Hofman (RN) said as follows, at [24] and [33]–[35]:

> "24. There has been a reduction in Registered Nurse numbers and hours over the last 20 years. These reductions affects the care of our residents. The Provider has reduced the number of hours of Registered Nurses but our workload and allocation of responsibilities from Management is increasing.

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160 Statement of Linda Hardman dated 29 October 2021 (tab 263 pages 13272–13273).

…

> 33. There are less RNs now on the floor than 20 years ago. In some aged care facilities, some tasks have been delegated to AINs/ PCWs/CSEs. For example, the introduction of dose administration aids like "Webster Packs" for AINs/ PCWs/ CSEs to use for assisting certain residents with their medications means RNs no longer administer medications for those residents. I am concerned that the distinction between "assisting" a resident with their medication and "administering" medication to a resident is blurred as AINs/ PCWs/ CSEs lack the relevant educational preparation to in effect administer medications. Also, in some aged care facilities, there is often not an RN rostered at night, which means that if any clinical issues arise during the night, the resident has to go to hospital.
>
> 34. There had been a reduction in registered nurses and an increased number of AINs/ PCWs/ CSEs employed in the aged care sector. When I started work on a day shift at Sans Souci, now called Anita Villa, there were three registered nurses rostered with AINs. At Bodington, I work with two CSEs in 1 wing and with an EN or casual RN (for part of the shift only) in another wing with two CSEs and a short shift CSE. This has resulted in increased scope and extent of responsibility for me as the registered nurse who remains accountable for the care delivered. It has also required increased exercise of judgement in prioritising resident care demands. This may even involve deferring my medication round to attend to an emergency situation like a resident choking, a fall or if I am designated as in charge of the facility, I will be called to other serious incident elsewhere in the facility. When a doctor visits his residents in the afternoon, I also defer my medication round so I can update the doctor with our resident's current status, email the Pharmacy on medication changes, follow up the medical directives and update the family member on the doctor's visit and changes.
>
> 35. The changes in staffing alone have substantially changed my work. But when combined with the other changes some of which are discussed below (e.g. complexity of resident health status) the result has been profound.
>
> 36. As a result of the staffing changes the delivery of care is always rushed. Daily work routines are pressured for the entire team of registered nurses, enrolled nurses and AINs/ PCWs/ CSEs. Accordingly, my work focus has shifted with a greater emphasis on exercising accountability for care. This means combining nursing assessments with other interventions, scanning residents at meal times to assess changes in such things as posture, mood, lack of appetite, as well as requiring and following up reports from care staff of changes in resident status."

230. Wendy Knights (EN) said, at [16], that it used to be that RNs primarily administered medicine. However, over time, the work of RNs came to be in the office rather than on the floor. So, "*administering medication more and more became the job of an EN*."[161] Similarly, at [26], Ms Knights said that RNs' administrative and paperwork load is much greater than it used to be, and hence they are more in the office than they used to

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161 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13440).

be.[162] Ms Knights gives examples of the kinds of paperwork RNs are tasked with completing at [27]. Paperwork is considered separately in Part E.4.4.

231. Christine Spangler (AIN / PCW) referred, at [21], to "*increasing demands on the RN*."[163] At [26], Ms Spangler refers to RNs and ENs having to do a lot of documentation, like risk assessments, skin assessments, and admission paperwork.[164]

232. Irene McInerney (RN) describes moving to Tasmania 8 years ago and working for Southern Cross Care (**SCC**) for 7 years. When she first began with SCC she considered their facilities to be very well resourced with nurses compared to her previous experience. However, the residents in the SCC facilities were older, frailer and required higher levels of care. Over the 7 years of her employment with SCC she observed the erosion of staffing levels, from a nurse on each of five wings to only two for the whole building. Her evidence is that this has occurred despite care needs having increased.[165]

Evidence of officials

233. Julianne Bryce (Senior Federal Professional Officer, ANMF) spoke to changes in aged-care staffing at [49]–[52] of her statement. Amongst other things, Ms Bryce refers to "*poorer staffing levels and skill mix*" (at [49]), which is to be understood as including a "*significant reduction in the number of nurses and substantial increase in the number of care workers*" (at [50]). This has led to a "*greatly increased burden of responsibility and accountability for registered nurses relating both to the provision of direct care and supervising and delegating nursing care provided by others*" (at [50]). These changes have made work "*far more difficult, if not impossible in some cases, for nurses to meet the NMBA standards for nursing practice and supervision and delegation responsibilities*," which has led to many RNs leaving the sector (at [52]).[166]

234. Kathryn Chrisfield (Occupational Health and Safety Team Manager, ANMF) refers to the occupational health and safety consequences of changed (especially diminished) staffing. So, at [24], Ms Chrisfield says that with reduced staffing it has become more difficult for members to comply with safe lifting techniques.[167] There are sometimes

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162 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13441).
163 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13013).
164 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13016)
165 Amended witness statement of Irene McInerney, 10 May 2022 at [13] (tab 260 page 13140).
166 Statement of Julianne Bryce dated 28 October 2021 (tab 189 page 13116).
167 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10743).

inadequate staff available to perform a lift on night shifts in particular, which leads sometimes to the performance of unsafe lifts, or reports being made against staff who refuse to perform an inadequately-staffed lift (see at [25]).[168]

235. Inadequacy of staff also affects the mental and psychological safety of staff, because they are forced to choose between their own safety (and compliance with policies), and the safety or comfort of residents (at [27]).[169] Further, there is inadequate time and staffing properly to respond to residents with dementia or other mental health conditions (at [32]–[33]).[170]

236. At [47], Ms Chrisfield spoke specifically about workload pressures associated with changed staffing (emphasis added):[171]

> "In my time at ANMF (Vic Branch), I have noted ongoing reductions in staffing levels across aged care. This has been reported to me by ANMF members in the sector and other officials. This has occurred where the number of residents has either remained constant, or increased, and the acuity of the residents and the care required has also increased. The increases in acuity are well documented in official reports. This has led to substantial work intensification. The residents require more intense care but there are fewer qualified staff to provide the care (as RN and EN numbers drop as a proportion of the workforce). Due to the reduction in the number of nurses, it means that the care workers are required to do more complex work which is often outside of their qualifications or experience. These workload pressures are present at all levels of the care staff and add to the concerns around completing their jobs."

237. In her evidence, Annie Butler (ANMF Federal Secretary) addresses the 2016 National Aged Care Workforce Census and Survey–The Aged Care Workforce, 2016 ("**2016 NILS Report**").[172] The 2016 NILS Report identified a significant change in the composition of the direct care workforce in residential aged care. The percentage of RNs reduced from 21 per cent of the direct care workforce in residential aged care in 2003 to 14.6 per cent in 2016.[173] Whereas the number of all direct care employees in the residential aged care workforce increased by 33 per cent during this period, the number of registered nurses decreased by 6.5 per cent in terms of headcount and

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168 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10743–10744).
169 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10744).
170 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10745).
171 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10748).
172 Kostas Mavromaras et al, Department of Health (Cth) and NILS, The Aged Care Workforce 2016 (Report, Released March 2017).
173 2016 NILS Report at 12 and Amended Witness Statement of Annie Butler dated 2 May 2022 at [67] and [68].

10.5 per cent on a full-time equivalent basis.[174] The evidence of Ms Butler also addresses the 2020 Aged Care Workforce Census Report ("**2020 Census Report**")[175] which estimated the percentage of RNs in the residential aged care direct care workforce to be 15.6 per cent as at 2020.[176]

238. The 2016 NILS Report also identified a reduction of enrolled nurses in the residential aged care direct care workforce from 13.1 per cent in 2003 to 10.2 per cent in 2016. In 2020, this was estimated to be 7.7 per cent.[177] By contrast, the 2016 NILS Report identified an increase in the number of care-workers, (AINs, PCWs however titled), from 67,143 in 2003 (being 56.5 per cent of the direct care workforce) to 108,126 in 2016 (being 71.5 per cent of the direct care workforce).[178] In 2020, this was estimated to be 71.2 per cent or 72.15 per cent including Personal Care Worker Traineeships.

239. A reduction in the percentage of nursing staff has also been identified in the home care and home support aged care workforce. The 2016 NILS report identified a reduction of RNs in this workforce from 10.2 per cent of the direct care workforce by headcount in 2007 (13.2 per cent of the FTE) to an estimated 8.1 per cent headcount (10.5 per cent FTE) in 2016. Enrolled Nurses reduced from an estimated 2.7 per cent of the direct care workforce in 2007 by headcount (2.6 per cent of the FTE) to an estimated 2.2 per cent by headcount (2.6 per cent FTE) in 2016. Over this same period, the percentage of Community Care Workers in the direct care workforce increased from an estimated

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174 2016 NILS Report at 12 and Amended Witness Statement of Annie Butler dated 2 May 2022 at [67] and [68].] (tab 181 page 9250 – 9251).

175 Department of Health (2021), 2020 Aged Care Workforce Census Report, Australian Government, September (**2020 Census Report**). The data recorded in the 2020 Census Report may be unreliable. The report at 51 notes that among the limitations of the findings cited in the report is that responses were only requested directly from providers, not individual workers. Therefore, the report notes, workers will be duplicated within service care type results if they work at more than one service and could also be duplicated across service care types. Further, by way of example, the report also notes at 12 that "some providers did not provide data for hours worked and this was more common for allied health professionals than for nurses and PCWs. Therefore, in addition to potential over counting in the headcount due to staff working in multiple jobs, the FTE totals may underrepresent the true figure due to unknown hours worked by all staff."

176 2020 Census Report, 11 (Table 2.2); Amended Witness Statement of Annie Butler dated 2 May 2022 at [84].] (tab 181 page 9254).

177 2020 Census Report, 11 (Table 2.2); Amended Witness Statement of Annie Butler dated 2 May 2022 at [84].] (tab 181 page 9254).

178 2016 NILS Report at 12 and Amended Witness Statement of Annie Butler dated 2 May 2022 at [67] and [68].] (tab 181 page 9250 – 9251).

81.8 per cent by headcount in 2007 (77.7 per cent of the FTE) to an estimated 83.8 per cent by headcount (78.7 per cent FTE) in 2016.[179]

240. The 2020 Census Report identified the following with respect to the HCCP direct care workforce in 2020:

(1) 4.7 per cent by headcount (4.9 per cent FTE) were RNs;

(2) 1.4 per cent by headcount (41.4 per cent FTE) were ENs;

(3) 86 per cent by headcount (87.8 per cent FTE) were Personal Care Workers; and

(4) A further 2.2 per cent by headcount (2.16 per cent FTE) were Personal Care Workers Traineeships.[180]

241. The 2020 Census Report identified the following with respect to the CHSP direct care workforce in 2020:

(1) 8.5 per cent by headcount (10.9 per cent FTE) were RNs;

(2) 2.9 per cent by headcount (3.8 per cent FTE) were ENs;

(3) 77.7 per cent by headcount (73.3 per cent FTE) were Personal Care Workers; and

(4) A further 2.1 per cent by headcount (1.5 per cent FTE) were Personal Care Workers Traineeships.[181]

242. The evidence of Ms Butler is that caring for elderly people, especially those with behavioural and psychological symptoms of dementia or other disabling health conditions, is a stressful occupation requiring the right people with the right skills and knowledge to develop holistic care plans customised to individual needs. Her unchallenged opinion is that this means that to ensure safe care for aged care residents it is critical to have the right skills mix of nurses and well-trained care-workers.[182]

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179 2016 NILS Report, 69–70 (Table 5.2 and Table 5.3); Amended Witness Statement of Annie Butler dated 2 May 2022 at [93]–[95].] (tab 181 page 9256 – 9257).

180 2020 Census Report, 26 (table 3.1); Amended Witness Statement of Annie Butler dated 2 May 2022 at [110].] (tab 181 page 9261).

181 2020 Census Report, 38 (table 4.1); Amended Witness Statement of Annie Butler dated 2 May 2022 at [113].] (tab 181 page 9261).

182 Amended Witness Statement of Annie Butler dated 2 May 2022 at [161].] (tab 181 page 9272).

243. Discussing the figures from the 2020 Census Report identifying changes to the skill mix in aged care, Paul Gilbert (Assistant Secretary of the Victorian Branch of the ANMF) says that these statistics are consistent with his observations. He identifies a "*seismic shift*" in the roles of AINs/PCWs, ENs and RNs, namely that the roles and responsibilities of both RNs and ENs have changed significantly as they become less "*hands-on*" for activities of daily living and more the care and systems managers, delegators of care, planners and the managers of the ENs/carers.[183]

244. Robert Bonner (Director, Operations and Strategy of the Australian Nursing and Midwifery Federation (SA Branch)) has given evidence of his primary responsibility for co-ordinating stage 2 of the ANMF's national aged care staffing and skill mix project, resulting in the ANMF Aged Care Staffing and Skills mix project Final Report 2016.[184] That research project explored the staffing volume or time required to complete interventions and also established the necessary skills mix by reference to the class of worker. One of the recommendations based on the findings of this report was:

> "That the average of 4.30 (Resident Nursing and Personal Care Hours Per Day) or 4 hours and eighteen minutes of care per day, with a skills mix requirement of RN 30 per cent, EN 20 per cent and Personal Care Worker 50 per cent is the evidence based minimum care requirement and skills mix to ensure safe residential and restorative care."[185]

245. Unsurprisingly, inadequate staffing and skill-mix was identified as a key concern of respondents to the ANMF National Aged Care Survey 2019, also addressed in the evidence of Mr Bonner.[186] That survey involved 2,775 staff working within the aged care sector from all States and Territories. 89 per cent of participants noted inadequate staffing in aged care. This was an increase from the 2016 results where 79.2 per cent indicated that staffing was inadequate. In 2019, three-quarters of participants indicated that staff ratios were inadequate, an increase from the 2016 results of 67.8 per cent. Two main themes arose from participants' responses; inappropriate pressure/responsibility onto less skilled/experienced workers, and; lack of suitable

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183 Amended Witness Statement of Paul Gilbert dated 3 May 2022 at [24]–[25].] (tab 186 pages 10781–10782).

184 Witness Statement of Robert Bonner dated 29 October 2021 at [15]; Annexure "RB 1"." (tab 187 page 10799 and 10821).

185 Witness Statement of Robert Bonner dated 29 October 2021 at [15]; Annexure "RB 1", p 9. (tab 187 page 10799 and 10829).

186 Witness Statement of Robert Bonner dated 29 October 2021, "RB 4" – Australian Nursing and Midwifery Federation (2019). *ANMF National Aged Care Survey 2019–Final Report*. Australian Nursing and Midwifery Federation (Federal Office), Melbourne, Victoria, p 9. (tab 187 page and 11028).

numbers/availability of registered nurses. These highlighted the effects inadequate ratios of registered nurses have on care delivery and care staff, including nurses.[187]

Evidence of employer witnesses

246. Paul Sadler (CEO, ACSA) stated that RNs have been diverted from direct care into the completion of ACFI assessments. This has affected both RNs and care workers, but, "*it has particularly impacted RN workloads*" (at [41]).[188]

247. Mark Sewell (CEO, Warrigal) likewise notes the frustration of RNs with their paperwork burden (at [41]).[189] Recording of observations, just to take an example, now takes about 1.5 hours per 8 hour shift, whereas it used to be a third of that.[190]

248. Mr Sewell also stated that the role of the RN has changed in that the role is now more administrative in nature: "*RN's [sic] are now spending more time undertaking duties such as compiling reports, conducting audits of documentation and completing care plans*" (at [113]).[191] As for AINs / PCWs, their role has (Mr Sewell says) become less physical and more cognitive (at [117]), and involves more engagement with the consumer (at [117]).[192] Mr Sewell is not there to be taken as suggesting that the amount of physical labour has decreased—the evidence of the lay witnesses makes plain that it has not (on the contrary, the greater need of residents for physical assistance, the prevalence of overweight or bariatric residents, *etc.*, means that the job remains physical). Rather, he is to be understood as suggesting an enhanced <u>focus</u> on the cognitive rather than the physical aspects of the work.

249. The evidence of Johannes Brockhaus (CEO of Buckland Aged Care Services) highlights the prevalence of AINs / PCWs across Buckland's residential aged care facility and home care services. He says that AINs / PCWs make up roughly 85 per cent of the total workforce.[193] Of the balance of the workforce, 8–10 per cent are

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187 Witness Statement of Robert Bonner dated 29 October 2021 at [15]; Annexure, "RB 4" – Australian Nursing and Midwifery Federation (2019). *ANMF National Aged Care Survey 2019–Final Report*. Australian Nursing and Midwifery Federation (Federal Office), Melbourne, Victoria, p 9. (tab 187 page and 11028).

188 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13587).

189 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14600).

190 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14601).

191 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14610).

192 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14611).

193 Statement of Johannes Brockhaus dated 3 March 2022 at [13(a)] (tab 293 page 14828).

general support officers (catering, kitchen, cleaning, laundry)[194] with RNs, ENs diversional therapists, chaplains, maintenance and administrative employees together making up the remaining portion.[195]

250. Mr Brockhaus also recognises that RNs are now required to undertake compliance based duties, care planning, conducting reviews, audits and various assessments.[196] His evidence (at [29]) is that this has meant that AINs / PCWs are undertaking more work which was historically undertaken by RNs and Buckland has to rely upon its AINs / PCWs to provide personal care to the residents. Under cross-examination, Mr Brockhaus accepted that this scenario also led to a situation where care work was performed by the EN and AIN / PCW with less direct supervision by the RN than was the case previously, although the RN was still available to provide supervision where required but less directly on the floor (at PN13846 - PN13847).

Findings of the Royal Commission

251. At [FR.2.29] appear some relevant statistics (current as of 2016), including numbers of Nurse Practitioners, RNs, ENs, and AINs / PCWs working in residential care and in home care and that:

(1) Registered nurses dropped from 21 per cent of the residential direct care workforce in 2003 to 15 per cent in 2016. Over the same period, ENs dropped from 13 per cent to 10 per cent. The proportion of residential aged care employees engaged in direct care dropped from 74 per cent in 2003 to 65 per cent in 2016 (see also [FR.3A.376]);

(2) This is in circumstances were the number of residential care places <u>increased</u> by 44 per cent between 2003 and 2020;

(3) In home care and home support, the total direct-care workforce <u>decreased</u> by 7 per cent between 2012 and 2016.

252. At [IR.1.65] the Royal Commission records that one of the most-common complaints made to the Aged Care Quality and Safety Commission was in relation to "*personnel*

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194 Statement of Johannes Brockhaus dated 3 March 2022 at [13(f)] (tab 293 page 14829).
195 Statement of Johannes Brockhaus dated 3 March 2022 at [13] (tab 293 page 14828).
196 Statement of Johannes Brockhaus dated 3 March 2022 at [27] and [28] (tab 293 page 14831), Cross-examination of Johannes Brockhaus at PN13837–PN138340.

numbers/ratio." And, at [IR.1.68], the Royal Commission observed that one of the problems that has "*continue[d] to plague the system*" is a "*serious current and projected shortages of nursing and personal care workers*."

253. Aged care is understaffed and the workforce underpaid ([FR.2.211]). These are not new issues ([FR.2.211] and [FR.3A 371-372]). After the removal of an obligation to spend a particular proportion of funding on direct-care staffing, many aged-care providers contain labour costs by replacing nurses with AINs / PCWs ([FR.2.211]).

254. At [FR.3A.371] the Royal Commission states:

> "In many cases, the mix of staff who provide care is not appropriately matched to the care needs of older people. The proportion of professionally qualified staff such as nurses and allied health workers is too low. The proportion of personal care workers is too high. The increasing medical acuity of people receiving aged care is not reflected in the staff mix."

Relevance of this evidence to work value

255. The conclusions to be drawn from the following are these:

(1) aged-care work is, increasingly, inadequately staffed;

(2) in particular, there are fewer RNs and ENs than used to be the case;

(3) this has the consequence that the same amount of work (or more) for RNs and ENs is done by fewer of them (changing their work requirements and enhancing their workload), and that AINs / PCWs are increasingly performing work that was previously performed by an RN or an EN (enhancing the complexity of their work, and possibly also their workload).

256. Staff shortages and inadequate skill mix as a consequence of labour supply constraints impact the work intensity and work requirements of existing staff. These are matters "*related to*" the nature of the work, the responsibilities involved and the conditions under which the work is performed. The evidence supports a conclusion that work intensity has been affected by staff shortages and that increased complexity of supervision and delegation as well as "*working up*" in relation to greater responsibility and increased skill demands has been a major and transformative feature of the changes in work and work requirements in recent years.

257. As submitted at [37(4)] of the ANMF's principal submissions, nothing in section 157(2A) suggests that increased workload cannot be relevant to whether work value reasons justify an increase in wages. Of course, if short staffing were temporary then it would be open to the Commission to find that nothing in the nature of the work, the skill involved, or its conditions, had changed. That is, the Commission may find that increased workload is a temporary aberration. The evidence is that short staffing has not simply resulted in the nursing team doing more of the same, but that in order to cope with the demands of delivering the care required, the work requirements of each classification in the nursing team have been transformed.

258. Nothing about the increase in workload caused by short staffing has been temporary, or aberrant. The nature of the work has changed. This is so *a fortiori* in regard to the change in staffing mix (*i.e.*, fewer nurses). It would, the ANMF submits, be a wrong approach to assume, in assessing the nature of the work that is being performed today, that workload and staffing mix was still at some unidentified past level, where there is no evidence to suggest that workload and staffing mix will ever return to that past level.

259. Again, then, the evidence set out above relates to at least the nature of the work performed and the skill involved in doing it, for the purposes of section 157(2A) of the *Fair Work Act 2009* (Cth). The evidence again tends in favour of a considerable increase in the amount that employees should be paid for doing the work that they do, across all classifications.

E.3 Changes to the philosophy and models of care - Lay Evidence Report Part D.3

Agreement between interested parties as to this factor

260. The Consensus Statement, at [9] and [17], states as follows in regard to changes to philosophy and models of care:

> "The expectations of aged care consumers and their families, and the community, about the provision of aged care services has risen over time. The philosophy of care is person-centred based on choice and control, and this requires a focus on the individual needs of each resident and client.
>
> …
>
> Consumer-directed Home Care Packages have resulted in a less structured stream of duties for home care workers, who must now perform a broader range of duties. Home care workers must plan and adapt to different duties and levels of expectations from client to client. The proportion of home care packages at levels 3 and 4 have increased. [footnote omitted]"

261. Background Document 1 (at [116.12]]) recognises the following as apparently uncontentious:

> "The philosophy or model of aged care has shifted to one that is person-centred and based on choice and control, requiring a focus on the individual needs and preferences of each resident or client. This shift has generated a need for additional resources and greater flexibility in staff rostering and requires employees to be responsive and adaptive [footnotes omitted]"

262. IRT submitted (at [8]) that, "*[c]hanging resident/customer and family expectations around person-centred care require employees to cater to individual physical, emotional, social and spiritual care needs*."[197]

263. UnitingCare Australia submitted at page 2 of its submission that, "*[t]he cultural transformation towards consumer directed care has increased demands on aged care workers, with a sharp increase in consumer expectations relating to their own (the consumer's) cultural, identity, social and linguistic needs.*"[198]

264. Uniting referred in its submissions (at page 2) to the value and complexity of aged care work increasing significantly over time including because of "*increased standards of care (driven in party by community expectations, understanding of best practice and regulation)*," by an "*increased focus on cultural, identity, social and linguistic needs*," and by "*new models of care.*"[199]

The Lay Evidence Report

265. The ANMF adopt the Lay Evidence Report [291]–[303]. In those paragraphs, reference is made to the evidence of (*inter alios*) Linda Hardman (AIN / PCW) at [42]–[45], Wendy Knights (EN) at [42]–[44] and [48], Christine Spangler (AIN / PCW) at [27], and Lisa Bayram (RN) at [62].

Evidence of other Frontline Workers

266. In addition, Hazel Bucher (NP) refers at [43(c)] to "*profound influence[s]*" on the work of aged care RNs, ENs and AINs / PCWs, since 2010 by changes in the regulation of the sector including "*the application of Care Standards and the introduction of the Aged Care Quality Standards*."[200]

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197 Submissions of IRT (tab 128 page 1118).
198 Submissions of UnitingCare (tab 129 page 1121).
199 Submissions of Uniting (tab 131 page 3122)
200 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13127).

267. Arising out of changes to the philosophy and models of care, the evidence of Lisa Bayram (RN) about advanced care planning and critical incident management identifies the challenges faced by RNs trying to balance the rights of the resident and doing the best by them clinically. She gives the example of a resident with end stage dementia who has specified in their advanced care plan that they don't want to go to hospital. However, if they then have a fall and have a considerable injury, this will give rise to are difficult decisions. Ms Bayram identifies the need to try to manage the expectations of the family, the decisions of the resident and the risk assessment (clinically) as to whether to send them to hospital and what resources are available to manage them if they are kept in the facility.[201]

268. Virginia Mashford (AIN) describes the work involved in providing a person-centred model of care. She says that whilst she agrees with this approach, providing person centred care requires resources. She must meet the requirements that residents have of her and the expectation of high standards of care set by her employer. She observes that it is right that residents have choice and control over their lives, but notes that giving residents choice to do things requires a lot more resources.[202] Ms Mashford's evidence is also that things like meals and medication rounds occur at prescribed times and so accommodating resident choice can be very difficult.[203]

Evidence of officials

269. The evidence of Andrew Venosta (RN and Industrial Officer) is that in or about 2012, "*consumer directed care*" was introduced as part of reforms across the sector. He describes consumer directed care as about ensuring that aged care residents are consulted and have choice with respect to the delivery of their care. For example, he identifies that under this model of care, residents will have the right to choose what time they have a shower, their meals, what time they go to bed. He identifies this is an alternative to the more old-fashioned task-orientated approach to nursing, particularly to assistance with ADLs and hygiene. He describes his experience of this representing

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201 Witness Statement of Lisa Bayram dated 29 October 2021 at [80].] (tab 262 page 13241).
202 Amended Witness Statement of Virginia Mashford dated 6 May 2022 at [33].] (tab 271 page 13430).
203 Amended Witness Statement of Virginia Mashford dated 6 May 2022 at [34].] (tab 271 page 13430).

a significant challenge for an understaffed workforce which is time-poor and struggles with the day-to-day workload.[204]

Evidence of employer witnesses

270. Paul Sadler (CEO, ACSA) identifies that the Aged Care Quality Standards were introduced on 01 July 2019 and have been in effect since that time (at [23]).[205] The new standards represented a shift from aged care consumers being treated as passive recipients of care to having an active role in choosing and directing how their care is delivered, and introduced "*additional requirements*" around the provision of clinical care (at [23]–[24]).[206] In particular, the 2019 standards emphasised the planning of services in conjunction with consumers (at [25]).[207]

271. In cross-examination, Mr Sadler agreed, by reference to the standard concerning making informed choices about care and services (see PN12254), that the objective of the process of audit is to ensure that the object of consumer choice and independence is fulfilled in the way that care staff and other staff perform their work on a day to day basis (PN12266). Providers will demonstrate compliance by showing that its staff, in the work they do day to day, meet the objects of the standard and the detailed requirements thereof (PN12269), and have the training and skills to do so (PN12270).

272. Further, Mr Sadler accepted that an aspect of consumer-centred care is that there are communications and negotiations about the best way to provide care, to endeavour to adapt to whatever choices and desires the consumer expresses (PN12329).

273. Mark Sewell (CEO, Warrigal) accepted in cross-examination that an aspect of the changes in the Aged Care Quality Standards was the philosophy of more person-centred care, and that each provider was required to demonstrate how its staff met that requirement (PN12916–12917)

274. Craig Smith (Executive Leader Service Integrated Communities, Warrigal) likewise details changes in regulation over time (at [16] ff).[208] He says that the focus of audits under the *Quality of Care Principles 1997* and the *Quality of Care Principles 2014* was

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204 Amended Witness statement of Andrew Venosta dated 3 May 2022 at [57]–[58] (tab 188 page 11135–11136).
205 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13584).
206 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13584).
207 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13584).
208 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14122).

on ensuring clinical care met standards (at [24]).[209] In 2019, the Aged Care Quality Standards were introduced, and these are "*more consumer focused*," than previous standards given that "*consumer dignity and choice is now the first standard and is now the foundation to all other standards*" (at [28]) [210]

275. The impact is that the roles of nurses and personal care workers went from being task-based and regimented to the consumer having greater involvement (at [31]). Mr Smith provided these examples (at [31]):[211]

> "(a) when setting care plans, the consumer and registered nurse (normally) now set the consumers goals together;
>
> (b) PCW and RN's now need to have improved communication skills to determine the needs and goals of the consumer; and
>
> (c) the care being provided is then in accordance with the care plan, this might involve the consumer wanting to shower at night time as that is their preferred time, rather than in the morning when the PCW might have done their shower rounds."

276. Mr Smith also identified a need for greater communication and to work more flexibly (at [33]).[212]

277. Mr Smith accepted that the Aged Care Quality Standards required an individualised consumer focus, which required nurses and AINs / PCWs to have improved communication skills to determine needs and goals (PN13176), to understand goals, preferences, or aspirations of residents (PN13182), to deliver care in a way that actualised those goals, preferences, or aspirations (PN13183), working in a way that is flexible to account for preferences, needs, behaviours (PN13184), and prioritise and reprioritise and reorder their work day to deal with needs, preferences, behaviours that might arise in the course of a day (PN13185). Mr Smith accepted that the introduction of the 2019 standards resulted in a change in the nature of and the skill involved in the work of providing personal care and nursing care to the residents of Warrigal's facilities (PN13186).

278. Anna-Maria Wade of ACSA said that she understood the 2019 Aged Care Quality Standards as involving "*a different way of looking at care*" (at [22]).[213] The former

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209 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14123).
210 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14124).
211 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14124–14125).
212 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14125).
213 Statement of Anna-Maria Wade dated 01 March 2022 (tab 296 page 15197).

standards were focused on collective "*consumers*" rather than an individual consumer. They focused on the majority of consumers being better off, rather than focusing on individual consumers (at [23]).[214] The new standards are about tailored and individualised consumer needs (at [24]), and require providers to shift their focus (at [25]).[215]

279. Ms Wade accepted in cross-examination that what "*person-centred*" care required was care that respected the autonomy of the individual resident, and that resident's choices (PN12495–12496). It involved a different way of providing care (PN12498). There is a need for nurses and personal care workers to know the needs, goals, and preferences of individual residents (PN12520), recognise deteriorations in consumer and respond to them in an individualised and responsive way (PN12524), and document information concerning conditions, needs, and preferences and provide care accordingly (PN12524–12527).

280. Initially, Ms Wade sought to suggest that, despite these changes in the way that care was to be provided as a result of the 2019 Aged Care Quality Standards, the skills involved in providing the care were the same (PN12534). However, to her credit, she then accepted that the care was more individualised, that recognising matters individual to a particular consumer and providing care in a way that differentiates between consumers were matters involving skill (PN12537–12539), and therefore that the quality standards, in requiring work to be performed in that way, did have the effect that there is now more skill involved in the work (PN12540).

281. Johannes Brockhaus (Buckland CEO) acknowledges that the new aged care standards have brought about changes by placing the person receiving care at the centre of every decision and giving them greater control over their care.[216] Under cross-examination he confirmed that the standards require that philosophy to be adopted in the personal care that's being delivered to residents in all aspects of life[217] and that Buckland is required to ensure that its staff are trained and have the skills to provide care in a manner which facilitates choice and independence on the part of the residents.[218]

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214 Statement of Anna-Maria Wade dated 01 March 2022 (tab 296 page 15198).
215 Statement of Anna-Maria Wade dated 01 March 2022 (tab 296 page 15198).
216 Statement of Johannes Brockhaus dated 3 March 2022 at [25] (tab 293 page 14830)
217 Cross-examination of Johannes Brockhaus PN13813.
218 Cross-examination of Johannes Brockhaus PN13817.

282. Emma Brown (Special Care Manager at Warrigal) describes the new quality standards as moving away from task orientated practice to providing the consumer with choice.[219] Ms Brown says that this impacts on the way work is performed by personal care workers, as the work may not be as routine as under the previous standards. She says that offering this choice places the emphasis on the care workers having to have understanding and knowledge of each of their customers to ensure that their choices and preferences are followed.[220] She identifies that this has also impacted on the RNs who are conducting the assessments and care plans.[221]

283. Ms Brown conducted a 'roadshow' of training in respect of the new quality standards discussing the standards and how these apply to everyday practice. She also explained some of the ways that employees could change their work practices to help meet the standards.[222]

284. Ms Brown also acknowledges that "Dignity of Risk" can place stress on the staff that support customers where customer choice may not be the choice of the clinical team.[223] Ms Brown also accepted that, dignity of risk is tricky and, if the resident's choice is recorded in their care plan, it will be the registered nurse who will have to sign off on this.[224]

Findings of the Royal Commission

285. At [FR.1.24] the Royal Commission commented on changing trends in models of care, observing "*The average size of residential aged care facilities has increased over recent years. In 2008, 39% of facilities had over 60 places; by 2019, 60% of facilities had over 60 places. We consider that, in general, residential aged care services should transition progressively away from large institutional design settings. Accessible and dementia-friendly design should be the norm for new or substantially refurbished residential aged care buildings.*"

286. At [FR.2.93] and referring to FR.3 Chapter 3, the Royal Commission defines the concept of high quality aged care, taking into account the community's expectations.

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219 Statement of Emma Brown dated 2 March 2022 at [23] (tab 290 page 13984).
220 Statement of Emma Brown dated 2 March 2022 at [25] (tab 290 page 13985).
221 Statement of Emma Brown dated 2 March 2022 at [26] (tab 290 page 13985).
222 Cross-examination of Emma Brown PN13394–PN13397.
223 Statement of Emma Brown dated 2 March 2022 at [27] (tab 290 page 13985).
224 Cross-examination of Emma Brown PN13412–13414.

'*In summary, high quality aged care puts older people first. It is a standard of care that meets the particular needs, aspirations and preferences of people receiving aged care."* The Royal Commission commissioned a survey and research paper from Flinders University, into assessing the views and preferences of the general public for quality care and future funding, which "*found 85% of the 10,315 respondents saw it as 'important' or 'very important' that staff members knew and valued the identity, culture and history of the older person."* [FR.3A.96]

Relevance of this evidence to work value

287. All of the evidence relevant to this topic supports the conclusion that the change in favour of "*person-centred*" care involves the application of greater skill than care provided in an undifferentiated way as between recipients of care. The necessity, as well, to differentiate or distinguish between residents in regard to the care to be provided to that resident involves a level of decisional responsibility that did not exist under undifferentiated models of care.

288. Again, then, the evidence set out above relates to at least the nature of the work performed and the skill involved in doing it, for the purposes of section 157(2A) of the *Fair Work Act 2009* (Cth). The evidence again tends in favour of a considerable increase in the amount that employees should be paid for doing the work that they do, across all classifications.

E.4 Changes in accountability, regulation and residents' expectations - Lay Evidence Report Part D.4

289. The specific sub-categories of this common issue and theme include the Serious Incident Response Scheme (**SIRS**), ACFI accreditation, reduced use of chemical and physical restraints, observation and documenting responsibilities including charting and making progress notes, care plans and interactions with families. The sub-categories are addressed below in more detail.

290. In this headline Part E.4.1, however—before getting into the sub-categories below—submissions are directed to the subject matter of Lay Evidence Report [304]–[313]. Mostly, but not entirely, these paragraphs address the Aged Care Quality Standards.

291. In addition to the funding process under the ACFI, providers of aged care services are also required to be accredited. Prior to 1 July 2019, this occurred in accordance with

the Accreditation Standards, set pursuant to Section 96 of the *Aged Care Act*, and identified in the *Quality of Care Principles 2014*. On 1 July 2019, the Accreditation Standards were replaced with the more complex Aged Care Quality Standards[225] (**ACQ Standards**), in accordance with amended *Quality of Care Principles 2014*[226] which are applicable to all aged care services.

292. The ACQ Standards comprise 8 standards. Organisations are required to comply with the Quality Standards and must demonstrate performance required of the standards on an ongoing basis. If the Quality Standards are not met, this can result in the Australian Government taking action against the organisation under aged care legislation or through the funding agreement with the organisation.[227]

Agreement between interested parties as to this factor

293. Consensus Statement [9] is relevant here, too, in relation to residents' expectations. It was quoted above in relation to, "*Changes to the philosophy and model of care*." Consensus Statement [23] is directed, in addition, to regulation:

> "There has been a change in the regulatory regime applying to aged care. Changes to the Aged Care Funding Instrument (ACFI) requirements and a new funding instrument is soon to be introduced. There have also been changes to regulations concerning the use of physical and chemical restraint and to incident reporting arrangements. These changes mean nurses and care workers are required to meet increased quality and safety standards and meet increased documentation requirements."

294. BaptistCare submitted (at [18]) that, "*Adherence to the Aged Care Quality Standards rightly requires a significant and increased focus on the wellbeing of residents.*"[228]

295. IRT's submission concerning changing resident/customer and family expectations around person-centred care (extracted above at [262]) is relevant here as well.[229] Further, IRT submitted (at [10]) that, "*the introduction of consumer directed care has resulted in a broader range of tasks*."[230]

296. UnitingCare Australia submitted (at page 2 of its submission) as follows:[231]

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225 Aged Care Quality and Safety Commission *Aged Care Quality Standards*
226 *Quality of Care Principles 2014* (Cth).
227 Amended Witness Statement of Annie Butler 2 May 2022 at [228].] (tab 181 page 9282).
228 Submissions of BaptistCare (tab 126 page 877).
229 Submissions of IRT at [8] (tab 128 page 1118).
230 Submissions of IRT at [8] (tab 128 page 1118).
231 Submissions of UnitingCare Australia (tab 129 page 1121).

> "The changes to legislative and policy settings mean this trend [of increasing complexity in Aged Care work] will continue, particularly given the Royal Commission's recommendation to include a statutory, non-delegable duty of care. The additional expectations of workers in the sector are reflected in the Aged Care Quality Standards as contained in the Quality of Care Principles 2014, which require increasing levels of technical and social support competencies.
>
> The cultural transformation towards consumer directed care has increased demands on aged care workers, with a sharp increase in consumer expectations relating to their own (the consumer's) cultural, identity, social and linguistic needs."

297. Uniting submitted (at page 2 of its submission) that:

> "the Aged Care Quality and Safety Standards require Uniting's workers to have greater levels of technical and social support competencies relevant to respective roles," and that, "[t]he increasing regulatory requirements have also asked aged care workers to bear more risk, something that must be recognised in the work value."[232]

298. Additionally, Background Document 1 (at [116.9]) recognises as apparently uncontentious that "*[t]here has been an increase in regulatory and administrative oversight of the Aged Care Industry."* [footnote omitted]

The Lay Evidence Report

299. The ANMF adopts Lay Evidence Report at [304]–[313]. This extracts evidence from (*inter alios*) Stephen Voogt (NP) at [44]–[46] and [54]–[55], [57]–[61], and from Jocelyn Hofman (RN) at [42].

Evidence of other Frontline Workers

300. Hazel Bucher (NP) states (at [34]) that the onus of responsibility imposed by the Aged Care Quality and Safety Commission for the management of antipsychotic medications has shifted more and more on residential aged care staff rather than the prescriber.[233] Ms Bucher also identifies (at [43(c)] the application of care standards and the introduction of the Aged Care Quality Standards as profoundly changing the work of aged care RNs, ENs, and AINs / PCWs.[234]

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232 Submissions of Uniting (tab 131 page 3122).
233 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13124).
234 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13127).

301. Wendy Knights identifies the additional documentation requirements associated with the new Quality Standards, at [66]:[235]

> "There are additional documentation requirements which require significant education and time to complete. For example, in the new Quality Standards they want us to document (preferably each shift, but certainly every day), how we have had contact or interactions with each resident. It might be talking to Mary about her trip to the dining room and her meal and documenting her descriptions of what she ate and whether she enjoyed it. On many days I have to do a minimum of 18 progress notes in the dementia unit that I didn't always have to do before. Previously it was only definitive changes that were documented. This daily interaction note often falls to me because the PCAs sometimes don't do them or aren't confident of their writing skills."

302. And, it is noteworthy that Christine Spangler has undertaken about 38 separate training courses directed specifically to the Aged Care Quality Standards (see list at [8]).[236]

303. The evidence of Virginia Mashford (AIN) is that during her time in aged care the work environment has changed in that there is a greater emphasis placed on meeting residents and their families' needs and providing care that is accountable. She identifies this as a positive change but notes that the care is expected to be provided in a cost-efficient manner from all staff. Her evidence is that an emphasis is placed on workers to make sure they document cares and fill in all other charts and other tasks. Despite this, she says that there is no acknowledgement of the time needed to complete these tasks and there is the minimum level of staffing provided to perform duties associated with care needs of the residents.[237]

Evidence of officials

304. Kathryn Chrisfield identifies at [9] that resident choice (which is a particular focus of person-centred care and consumer choice, required by the Aged Care Quality Standards) creates difficulties for aged-care workers:[238]

> "A particular issue that is a constant in aged care is that the resident's (and family's) wishes may be in conflict with what is required for the safety of staff. A particular example of this is where, due to deterioration of a resident's mental health, it may be preferable for them to move to a psychogeriatric facility or, alternately, to have particular clinical treatment to address behaviours of concern (which may include some pharmacological intervention). However, the family or resident refuse to move or consider alternative accommodation where this can be provided, or refuse the treatment

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235 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13447).
236 Statement of Christine Spangler dated 29 October 2021 (tab 257 pages 13010–13011).
237 Amended Witness Statement of Virginia Mashford dated 6 May 2022 at [63].] (tab 271 page 13436).
238 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10740).

> needed. This then results in ongoing behaviours of concern for the resident, which causes a significant risk to the health and safety of the staff (and often the resident also)."

305. The evidence of Annie Butler (ANMF Federal Secretary) is that compared to the Accreditation Standards, the ACQ Standards are significantly increased both in the number of standards and expectations to be met and the requirements to demonstrate the Standards have been met are significantly more demanding than previously.[239]

306. Ms Butler also identifies at least 72 inquiries and reports into aged care in the period between 1982 and 2021.[240] Unsurprisingly, arising from those reports and inquiries has been a range of reforms over many years. Ms Butler's evidence is that the pace of reform has accelerated in the last 3-5 years due to implementation of recommendations from the many reviews into aged care in recent years. The findings from the Royal Commission Interim Report: Neglect, was a catalyst for the introduction of a number of regulatory reforms aimed at improving quality and safety of aged care services.[241]

307. The evidence of Andrew Ventosa (RN and Industrial Officer) addresses his experience with the accreditation process when employed in aged care. He describes that despite the process being conducted on a three-year cycle, providers were expected to maintain compliance 24 hours a day, 7 days per week and could be subject to unannounced visits by the then Aged Care Standards and Accreditation Agency. Such unannounced visits started in the early 2000s and contributed to him experiencing more stress and the feeling that "*every day is accreditation day*", putting additional pressure on RNs and other staff.[242] His evidence is that RNs played a key role in the accreditation process as their focus was to ensure all resident assessments and care plans are consistently up to date.[243]

Evidence of employer witnesses

308. The evidence of Paul Sadler (CEO, ACSA) is strongly supportive of the proposition that regulation is constantly evolving, and increasing in complexity and onerousness. His history starts in 1997 with the introduction of the *Aged Care Act 1997* (Cth), which

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239 Amended Witness Statement of Annie Butler 2 May 2022 at [228].] (tab 181 page 9282).

240 Amended Witness Statement of Annie Butler dated 2 May 2022 at [195] and "AB 8"." (tab 181 page 9276 and 9306).

241 Amended Witness Statement of Annie Butler dated 2 May 2022 at [213].] (tab 181 page 9280).

242 Amended Witness statement of Andrew Venosta dated 3 May 2022 at [85].] (tab 188 page 11140).

243 Amended Witness statement of Andrew Venosta dated 3 May 2022 at [101].] (tab 188 page 11142).

"*brought about substantial changes to the way residential and home care providers operate*" (at [15]).[244] In particular, "*a new set of residential care and home care standards were introduced*" (at [16]).[245]

309. Next (relevantly), on 01 July 2019 the ACQ Standards were introduced. They "*represented a shift from aged care consumers being treated as passive recipients of care to having an active role in choosing and directing how their care is delivered*," which introduced additional requirements around clinical care (at [23]–[24]).[246] What this means in terms of philosophy of care has already been discussed above, in Part E.3.

310. Mark Sewell (CEO, Warrigal) likewise stated that, "*[t]he [aged care] industry has always been known as being very highly regulated, this has increased even more with time*" (at [30]).[247] Warrigal's response have been to have a dedicated team which is responsible for compliance and reporting (see [32]–[35]).[248] The work of this team is to check to ensure the documentation is all collated appropriately and covers the information that is necessary for the external report (PN12911). Without this, "*a lot of the work would fall onto our direct care employees*" (at [32]).[249] The clear corollary is that, in the case of providers who do not have the resources or inclination to provide such a compliance team, the work <u>does</u> fall onto the direct care employees.

311. And in any case, the raw material that goes into any report is still identified by direct care employees, who report issues to the RN, who in turn must make decisions about whether the information requires reporting (see at [35]–[37]).[250] The regulatory burden on direct care workers remains high enough that Mr Sewell has "*witnessed a general level of frustration 'on the floor' amongst RN's, regarding the level of regulation and the requirement to complete increased levels of paperwork*" (at [41]).[251]

312. As acknowledged by Mr Brockhaus, (CEO of Buckland) the reality of the situation is that there is a lot of regulation in the aged care industry. His evidence is that the amount of auditing and reporting required by the provider to prove that it is supporting the

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244 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13583).
245 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13583).
246 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13584).
247 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14599).
248 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14599–14600).
249 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14599).
250 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14600).
251 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14600).

resident to make choices regarding their care and delivering that care in accordance with their decision, is extensive.[252]

Findings of the Royal Commission

313. At [FR.2.41-48] the Royal Commission provides an overview of how aged care is regulated and summarises the chief regulatory changes that have been introduced in the last decades and, indeed, during the course of the running of the Royal Commission. The cumulative nature of regulatory change is described at [FR.2.48] as follows:

> "In recent decades, the aged care system in Australia has evolved and has been changed in a myriad [of] ways. During the time of our inquiry, as new initiatives and policies were announced by the Australian Government, the system has changed further. Some changes to the system have been large, some incremental, but all have contributed to the piecemeal development of the aged care system."

314. At [FR.2.7-12] the Royal Commission also provides an overview of historical development of aged care.

315. Despite the quantity of evidence as to the onerousness of documentation associated with the Aged Care Quality Standards, and the significance of the changes associated therewith, it is fair to say (by way of summary) that the Royal Commission was not especially impressed by those standards. Comments showing this are at [FR.1.92–96], [FR.1.134–135], [FR.2.92], [FR.3(a).119–134], and [FR.3(b).478].

316. Indeed, the Royal Commission recommended an independent review of the Aged Care Quality Standards with amendment, if considered appropriate, in relation to (relevantly) best practice oral care, medication management, pressure care, wound management, continence care, falls prevention and mobility, and infection control, dementia care, and palliative care (see [FR.1.223]).

317. If anything, then, it is safe to expect the obligations (including documentary obligations) of aged-care workers to increase, and the standards to further change (and presumably heighten).

E.4.1 Serious Incident Response Scheme (SIRS) - Lay Evidence Report Part D.4.1

318. In summary, the SIRS scheme did essentially two things: it imposed on obligation upon providers to establish their own internal incident management systems and it imposed

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252 Statement of Johannes Brockhaus dated 3 March 2022 at [26] (tab 293 page 14831).

additional reporting requirements (see PN12291, in the evidence of Paul Sadler, ACSA CEO). This has increased the regulatory burden on, and increased the work of, RNs, ENs, and AINs / PCWs, as the evidence summarised below shows.

The Lay Evidence Report

319. The ANMF adopts the content of Lay Evidence Report [314]–[320]. This extracts (*inter alia*) evidence of Lisa Bayram (RN) at [65] and [72], and Wendy Knights (EN) at [55]–[60].

Evidence of other Frontline Workers

320. Linda Hardman (AIN / PCW) said under cross-examination that SIRS is still pretty new and "*[w]e're all still getting quite used to it*." She agreed that a tear in the skin or a bruise will be described as an "*adverse event*" for the purpose of SIRS.[253]

Evidence of officials

321. The evidence of Annie Butler identifies that SIRS was introduced by the Aged Care Quality and Safety Commission from 1 April 2021 and requires aged care providers to have an effective incident management system. Aged care providers are also now required to report a range of serious incidents to the ACQS Commission within 24 hours of becoming aware of them. Further, the SIRS requires a broader range of allegations and suspicions of serious incidents to be reported than was previously the case. Consistent with the summary provided above, Ms Butler explained that SIRS requires providers to have an effective incident management system in place to reduce serious injuries and other incidents, and to respond appropriately to incidents when they occur.[254]

Evidence of employer witnesses

322. Paul Sadler (CEO, ACSA) states that SIRS was introduced in 2021 for residential care, and will be introduced into home care shortly (at [30]).[255] This requires providers now to report upon the following matters (set out at [32]):[256]

> "(a) unreasonable use of force;

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253 Cross-examination of Linda Hardman at PN9828–PN9829.
254 Amended Witness Statement of Annie Butler 2 May 2022 at [234]–[235].] (tab 181 page 9283).
255 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13585).
256 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13586).

(b) unlawful sexual contact or inappropriate sexual conduct;

(c) neglect of a consumer;

(d) psychological or emotional abuse;

(e) unexpected death;

(f) stealing or financial coercion by a staff member;

(g) inappropriate use of restrictive practices; and

(h) unexplained absence from care."

323. The result is that, "*[c]are workers are now required to identify potential issues and provide their concerns to the registered nurse*," and the RN is then "*required to document the report in the providers internal reporting systems*" (at [34]).[257] That is, the way that the organisation acquits its reporting requirement is by having in place systems that require employees to notify and report and document in an appropriate manner (PN12303–PN12304). All organisations will have incident management systems that require reporting by individual staff (PN12307)

324. Mr Sadler also accepted that the process of a SIRS report being made would involve an RN, EN, or AIN / PCW actually noticing an issue that may potentially be reportable (PN12411–12413), the RN documenting and investigating if necessary the possible reportable event, which might involve speaking with the first responder (PN12415), assessing (physically and cognitively) the resident (PN12415), doing neurological observations and other clinical interventions on the resident with a view to assessing the impact of the event on the resident (PN12416), and then forming and documenting a view about whether the incident was in fact reportable (PN12417–PN12420). The formation of a judgment as to whether the incident is reportable are questions of clinical judgment, in which training and skill are brought to bear (PN12421).

325. Craig Smith (Executive Leader Service Integrated Communities, Warrigal) likewise said that the SIRS process now requires providers to report on a broader range of incidents through the regulatory body's portal (at [53]).[258] The process for making such reports includes AINs / PCWs making observations, noting a concern, documenting

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257 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13586).

258 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14128).

their observation or reporting it to an RN, the RN then collating information into a system, and the centralised reporting team reviewing that information (at [55]).[259]

326. Mr Smith agreed that the training of RNs, ENs, and AINs / PCWs in relation to SIRS was designed to ensure that RNs, ENs, and AINs / PCWs were astute to notice indications of what might potentially be a SIRS-reportable event (PN13216). They would make an initial judgment about whether it might be reportable (PN13217), erring on the side of caution (PN13218). Near misses are documented by Warrigal, in addition to actual incidents (PN13219). AINs / PCWs who notice something that might be reportable would make a report that would either directly, or indirectly, end up with an RN (PN13220–13223), and this would be documented (PN13224).

327. The RN to whom the report is made would conduct investigations—taking "*neglect of a consumer*" as an example, the RN might speak with the care workers involved in care (PN13227), speak with the resident (PN13228), perform clinical tests (PN13229), initiate revised interventions for the resident (PN13230), arrange medical follow-up, update the care plan (PN13231), and ultimately form a view about whether the incident is SIRS-reportable (PN13232). Thereafter, the central reporting team would "*run the ruler over the information that's been prepared and decide[] whether it is reportable and, if so, how*" (PN13234). Mr Smith accepted that his estimate of the number of reports per week did not include incidents that do not make it as far as a report (because, *e.g.*, during investigation it is decided that a reportable incident has not occurred) (PN13240).

328. Emma Brown (Special Care Project Manager at Warrigal) describes SIRS as an administrative task involving personal care workers who are required to document incidents and near misses and RNs who are required to document, investigate and manage the incident.[260] She recognises the impact that this has had on personal care workers and the clinical management team.[261]

Findings of the Royal Commission

329. A brief summary of the introduction of the SIRS is at [FR.2.45]:

> "In June 2020, the Australian Government announced that it would introduce

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259 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14128).
260 Statement of Emma Brown 2 March 2022 at [37] (tab 290 page 13986).
261 Statement of Emma Brown 2 March 2022 at [38] (tab 290 page 13987).

> a Serious Incident Response Scheme from July 2021. This scheme will require reporting of a broader range of serious incidents, including incidents of abuse in aged care where the resident who allegedly commits an incident has a cognitive or mental impairment."

330. As with the Aged Care Quality Standards, the Royal Commission's general approach to the SIRS was that it did not go far enough. Hence, the Commissioners said (at [FR.3(b).524]) as follows:

> "We consider that the new Serious Incident Response Scheme should be extended to cover allegations of certain serious incidents perpetrated by aged care workers against people receiving aged care in home settings."

331. The Royal Commission also stated that the objectives of the SIRS should be set out in legislation, and that their central object must be "*to protect people receiving aged care services from harm*" (where previously their aims had been broader than, but inclusive of, this aim) (see [FR.1.140]).

332. Accordingly, there is again no reason to think that the increased workload associated with the SIRS will diminish; if anything, the contrary (an increased associated workload) is the more likely future.

E.4.2 ACFI accreditation - Lay Evidence Report Part D.4.2

Agreement between interested parties as to this factor

333. The Consensus Statement at [23] recognised that changes to the ACFI and a new funding instrument were shortly to be introduced.

The Lay Evidence Report

334. The ANMF adopts Lay Evidence Report [321]–[330]. This part of the report extracts or refers to (*inter alia*) evidence of Suzanne Hewson (EN) at [42]–[43], Linda Hardman (AIN / PCW) at [40]–[41], Wendy Knights (EN) at [64], Dianne Power (AIN / PCW) at [59], Maree Bernoth (RN) at [36], and Pauline Breen (RN) at [19].

335. Also relevant is [26] of Ms Hewson's statement, where she records that there remains paper-based reporting on pain management, treatments such as heat packs, sleep charts, behaviour charts, and for ACFI purposes.[262]

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262 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13423).

336. In cross-examination, Wendy Knights (EN) explained the role of AINs / PCWs regarding ACFI paperwork (PN9321):

> "-PCAs will do their weight, their BP, that sort of thing. They will ask them are they happy with their care, are there any issues that you, you know, you think we can improve on already, that sort of thing. And then that gets filled into the paperwork and then the EN's role is to go through and read all the progress notes for that month or three-month period, whichever it may be, and document in it that–if there's any changes in medication, any changes in their care, whether they're now needing glasses, their hearing aids and dentures. We document that and then that all upgrades, goes to the ACFI lady within the organisation which is an RN, and she documents that and then it just classifies their level of care."

337. She explained that this involves also collecting the information that goes into the report—so, for example, for weight, it might involve putting the resident in a weighing chair (PN9239), and the same again in regard to blood pressure (PN9243), including comparing that blood pressure against a "*traffic light*" system (PN9244).

Evidence of other Frontline Workers

338. Hazel Bucher noted that care plans were lengthy and, whilst evidencing resident choice, they were also directed to ACFI requirements (at [38]).[263] Ms Bucher also referred to "*increased documentation and reporting and the demands of the Aged Care Funding Instrument*" (at [43(c)]).[264]

339. Jocelyn Hofman refers to "*[m]ajor changes in funding arrangements*," which, together with changes in recording and reporting, almost always impact upon the work of RNs (where seldom is that impact in the nature of a reduction in work) (at [20]).[265]

Evidence of officials

340. Andrew Venosta gave evidence that the ACFI model is based on the principle of "*the higher the care needs, the higher the funding*" but that paradoxically, residents with higher care needs tend to deteriorate rapidly and, sadly, die more quickly. He said that this results in a higher turnover of residents as they pass away.[266] Under cross-examination he explained that the facility manager is responsible to the organisation for ensuring the ACFI assessments are up to date, correct and managed according to

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263 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13125).
264 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13127).
265 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13153).
266 Amended Witness Statement of Andrew Venosta dated 3 May 2022 at [92] (tab 188 page 11141).

schedule and that they are accurate, so the funding is maximised. But then there is a whole system and process that must follow on underneath that. The care coordinator would probably be the lead role, managing and supporting the care and medical staff, in particular the RNs.[267]

Employer evidence

341. Paul Sadler (CEO, ACSA) stated that RNs have been diverted from direct care into the completion of ACFI assessments. This has affected both RNs and care workers, but, "*it has particularly impacted RN workloads*" (at [41]).[268] In cross-examination, Mr Sadler accepted that care workers may be consulted about changes in residents' behaviours or conditions, for the purpose of completing ACFI assessments (PN12313).

E.4.3 Reduced use of chemical and physical restraints - Lay Evidence Report Part D.4.3

342. In line with the Royal Commission *Recommendation 17: Regulation of restraints*, from 1 July 2021, approved providers have updated and specific responsibilities under the *Aged Care Act* and the *Quality of Care Principles 2014* relating to the use of any restrictive practice in residential age care and short-term restorative care in a residential setting. Amendments to the *Aged Care Act* and *Quality of Care Principles* have been implemented to minimise the use of restrictive practices, and where a restrictive practice is used, to ensure that it is used or applied in accordance with legislative obligations. A factsheet published by the ACQSC[269] providing a summary of the key legislative changes for providers which identifies the new definitions, new requirements, strengthening and clarifying of existing obligations pertaining to the use of restrictive practices.

Agreement between interested parties as to this factor

343. The Consensus Statement recognised (at [23]) that there have been changes in regulations concerning the use of physical and chemical restraints. The effect of this is detailed in the Lay Evidence Report and in other evidence.

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267 Cross Examination of Andrew Venosta at PN3957.

268 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13587).

269 Aged Care Quality and Safety Commission Summary of Key Changes in Restrictive Practices Factsheet (ANMF 58)

The Lay Evidence Report

344. The ANMF adopts Lay Evidence Report [331]–[336]. This contains extracts from the evidence of (*inter alios*) Stephen Voogt (NP) at [32]–[41] and [59], Lisa Bayram (RN) at [53], Wendy Knights (EN) at [49]–[52], and Patricia McLean (EN) at [41]–[42].

345. In addition to what Ms Knights said at [49]–[52], what she said at [70] is relevant:[270]

> "There have also been changes as a result of the Royal Commission with regard to pain relief and restraint medication. While the reduction or elimination of some drugs is welcome, it has also led to changes in behaviours and more difficulty in managing them in an environment where we don't have extra people to manage or monitor those residents."

346. And, Ms Knights said this (at [88]) in relation to the connection between her advocacy role and medication (including physical and chemical restraint) (emphasis added):[271]

> Another example of advocacy for me is the gap between managing resident behaviours and the quite proper limitations on use of chemical restraints or over-use of pain relief. I think in our facility and many aged care facilities there isn't enough thought and policy around how to manage the consequences of less restraint and less pain relief. I have written, with the support of other ENs and RNs, to our CEO and Board requesting a working party to look at this issue so we can develop comprehensive policies and protocols around this issue.
>
> My view is that there are now so many regulations concerning pain relief that when it is really needed, it is difficult to get and takes too long. Many of our residents worked physically-demanding jobs and have a corresponding need for pain mediation, including strong pain medication. Post-Royal Commission, doctors are more reluctant to write scripts for pain medication. Sometimes scripts run out and we cannot get a replacement for several days, or until after a weekend. Pain management, and dealing with behaviours caused by unmanaged pain, occupies more time than it used to."

Evidence of other Frontline Workers

347. In addition, Hazel Bucher also refers to the profound influence on the work of RNs, ENs, and AINs / PCWs caused by (amongst other things) regulation in respect of restraint (at [43(b)]).[272]

348. Jocelyn Hofman (RN) referred (at [43]) to the recent introduction of additional documentary requirements in regard to chemical and physical restraint.[273]

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270 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13448).
271 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13451).
272 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13127).
273 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13157).

349. Linda Hardman (AIN / PCW) said as follows at [50] of her statement:[274]

> "Another factor that leads to behaviours is that, especially after the Royal Commission, there has been a push to get residents off anti-psychotics or on reduced doses. In theory this is a good idea. In practice, my experience has been that when residents are taken off antipsychotics, often their behaviours get worse. As an AIN, I feed that back to the ENs and RNs, but even if doses are re-increased, in the meantime I am dealing with the behaviours."

350. Sheree Clarke (AIN) describes medications as a quick and simple way of dealing with behavioural problems. She observes that non-medical interventions to stop escalating behaviour take time and require adequate staffing. Her evidence is that as an AIN, she is constantly addressing falls risk, ensuring that the dignity of residents is preserved and that residents are safe. She observes that if she needed to spend an extended period of time deescalating resident behaviour, she is taken away from performing that other work.[275]

Evidence of officials

351. The evidence of Annie Butler is that from 1 July 2021, approved providers have updated and specific responsibilities under the *Aged Care Act* and the *Quality of Care Principles 2014* relating to the use of any restrictive practice in residential age care and short-term restorative care in a residential setting.[276] She describes these reforms as welcome steps towards ensuring safe and quality care. However, she notes that both implementation of reform and the necessary changes to work practice to ensure compliance have increased work complexity and required changes to the way work is performed.[277]

Evidence of employer witnesses

352. Craig Smith (Executive Leader Service Integrated Communities, Warrigal) accepted in cross-examination that dementia can lead to challenging behaviours such as wandering and falling (PN13248–13249). He agreed that there was a category of people in facilities that have symptoms of dementia or some other cognitive condition but not a formal diagnosis (PN13253), and—because they do not have the diagnosis—cannot receive chemical restraint (PN13252). Accordingly, there are fewer residents now, in comparison with prior to the implementation of the National Aged Care Mandatory

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274 Statement of Linda Hardman dated 29 October 2021 (tab 263 page 13271).
275 Witness Statement of Sheree Clarke dated 29 October 2021 at [56].] (tab 268 page 13373).
276 Amended Witness Statement of Annie Butler dated 2 May 2022 at [236].] (tab 181 page 9283).
277 Amended Witness Statement of Annie Butler dated 2 May 2022 at [239].] (tab 181 page 9283).

Quality Indicator Program (NACMQIP) in 2021, who are chemically restrained (PN13254). On the whole, there had been a reduction in the use of restraints (including physical restraints) in Warrigal, and certain types of physical restraints had almost been eliminated (PN13284–13285)

353. Ms Smith accepted that the reduction in the use of restraints might create an increase in unexpected behaviours and falls (PN13225). At Warrigal, it had certainly increased wandering and aggressive behaviours (PN13256), but he could not say whether it had increased falls because he did not have figures to hand (PN13257). He agreed that this enhanced the complexity and amount of work for nurses and AINs / PCWs (PN13258–13259).

354. Emma Brown (Special Care Project Manager at Warrigal) described the impact of the update to the *Quality of Care Principles* which commenced on 1 July 2021. She described this as requiring more documentation and assessments by a RN in order to undertake restrictive practices. She said that that care staff under the guidance of a RN must support the customer with alternative interventions prior to any of the restrictive practices.[278]

355. Ms Brown also gave evidence under cross-examination agreeing that with the reduced use of chemical restrains, other measures and additional recourses such as diversional therapy and understanding of behaviour management strategies were need to manage underlying anti-social or dangerous behaviours.[279]

E.4.4 Observation and documenting responsibilities including charting and making progress notes - Lay Evidence Report Part D.4.4

Agreement between interested parties as to this factor

356. The Consensus Statement refers (at [23]) to "*increased documentation requirements*" as a result of changes to the regulatory regime applicable to aged care work. Many of these increased documentation requirements have been outlined above in regard to specific subject matters (such as ACFI), but further matters are outlined in this section.

357. BaptistCare submitted (at [17]) as follows:[280]

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278 Statement of Emma Brown dated 2 March 2022 at [17] (tab 290 page 13983).
279 Cross-examination of Emma Brown at PN13367 and PN13392.
280 Submissions of BaptistCare (tab 126 page 876).

> "Over time, the role of frontline care staff has required requires more assessment, care documentation and practices that assist the clinical staff. This includes assisting with medication, simple wound dressing, assisting with the implementation of continence programs, attend to regular checks including urinalysis, blood pressure, temperature and pulse checks, blood sugar level checks and assist and support diabetic clients in the management of their insulin and diet."

358. IRT submitted that "*[i]ncreasing regulation now requires a vast amount of additional documentation and reporting*."[281]

The Lay Evidence Report

359. The ANMF adopts Lay Evidence Report [337]–[356]. These paragraphs refer to or extract evidence from Lisa Bayram (RN) at [51], Maree Bernoth (RN) at [36]–[37], Linda Hardman (AIN / PCW) at [34]–[35] and [37]–[39], Suzanne Hewson (EN) at [25]), Jocelyn Hofman (RN) at [43], Wendy Knights (EN) at [62]–[68]), and Christine Spangler (AIN / PCW) at [26]).

360. In addition to [25] of Ms Hewson's statement, [26] is also relevant:[282]

> "We have to record vital signs in both the PCS and Medimap. We also need to write progress notes. In the case of high risk residents, progress notes need to be updated every shift. We also still have additional paper-based reporting on pain management, treatments such as heat packs, sleep charts, behaviour charts, and for ACFI purposes. I am allocated less than 15 minutes per shift to complete all this documentation, which is simply not enough time."

361. And, Ms Knights's statement at [26]–[27] is relevant as well:[283]

> "26. I said at paragraph 16 above that the role of an RN has changed in my time in aged care. RNs used to be on the floor much of the time. Now, they are much more in the office. To my observation, that is because the administrative and paperwork load is much greater for RNs than it used to be.
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> 27. For example, if a transfer to hospital is required, the RN does the administration side of that. That may involve ringing management, ringing the resident's family, and ringing the resident's doctor, amongst other things. The RN also makes appointments, scans notes, books followup appointments, arranges changes in mediation, and things of this kind. RNs also are involved in producing care plans, reviews, and updates to care plans. I've observed that this work for the RN in Princes Court takes up most of her shift. Though, she is still required on the floor when, for example, ENs or PCWs ask for assistance or evaluation, or if there is a fall."

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281 Submissions of UnitingCare (tab 128 page 1117).

282 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13423)

283 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13441).

362. Ms Hardman's evidence was that progress notes and charting would take at least half an hour at the end of each day, assuming there were no interruptions (PN9847–9848).

Evidence of other Frontline Workers

363. Hazel Bucher (NP) refers to more documentation being required for wound care (at [42(a)]).[284] Ms Bucher also referred to an increase in the quantity of documentation at [43(c)].[285]

Evidence of officials

364. Andrew Venosta (RN and Industrial Officer) notes the increased pressure and expectation on PCWs to fully document and chart the care that has been provided for use in ACFI care assessments. His evidence is that a failure to capture the changing care needs of residents with accurate and up to date charts, assessment and clinical notes might result in care plans not being reflective of resident care needs, potentially not complying with the Accreditation Standards, and not maximising funding under the ACFI.[286]

Evidence of employer witnesses

365. In addition to the documentation requirements discussed in other sections of these submissions, Craig Smith (Executive Leader Service Integrated Communities, Warrigal) outlines the requirement, implemented on 01 July 2021, for residential aged care facility providers to collect and report on these indicators (at [43]):[287]

> "(a) Pressure injuries:
>
> (b) Physical restraints;
>
> (c) Unplanned weight loss;
>
> (d) Falls and major injury; and
>
> (e) Medication management."

366. There is now an additional reporting requirement for Warrigal's compliance team (at [46]).[288]

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284 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13126).
285 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13127).
286 Amended Witness Statement of Andrew Venosta dated 3 May 2022 at [95] and [97] (tab 188 page 11141).
287 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14126).
288 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14127).

367. Mr Smith accepted that the process of collecting and reporting on indicators would involve nurses and AINs / PCWs documenting, for example, a pressure injury (PN13198) in progress notes or incident forms (PN13199), and reporting that situation to an RN (PN13200). The process of determining whether a reportable incident had happened would involve things like conducting clinical investigations of residents (PN13203).

368. Taking, for example, an incident of unplanned weight loss, an RN might conduct a clinical investigation to find out why that weight loss had occurred (PN13205), develop a plan to deal with it (PN13206), update a care plan (PN13207), and delegate tasks to AINs / PCWs (PN13208). A plan to deal with the unplanned weight loss would be prepared, and then there would be a process of documenting the following through of that plan (PN13212). That would all involve creating documentation by the clinical care team, including the RN (PN13213).

369. The evidence of Cheyne Woolsey (Chief Human Resources Officer at KinCare) is that home care workers at KinCare must be capable of observing and detecting any change in the customer's health and wellbeing, including:

    (1) Physical–such as observing impaired mobility, a lesion on a limb, a difficulty with buttons and laces and so on;

    (2) Mental–where the home care worker observes a change in speech, attention, mood and other indicators of health and wellbeing; and

    (3) Environmental–such as a pet that the customer may or may not be able to care for or control, or someone in the home who may pose a threat of abuse to the customer or home care worker.[289]

370. Mr Woolsey recognises that KinCare's home care employees are best placed to be able to provide KinCare's customer care managers with the information that is essential to ensure that the care plan is appropriate to the customer's needs.[290]

371. Sue Cudmore (who has operational control of Alliance Community) describes that home care employees who notice signs of poor circulation, skin damage or a wound are

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289 Statement of Cheyne Woolsey dated 4 March 2022 at [44] (tab 297 page 15719).

290 Statement of Cheyne Woolsey dated 4 March 2022 at [45] (tab 297 page 15719).

to report this to the care coordinator.[291] Ms Cudmore accepted that Alliance Community relies on care workers to document incidents that they observe in providing home care.[292] She estimates that after each service, a home care employee will spend 5 to 10 minutes completing documentation about the visit, containing a brief note of the service that was performed and any general observations on the client.[293]

372. The evidence of Kim Bradshaw (General Manager at Warrigal's Stirling Facility) is that compared to her experience in the hospital system, she has found the aged care industry to be heavily regulated. She describes recent changes to mandatory reporting within the last 12-18 months and that front line carers as being required to document their observations then help make up the reports from RNs and the clinical care managers. She recognises that it may take more time for a front-line employee to document their observations as there is more to observe given the change in resident condition.[294]

373. Ms Bradshaw estimates that it now takes approximately 2 hours each day for RNs and clinical care managers to complete the required documentation and reporting.[295] She says that the AIN will also document their observations on the behaviours and activities, mobility, continence, feeding, grooming, mood and behaviours of the resident.[296]

E.4.5 Care plans - Lay Evidence Report Part D.4.5

The Lay Evidence Report

374. The ANMF adopts Lay Evidence Report [357]–[371]. This extracts or refers to evidence from (*inter alios*) Lisa Bayram (RN) at [46], Pauline Breen (RN) at [14], Wendy Knights (EN) at [65] and [67], and Sherree Clarke (AIN / PCW) at [51]–[53].

Evidence of other Frontline Workers

375. Further evidence as to the nature of care plans is in the statement of Hazel Bucher (NP) at [27],[297] and at [38]—the latter of which states as follows:[298]

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291 Statement of Sue Cudmore dated 4 March 2022 at [45] (tab 295 page 15072).
292 Cross-examination of Sue Cudmore at PN13648.
293 Statement of Sue Cudmore dated 4 March 2022 at [48]–[49] (tab 295 page 15073).
294 Statement of Kim Bradshaw dated 4 March 2022 at [24]–[25] (tab 294 page 14940–14941).
295 Statement of Kim Bradshaw dated 4 March 2022 at [22] (tab 294 page 14940).
296 Statement of Kim Bradshaw dated 4 March 2022 at [43] (tab 294 page 14943).
297 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13120).
298 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13125).

> "The care plans that are required to be written are lengthy, and whilst evidencing resident choice they are also directed to ACFI requirements. Resident care plans provide evidence to the ACQSC that we know our residents well however, day to day care staff rely on verbal reports and knowing the resident and needs are communicated through mentoring for new staff. Thus generally, care staff rely on verbal instructions and asking questions/mentoring. The care plans are important in documenting care needs both for care provision for new staff and to ensure an understanding of the care needs of the resident."

376. At [39] of her statement, Linda Hardman (AIN / PCW) observed that care plans are now much more detailed than they used to be, and that—while RNs are responsible for preparing care plans—AINs / PCWs are expected to keep "*very detailed records,*" as those records will form part of the input into the care plan.[299]

377. Jocelyn Hofman (RN), at [26] of her statement, describes the care plan as the "*core document that informs the delivery of care in accordance with [the] resident's needs*."[300] In her facility, the responsibility of creating care plans is shared between the RNs together (PN9639–9640).

378. Wendy Knights (EN) explained in cross-examination the process for developing a care plan for persons admitted for respite care. An admissions officer, who is an RN, gets as much information as she can so that there is a ground level to work with (PN9159–9160). Ms Knights continued (PN9162):

> "We ring the doctor and get a medication summary and medical history so that we know whether they've got diabetes, congestive heart failure, arthritis, osteoporosis, so that we need to be more vigilant if there's a fall. If she is non compos one day and it could be she could be in a hypo with diabetes, so, yes, more of that sort of thing. So she's got to know all that so we know that."

379. Nurses would try to get scripts transferred to a nearby chemist (PN9164).

380. With all care plans, Ms Knights explained, observations are filtered back to the RN so that they can be included in subsequent versions of the care plan (PN9201–9202).

Evidence of officials

381. Annie Butler (ANMF Federal Secretary) identifies the care plan as providing a framework for the delivery of care that reflects individual wishes, preferences and

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299 Statement of Linda Hardman dated 29 October 2021 (tab 263 page 13270).

300 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13154).

interests as well as identifying who is responsible for delivery of care under the supervision of the RN.[301]

382. The evidence of Andrew Venosta (RN and Industrial Officer) identifies the significance of the care plan (at [109] and [111]) as follows:[302]

> "The 'care plan' is the central pillar for the provision of care to residents in the aged care sector. Care planning was also a key outcome of the Accreditation Standards. It is the key point of reference for all levels of care staff with respect to the care to be provided to the resident. During the early years of my career it was largely the role of the RN to review residents' care needs, complete assessments, and update care plans. The EN would support the assessment process under the supervision of the RN.
>
> …
>
> Over the years, the increasing complexity of residents' co-morbidities, frailty and care needs has required the entire care team to adapt. There is now a much greater reliance on the 'care team' as a whole. RNs have to rely on PCWs to be observing changes in resident care needs and reporting these changes to the RNs. PCWs are expected to report to the RN about changes in skin integrity, wounds, oral intake, behaviour, and other signs and symptoms which might indicate a deterioration in condition such as fever, coughing and conscious state."

Evidence of employer witnesses

383. Paul Sadler (CEO, ACSA) gave evidence in cross-examination that RNs, ENs, AINs / PCWs, possibly doctors, and others, have input into the content of a care plan (PN12427). And, the RN producing the care plan will review documentation prepared by AINs / PCWs and ENs in the course of so producing (PN12430).

384. Similarly, Mark Sewell (CEO, Warrigal) agreed that all care workers have input into care planning in the sense that progress notes and feedback from care workers are utilised in relation to considering and adjusting care plans (PN13023). The person writing the plan will usually be the clinical nurse specialist or the RN (PN13027), whoever is writing the care plan will ask for input from others (PN13027–13030).

385. Emma Brown (Special Care Project Manager at Warrigal) gives evidence of the process involved in creating a care plan. She describes an initial care plan being completed by a registered nurse with the consumer, setting out information about the consumer such as domains of care, social situation and family support.[303] A more comprehensive care

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301 Amended Witness Statement of Annie Butler dated 2 May 2022 at [183].] (tab 181 page 9274).
302 Amended Witness Statement of Andrew Venosta dated 3 May 2022 at [109] (tab 188 page 11143).
303 Statement of Emma Brown dated 2 March 2022 at [58] (tab 290 page 13990).

plan will then be created by a RN with input from a physiotherapist and from the recreational and lifestyle employees with the responsibility for developing the care plan remaining with the RN.[304] The care plan will then be reviewed every three months.[305]

386. Under cross-examination Ms Brown agreed that sometimes the creation of a care plan may occur in a crisis situation where someone is being admitted directly from hospital. She accepted that the quality of the information handed over from a hospital can vary.[306]

387. Ms Brown's evidence is that ultimately it is responsibility of the RN to ensure that the care plan is met with the personal care worker identifying the changes in the consumer and documenting these through their normal progress notes.[307] However, she also agreed in cross-examination that care worker will would identify when there is a change or if they read a resident's care plan and they thought that that wasn't actually the case, and then they would escalate that to the registered nurse to have further discussion.[308]

E.4.6 Interactions with families - Lay Evidence Report Part D.4.6

Agreement between interested parties as to this factor

388. The Consensus Statement records (at [9]) that, "*[t]he expectations of aged care consumer and their families, and the community, about the provision of aged care services has risen over time*." And, at [12], it is said that, "*[c]ommunication with consumer and their families requires skills in interpersonal communication and cross cultural awareness*."

389. Additionally, Background Document 1 (at [116.13]) recognises as apparently uncontentious that "*[a]ged care employees have greater engagement with family and next of kin of clients and residents*" [footnote omitted].

390. IRT submits that family expectations around person-centred care have changed (*i.e.*, increased).[309]

391. These paragraphs recognise what is otherwise supported by the evidence: that communication between aged-care workers and the families of aged-care residents is

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304 Statement of Emma Brown dated 2 March 2022 at [59] (tab 290 page 13990).
305 Statement of Emma Brown dated 2 March 2022 at [60] (tab 290 page 13990).
306 Cross-examination of Emma Brown at PN13334–PN13335.
307 Statement of Emma Brown dated 2 March 2022 at [63] (tab 290 page 13990).
308 Cross-examination of Emma Brown at PN13344.
309 Submissions of IRT (tab 128 page 1118).

an increasingly prevalent, and increasingly difficult, feature of the work. This is outlined in further detail below.

The Lay Evidence Report

392. The ANMF adopts Lay Evidence Report [372]–[384]. This extracts or refers to evidence from (*inter alios*) Suzanne Hewson (EN) at [28], Wendy Knights (EN) at [78], Hazel Bucher (NP) at [43(d)], and Maree Bernoth (RN) at [49].

393. In addition to what Ms Bucher said at [43(d)], she said this at [41] (emphasis added):[310]

> "Family members with pre-existing mental health illnesses such as anxiety can be challenging to manage for the RNs as at times phone calls can be abusive and difficult to end. Over time interactions with families has become more frequent, with expectations and a need to provide feed back to and consultation with families increasing."

394. She also referred, in [42(i)], to the challenge of providing social support to families, which is often complex given guilt issues or high expectations as to what was possible.[311]

395. In addition to what Ms Knights said at [78], she referred at [56], [58], [62], and [63] to new obligations to notify families of particular matters arising in the provision of care to aged care residents.[312] At [86] she referred to the fact that families have increased expectations in comparison with a decade ago.[313] And, at [95], Ms Knights refers to sometimes being abused by families.[314] In cross-examination, Ms Knights said that notifying families was generally the job of the RN, but sometimes the EN, and that a short report would then be written of what had been observed (PN9222–9223)

396. Christine Spangler (AIN / PCW) states (at [24(k)(ii) that residents' families generally have higher expectations than they used to about the standard of service.[315] She has been required to develop greater empathy for families, better understanding of their expectations, and better communication skills in order to deal with them (at [25]).[316]

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310 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13126).
311 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13126).
312 Statement of Wendy Knights dated 29 October 2021 (tab 272 pages 13446–13447).
313 Statement of Wendy Knights dated 29 October 2021 (tab 272 pages 13451).
314 Statement of Wendy Knights dated 29 October 2021 (tab 272 pages 13452).
315 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13016).
316 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13016).

COVID-19 was especially hard on families, who got upset about not being able to visit, or not being able to take residents outside. Some refused to wear masks (at [39]).

Evidence of other Frontline Workers

397. In addition to the witnesses mentioned in the Lay Evidence Report, Pauline Breen (RN) said at [12] that relatives of parents do not understand her workload and the number of patients she needs to see in a shift and express disappointment about the limited available time.[317] Ms Breen also refers to her "*regular[] interact[ion] with the families of patients*," and the need to deal with family conflict (at [25]).[318] During COVID-19, Ms Breen was required at times to counteract family members' views about vaccines (at [27]).[319]

398. Linda Hardman (AIN / PCW) describes, at [22(c)], what she calls her "PR" skills. As she explains:[320]

> "AINs are often the face of the facility, as far as residents' families are concerned. It is an important part of our job to maintain relationships with residents' families as well as residents. Also, though, we need to recognise what is not our area, and to involve ENs and RNs where questions are asked that need their expertise."

399. Ms Hardman also says, at [25], that she interacts with families whenever they're allowed to visit, which is at any time of day including evenings and weekends.[321] And, at [69], Ms Hardman states that families do not appreciate the amount of work that goes into properly performed aged care, and have unrealistic expectations (given staffing levels in particular) about how quickly requests can be actioned. This sometimes results in verbal abuse of AINs / PCWs.[322]

400. Jocelyn Hofman (RN) refers to her dealings with residents' families during the course of a normal shift, at [15].[323] At [29], she says that her interactions with families is very important, and it is part of her role to contact families to notify them of changes in a resident's health or condition.[324] At [42], Ms Hofman states that there has, over time,

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317 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13349).
318 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13351).
319 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13352).
320 Statement of Linda Hardman dated 29 October 2021 (tab 263 page 13267).
321 Statement of Linda Hardman dated 29 October 2021 (tab 263 page 13268).
322 Statement of Linda Hardman dated 29 October 2021 (tab 263 page 13273–13274).
323 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13153–13154).
324 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13154).

been an increase in the expectation of (amongst others) family members in regard to the provision of care to residents. This has had a direct and practical implication for her work as a registered nurse, in particular in regard to reporting to families.[325]

Evidence of officials

401. Kathryn Chrisfield (Occupational Health and Safety Team Manager, ANMF) refers at [31] of her statement to a rising awareness and recognition of incidents of occupational violence and aggression perpetrated by residents and family members on staff in aged care facilities.[326] At [37], Ms Chrisfield provides further evidence in regard to intentional occupational violence and aggression perpetrated by residents, families, or visitors.[327] And, at [39], Ms Chrisfield refers to reports of aggression when family members are dissatisfied with care, which they express in the form of verbal and sometimes physical abuse, harassment, constant questions, and phone calls.[328]

402. Andrew Venosta's evidence is that in the challenging environment of complex clinical care in aged care, staff would often be engaged in managing difficult family members dealing with grief, denial of their loved one's condition, and having unrealistic expectations regarding care outcomes. He identifies PCWs as being particularly exposed to this issue as they were most visible on the floor of the facility and would be approached to discuss resident care.[329]

Evidence of employer witnesses

403. Paul Sadler (CEO, ACSA) was careful in his statement (at [85]–[93]) to distinguish between the kinds of interactions with families that are within, and those that are not within, the responsibilities of AINs / PCWs.[330] But, he allowed (appropriately, and consistently with the union lay witness evidence) that such interactions are more common now than they had been in the past (at [89]).[331] And, he accepted that, due to the focus on "*consumer-centred care*," interactions are now more "*conscious*," which is to say that workers are careful to ensure that they consider the consumer in their

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325 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13157).
326 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10745).
327 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10746).
328 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10747).
329 Amended Witness Statement of Andrew Venosta dated 3 May 2022 at [69] (tab 188 page 11137).
330 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13593).
331 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13593).

communications (at [90]).[332] AINs / PCWs in home care, while some matters will require escalation, are the "*first point of contact for the family*" (at [93]).[333]

404. Mr Sadler accepted that it happens that nurses and AINs / PCWs are faced with rudeness from families, as well as families being demanding and taking out frustrations (PN12431–12432). There may be fine lines for people confronted with that sort of conduct whether they can deal with themselves, or whether it should be escalated (PN12433), which decisions have to be made in real time (PN12434).

405. Mark Sewell (CEO, Warrigal) also distinguished in his statement between interactions that were, and those that were not, within the scope of an AIN's / PCW's duties (at [96]–[111]).[334] But again Mr Sewell appropriately allowed that employees had to deal with "*enormous issues*" such as grief, had to have the "*skill to diffuse sensitive situations*," had to know when to refer situations to supervisors, and were more likely than previously to engage with external authorities and regulatory bodies (at [103], [104], [107]).[335]

406. Mr Sewell, unlike other witnesses, was of the view that there had been a <u>decrease</u> in engagement with families (at [107]–[108]).[336] Though he said further in cross-examination that there is a trend of higher social expectations for customer service and quality care (PN13011). So far as Mr Sewell's evidence is to be understood as suggesting families were increasingly <u>dis</u>engaged (and it is not clear that it is so to be understood), other employer witnesses (*e.g.*, Mr Sadler) and all or nearly all of the frontline workers who gave evidence about the topic had a different experience—of more engagement. The evidence of these witnesses, who are (with respect) better positioned than Mr Sewell to speak to what their work entails, would be accepted.

407. Mr Sewell accepted that sometimes families of residents are rude to employees (PN13111), might take out frustrations on employees (PN13112), and that there might be situations where employees have to make very quick judgements about whether an employee should deal with a situation herself or himself, or escalate it (PN13113). Mr Sewell also accepted that the requirement of open disclosure required a lot more

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332 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13594).
333 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13594).
334 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14608–14610).
335 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14608–14609).
336 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14609).

initiating of contact from the facility, from nurses and AINs / PCWs, to families (PN13115).

408. Under cross-examination, Johannes Brockhaus (Buckland CEO) identified that relatives and next of kin had become more demanding since the Royal Commission into Aged Care started. Mr Brockhaus said that this meant that people were more aware of aged care and the issues arising within, which prompted a lot of relatives and friends of Buckland residents to be more inquisitive about the care provided by Buckland.[337] He accepted that there's been more contact from residents and next of kin and that they wanted to be more engaged in the care that is provided.[338]

409. Emma Brown (Special Care Project Manager at Warrigal) describes her observations at Warrigal of:

(1) An increase over time with the level of engagement from the family of a consumer or their nominated/responsible person;

(2) An increase in questions being asked; and

(3) The introduction of open disclosure requirements (discussing with people receiving care/their family when something goes wrong).[339]

410. Ms Brown also accepted that family members and responsible persons can at times become quite frustrated with the facility and that his frustration can sometimes manifest in abuse towards staff members.[340]

411. The evidence of Kim Bradshaw (General Manager at Warrigal's Stirling Facility) is that the AIN can be the first point of contact for family concerns and that family members often have conversations with the AIN when they visit their loved one and, from her experience, they will often express their expectation for the resident to the carer.[341] Under cross-examination, Ms Bradshaw accepted that those expectations can somehow sometimes be expressed as anger or frustration.[342]

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337 Cross-examination of Johannes Brockhaus at PN13885.
338 Cross-examination of Johannes Brockhaus at PN13885.
339 Statement of Emma Brown dated 2 March 2022 at [80] (tab 290 page 13995).
340 Cross-examination of Emma Brown at PN13472–PN13473.
341 Statement of Kim Bradshaw dated 4 March 2022 at [44] (tab 294 page 14943).
342 Cross-examination of Kim Bradshaw at PN12781.

E.4.7 Work value conclusion arising from changes in accountability, regulation and residents' expectations

412. Based on the evidence set out above, the FWC can safely find that:

(1) residents and residents' families expect a higher standard of personalised care than had previously been the case;

(2) the regulatory burden on aged-care workers is considerable, and has been increasing;

(3) in particular, despite that the obligation to actually make a SIRS report falls on the employer, this obligation is fulfilled via the work of the employer's employees, and the work involved in documenting, investigating, and reporting SIRS-reportable incidents is considerable and (in many cases) new;

(4) RNs have been diverted to some degree from direct care into the preparation of ACFI paperwork which has impacted RN workloads as well as their supervisory and delegation responsibilities in respect of care delivery. Similarly, the workloads and work demands of those workers (perhaps especially ENs) who fill gaps created by RNs having been so diverted are also impacted;

(5) regulation has caused a reduction in the use of chemical and physical restrain, which increases the amount of work performed (due to, for example, increased wandering and falls), its complexity (due to an increased prevalence in problematic behaviours), and its risk (due to an increased incidence of violence), and skill (due to increased need to de-escalate behaviour or divert attention);

(6) the work involved in documenting and reporting is more time-consuming now than previously, which leaves less time for other work (enhancing the time pressure of that work), and creating additional responsibility in regard to work performed to meet regulatory burden;

(7) the care plan is foundational in the care to be provided by the nursing team, and the responsibility that falls on RNs (who have primary responsibility for these documents) is considerable. The work involved in preparing and keeping updated a care plan sufficient to enable person-centred care to be provided is also considerable, and greater than under previous models of care; and

(8) interactions with families are more frequent than in previous years.

413. Accordingly, the FWC can be satisfied that changes in accountability, regulation and residents' expectations have led to fundamental changes in the nature of the work of AINs/ PCWs, ENs and RNs. These changes are related to the work becoming more challenging and demanding, requiring greater levels of skill and responsibility and to the conditions under which the work is done.

E.5 Skills exercised by aged care employees- Lay Evidence Report Part D.5

Agreement between interested parties as to this factor

414. The effect of changes in aged-care work over time on the skill required to perform the job was addressed in many of the paragraphs of the Consensus Statement, most of which have been referred to already—see [1]–[3], [5]–[21] in the Consensus Statement.

415. Further, BaptistCare submitted, at [17], as follows:[343]

> "Over time, the role of frontline care staff has required requires [sic] more assessment, care documentation and practices that assist the clinical staff. This includes assisting with medication, simple wound dressing, assisting with the implementation of continence programs, attend to regular checks including urinalysis, blood pressure, temperature and pulse checks, blood sugar level checks and assist and support diabetic clients in the management of their insulin and diet."

416. Many of the matters that feed into the increased level of skill have been discussed above, or will be discussed below. This Part should not be read as exhaustively treating the skills exercised by aged care employees.

The Lay Evidence Report and other evidence

417. The ANMF adopts Lay Evidence Report [385]–[392]. This evidence is of a more general nature than the evidence in the sub-parts that follow. It extracts or refers to evidence of (*inter alios*) Stephen Voogt (NP) at [58], Lisa Bayram (RN) at [58], Hazel Bucher (NO) at [42]–[44], Jocelyn Hofman (RN) at [31], [39]–[41], Wendy Knights (EN) at [86], Patricia McLean (EN) at [31], [39]–[40], [77], [80].

418. Also relevant at the more-general level is [28] of Ms Bucher's statement:[344]

> "The skills I use in my work day to day are predominantly highly developed communication skills, assessment skills, critical reasoning and mentoring

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343 Submissions of BaptistCare (tab 126 page 876).

344 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13122).

> skills. I provide informal education most of the time by encouraging clinical reasoning and critical thinking whilst mentoring."

419. And, at [56] and [58] of Linda Hardman's statement, she refers to the use of skills such as emptying catheter bags, manual handling of residents, how to walk residents safely, being aware of skin tears, behaviour, pain levels, hydration levels, and toileting requirements.[345]

420. At [31] of Ms Knights's statement, she (non-exhaustively) lists some of the skills brought to bear in the course of a standard shift:

> "I'm in charge of doing the two medication rounds during the shift. I need to check the S8 drugs (DDs) in the drug cupboard with the RN at the start or end of my shift. I'm responsible for checking incomplete tasks from the AM shift. For example, it could be wound dressings, observations, the COVID testing for residents (temperature and health questionnaire) and so on. We also monitor the feeding as we have choking risks among the residents who can't swallow easily."

421. In addition to her evidence at [58] Lisa Bayram (RN) describes the additional nursing requirements that emerged even since 2015, including:

(1) A greater need for more advanced clinical assessment;

(2) More haemodialysis residents living in aged care;[346]

(3) Greater use of morphine syringe drivers and better palliative care management skills are required;[347]

(4) Increased prevalence of oxygen therapy;[348] and

(5) More residents using CPAP machines to assist sleep apnoea.[349]

422. Thereafter, the Lay Evidence Report sets out evidence in relation to particular skills that were common between the evidence of various witnesses.

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345 Statement of Linda Hardman dated 29 October 2021 (tab 263 page 13272).
346 Witness Statement of Lisa Bayram dated 29 October 2021 at [74].] (tab 262 page 13240).
347 Witness Statement of Lisa Bayram dated 29 October 2021 at [75].] (tab 262 page 13240).
348 Witness Statement of Lisa Bayram dated 29 October 2021 at [76].] (tab 262 page 13240).
349 Witness Statement of Lisa Bayram dated 29 October 2021 at [77].] (tab 262 page 13240).

Observational skills—Lay Evidence Report [393]–[400]

423. The ANMF adopts Lay Evidence Report [393]–[400]. This contains extracts from the evidence of Stephen Voogt (NP) at [52], Linda Hardman (AIN / PCW) at [22], Suzanne Hewson (EN) at [29].

424. In Ms Hardman's cross-examination, she gave examples of the kinds of observations she would recognise as meaningful—being less talkative than normal; sleeping more than normal (PN9830). She would also recognise skin tears, bruises, changes in skin pigmentation—"*even the slightest little thing*" (PN9822–9823).

425. Also relevant is the evidence of Jocelyn Hofman (RN) at [15], where Ms Hofman describes (*inter alia*) constantly assessing the efficacy of residents' current medication regimes so that they are not in pain, agitated, or distressed, assessing wounds, and screening for delirium.[350]

426. And, at [30], Ms Hofman said as follows:[351]

> "Registered Nurses' scope of practice involve clinical assessments, plan, provide timely clinical intervention, evaluate and monitor care services. For example, when I administer medication during my medication rounds, I assess my resident's status. Is their swallowing compromised? Are they depressed? Are they in pain? As a Registered Nurse, it becomes second nature to observe changes when interacting with residents."

427. At [39], Ms Hofman describes the range of assessments she performs while performing other tasks, such as administering medication—many of which assessments involve observational skills:[352]

> "• Checking on side-effects of the medication, both immediate and longer term and assessing the benefit of the medication consistent with quality use of medicine guidelines;
>
> • Assessing changes in the communication and cognitive capacity of the resident;
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> • Assessing the resident's overall well-being, oral and personal hygiene;
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> • Falls risk strategies are in place;
>
> • Reviewing continence care;
>
> • Ensuring adequate hydration and nutrition;

350 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13152–13153).
351 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13154).
352 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13156–13157).

> • Maintain our residents' skin integrity;
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> • Safe behavioural management in dementia care;
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> • Health emergency responses like identifying acute deterioration in residents related to infections compounded by co morbidities;
>
> • Infection prevention and control;
>
> • Palliative care including complex pain management;
>
> • Oversee safe and effective care work carried out by the rest of my care team."

428. Ms Hofman expressly states, at [40], that the range of assessments that are now required as a result of the increased acuity of residents "*require[s] greater attention.*"[353]

429. Wendy Knights's (EN) statement at [66] is also relevant to understanding the kinds of observations that are required. She outlines the kind of information that is now required to be inserted into progress notes (and therefore requires observation for that purpose):[354]

> "There are additional documentation requirements which require significant education and time to complete. For example, in the new Quality Standards they want us to document (preferably each shift, but certainly every day), how we have had contact or interactions with each resident. It might be talking to Mary about her trip to the dining room and her meal and documenting her descriptions of what she ate and whether she enjoyed it. On many days I have to do a minimum of 18 progress notes in the dementia unit that I didn't always have to do before. Previously it was only definitive changes that were documented. This daily interaction note often falls to me because the PCAs sometimes don't do them or aren't confident of their writing skills."

430. Rose Nasemena (AIN / PCW) described (at PN8587), "*constant monitoring*" of residents who presented a fall risk. Ms Nasemena said that in the dementia section it was "*full on*" to the point that she needed to have "*four eyes*."

431. In cross-examination, Mark Sewell (CEO, Warrigal) said that Warrigal relied upon direct care workers to identify changes in condition of residents and behaviours that might give rise to a clinical concern (PN12925), which was an appropriate role given that care workers are the people within the organisation who have the most direct contact with residents and detailed knowledge of their behaviour and general or usual condition (PN12926).

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353 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13157).

354 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13447).

Interpersonal skills—Lay Evidence Report [401]–[411]

432. The ANMF adopts Lay Evidence Report [401]–[411]. This contains extracts from the evidence of Lisa Bayram (RN) at [66].

433. In addition, at [31] of her statement, Hazel Bucher (NP) said that, "*[t]here are many competing priorities creating a home like environment but providing clinical grade service is challenging*."[355] She continued, "*[n]avigating the fine line between allowing the resident to steer the course of their day versus what is clinically better resulting in a healthier outcomes and improved quality of life is challenging.*"[356] Navigating this line requires highly-developed interpersonal skill: "*staying as engaged as possible to maintain strength and communication skills requires gentle persistence and energy from nursing and care staff.*"[357]

434. Kathryn Chrisfield (Occupational Health and Safety Team Manager, ANMF) said (at [30]), in relation to dealing with bariatric residents, that:

> "… the staff have to have the knowledge and insight as to how to care for the resident's clinical, social and emotional needs, as well as operate the equipment and implement the specialist techniques required to be able to safely manoeuvre and transfer the resident."[358]

435. And, in relation to dealing with aggression, Ms Chrisfield said as follows at [32]:[359]

> "Due to the increasing numbers of these residents [*i.e.*, residents with dementia or other altered mental states] within regular aged care facilities, aged care workers are required to have an understanding and knowledge about the particular condition of the resident, how it may be triggered and how it may present. These are complex, varied conditions that staff must be able to accommodate, without staff necessarily being provided education and training around how to recognise deterioration, what may trigger each resident, how best to de-escalate situations, how to protect other residents should a resident become aggressive etc."

436. Linda Hardman (AIN / PCW) said as follows at [22(c)]–[22(d)] and [23]:[360]

> "… my view is that AINs have and exercise the following skills in carrying out their work:
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> …
>
> (c) What I call "PR" skills. AINs are often the face of the facility, as far as

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355 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13123).
356 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13123).
357 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13123).
358 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10744).
359 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10745).
360 Statement of Linda Hardman dated 20 October 2021 (tab 263 pages 13267–13268).

> residents' families are concerned. It is an important part of our job to maintain relationships with residents' families as well as residents. Also, though, we need to recognise what is not our area, and to involve ENs and RNs where questions are asked that need their expertise.
>
> (d) Also in the area of PR skills is advocating for residents, which I mentioned above. Sometimes that means taking requests or complaints from residents to management or other staff. Or, keeping our eyes open for safety issues and requesting changes in procedures where we think they are necessary.
>
> 23. I also think that our ability to be adaptable and diplomatic has increased over the years I've worked in aged care. I think AINs have excellent time management and team skills because there are so many tasks that need to be finished in a shift."

437. Ms Hardman gave a further explanation of what she meant by "*PR skills*" in cross-examination (at PN9835):

> "PR skills - that means, particularly because we have a lot to do with residents' families, so really you're the face of the company, which means that if a resident's family comes and they're asking you for a lot of detail, you don't get in over your head; you refer to the RN. I mean, you can–if it's just normal chit chat, that's fine, but I always tell staff to keep professional distance and don't get in over your head, because, you know, you could say the wrong thing, and some residents' families can get quite pushy, so then you refer to the EN or the RN."

438. And, at [51]–[52], Ms Hardman described the use of various strategies with a view to providing care to dementia-affected patients (*e.g.*, changing staff, redirection, distraction, *etc*.). She developed this further in cross-examination at PN9858–PN9859. These are examples of interpersonal skills.[361] Interpersonal skills, of course, extend to the relationships between employees—Ms Hardman's evidence at PN9811–9818 exemplifies this, in that she describes a disadvantage of working with agency RNs as being that RNs with whom an AIN / PCW has a relationship know, just from a tone of voice, that a situation is an emergency. This is an example of a "*hidden skill*" of the kind Hon Assoc Prof Junor discusses (considered later in these submissions).

439. At [24(d)] of the statement of Suzanne Hewson (EN), Ms Hewson describes providing "*social support*" to residents who are lonely, affected by dementia, or by depression. This involves trying to ensure that there is some levity in the day and that each residents feels valued.[362] In re-examination, Ms Hewson described what she meant when she said that "*approaching people*" was a skill (at PN8324):

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361 Statement of Linda Hardman dated 20 October 2021 (tab 263 pages 13271.

362 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13422).

> "People with dementia, you need to be quite careful on how you approach them. You need to be openly engaged. You need to ensure that you are speaking to them clearly and concisely and that you need to show that you're listening as well as speaking to them. I feel that some people don't have the skills to be able to manage what you call chitchat, being able to say to them good morning, how's such and such. How are you going today? Did you have a good sleep? Is there anything else I can help you with? Or you ask some questions about their family, did you have a good visit with them yesterday? So that you're interacting with them constantly and making the visit more personal to them. And I always used to try to make it so that they knew that I was interested in them as a person and yet aware of what was happening around them as well. And I think that's a skill that is learnt."

440. Wendy Knights (EN) says as follows at [72]:[363]

> "I think that this [decreased use of pain relief and restraint mediation] really means nurses and carers are informally learning new skills to de-escalate situations and calm or console residents. However, there really isn't any training that we have done to help us with this. The whole psycho-geriatric needs of residents have changed."

441. Ms Knights, like other lay witnesses, gave evidence (in cross-examination) about the use of diversional or de-escalation techniques designed to assist in the care of dementia-affected residents (PN9253–9258).

Observations—Lay Evidence Report [413]–[415]

442. The ANMF adopts Lay Evidence Report [413]–[415]. This evidence is in relation to matters such as checking blood pressure and blood glucose levels. Suzanne Hewson (EN) refers at [26] to the documenting of vital signs.[364] Christine Spangler (AIN / PCW) refers to checking blood glucose levels, at [17(b)].[365]

443. Wendy Knights (EN) explained in cross-examination that AINs / PCWs are involved in collecting data that ultimately ends up in ACFI paperwork. This involves, for example, for weight, putting the resident in a weighing chair (PN9239), and the same again in regard to blood pressure (PN9243), including comparing that blood pressure against a "*traffic light*" system (PN9244).

Dealing with falls—Lay Evidence Report [416]–[422]

444. The ANMF adopts Lay Evidence Report [416]–[422]. This part of the report refers to the evidence of (*inter alios*) Sherree Clarke (AIN / PCW) at [48].

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363 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13448).
364 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13423).
365 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13012)

445. And, Christine Spangler (AIN / PCW) gives evidence as to her responsibilities in the event of a fall, at [24(h)]:

> "i. On night shift, there are floor alarms activated. Residents who are at a high risk of falls have their beds lowered to the ground, and the floor mat is connected to the annunciator panel at the nurses' station, which alerts us when they get out of bed. Quite a few residents have this in the facility. The problem is that, if we are at the other end of the wing, we cannot see or hear the annunciator panel. We have no portable alarm or phone. This is dangerous, as the residents can fall. I am very nervous about this and have to keep going back to the nurses' station from whatever I am doing to check the annunciator panel.
>
> ii. Many residents have crash mats so that, if and when they do fall out of bed, they are less likely to injure themselves. If they do fall, we will pick them up and get them back into bed. Sometimes we use a lifter for this. Otherwise two of us can lift the lighter residents.
>
> iii. When residents are using walking frames, we have to have a carer assisting them, otherwise they can walk into things."

446. In cross-examination, Jocelyn Hofman (RN) gave evidence of the procedure that is adopted in the event of a fall, including where that fall occurred in the dementia unit (PN9641–9642). In regard to the dementia, unit, Ms Hofman drew attention to the difficulty created by some patients being unable to express themselves or articulate pain after a fall (PN9641–9647).

447. Linda Hardman (AIN / PCW) gave evidence as to falls procedure in cross-examination (PN9869–9872).

448. Under cross-examination, Ms Bayram described the roles of AINs/PCWs, ENs and RNs when a resident has a fall in the following terms:[366]

> "The PCAs are usually the first people to know that something's happened. I would expect them to stay with the resident, keep them comfortable, pull the alarm bell so that the nursing staff come. The ENs if they get there before the RN make an initial assessment, but they would wait for the registered nurse to come to decide what's going to happen, and that's even from whether or not we're going to move the person or not. The PCAs then provide assistance. So if I decided that we needed - if someone was stuck in the bathroom and we needed to get them out I would say we've got to get them out. The PCAs would be the ones who would help me do that. They would get the equipment, they would give me some advice on their way to manage that, and then once we had made the person safe the nursing staff would take over making - the decision-making, and the PCAs would just follow my directions."

366 Cross-examination of Lisa Bayram at PN8238.

449. Asked in cross-examination if the registered nurse would be the primary decision-maker about the clinical wellbeing of the person who has a fall, Annie Butler (ANMF Federal Secretary) responded:[367]

> "The registered nurse has the capacity to make that assessment and decision and what needs to happen. Apart from all what would be procedurally required and protocols and processes, but in terms of a medical health assessment, yes."

450. Ms Butler went on to explain that the requirement to document the fall, the nature of the incident, but then there would need to be assessments about why the fall occurred. The rest of the team would contribute to that information.[368]

Wound care, skin tears, bruises—Lay Evidence Report [423]–[434]

451. The ANMF adopts Lay Evidence Report [423]–[434]. In addition to that evidence, Linda Hardman's statement at [33] is relevant to the effect of the need for more wound care on AINs / PCWs:[369] "*And, higher-acuity patients tend to have a greater need for wound care. For the AINs, that means a greater workload in terms of lifting and transferring so that ENs or RNs can attend to wounds.*"

452. Jocelyn Hofman (RN) gave evidence about the importance of nurses and AINS / PCWs monitoring skin tears and bruises, and creating incident reports in regard to any such tears (PN9648–9650).

453. Wendy Knights also gives evidence relevant to the nature of wound care (and observations in relation to the same) at [58]–[61] of her statement:[370]

> "58. Bruises and skin tears, no matter how minor, are required to be reported as an adverse event. This requires notification of family, next of kin, and the treating doctor. I understand that the rationale is that a bruise or a skin tear can indicate mistreatment. But the reality is that the vast majority of bruises and skin tears are accidental. A resident might bump a leg on a chair and get a bruise. Or, a resident might bump an arm or leg against a nut or a bolt, or an exposed brake wire (or similar) on a walker and get a minor skin tear.
>
> 59. Previously, we would treat as serious any bruise or skin tear for which the resident did not have a good explanation. Now, even where there is a very good explanation and it is innocent, the notification requirements apply and they take up time.
>
> 60. With wounds we now use our phones to communicate remotely with the RN. This can involve sending pictures of a wound and get advice that way.

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367 Cross-examination of Annie Butler at PN3422.
368 Cross-examination of Annie Butler at PN3425.
369 Statement of Linda Hardman dated 20 October 2021 (tab 263 pages 13267–13269).
370 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13446).

> Instead of an RN being on the floor this means extra workload for the EN.
>
> 61. With the wound dressings our RN clinicians will look at it and dress it according to best practice. They will document it and then ENs will do subsequent dressings and monitor it. The RN clinician will then do a periodic assessment and again leave the ENs to implement any changes to dressings. In the interim we need to monitor it and report any changes or lack of improvement."

454. In cross-examination, Ms Knights explained that if there was a skin tear, the protocol was that an EN or RN had to be called, and the nurse would evaluate whether or not the reason for the skin tear gives rise to a SIRS notification. The RN (or sometimes an EN) would generally dress the wound (PN9179–9185).

455. And, Christine Spangler describes the various responsibilities for wound care at [24(a)], as follows:[371]

> "If it is simple wound care, like just taking off and replacing a bandage, then I can do it. If it is complex, the RN or an Enrolled Nurse (EN) has to do it. This is something I do a fair bit as residents will have wounds from pressure areas and falls. If it is a new wound or a new skin tear, an RN or EN has to look at it first. If it is a simple dressing, they will tell me what to do and I will do it. If it is more complex, they will do it. They then review it every couple of days and tell me what to do, for example, put on a fresh bandage."

456. In cross-examination, Ms Spangler explained that a "*complex*" situation of wound care meant, for example, if a resident had a really bad fall and had split his or her head open (PN8678).

457. Julianne Bryce (Senior Professional Officer, ANMF) explained that not all wound care can be delegated to an AIN / PCW (PN3745). The line is drawn by the RN, who is responsible for delegating, in this way (PN3746):

> "Well, a registered nurse would have to assess it in every situation before they could delegate that care, every time. So as far as the wound goes, they would need to be able to see it and assess it to determine whether it's appropriate for them to do the dressing, for them to delegate the dressing, either to an enrolled nurse or to a care worker, depending on people's qualifications and their safety and competence to be able to do that."

458. That is, it is not the case that particular classes of wound are the domain of one or another group, rather it is that the RN assesses, in regard to each wound, who should treat it and how (PN3748).

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371 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13014).

459. The evidence of Stephen Voogt, (Nurse Practitioner in Gerontology) is that there is an increased complexity of wounds with residents coming from hospital system within the residential aged care system. He says that the RNs and ENs in aged care lack access to wound consultants (unlike the public system) leaving aged care nurses to manage complex wounds.[372]

Catheters etc.—Lay Evidence Report [435]–[441]

460. The ANMF adopts Lay Evidence Report [435]–[441]. This refers to (*inter alia*) the evidence of Lisa Bayram (RN) at [59], Rose Nasemena (AIN / PCW) at [43], Sherree Clarke (AIN / PCW) at [49].

461. Under cross-examination, Sheree Clarke (AIN) explained her role removing and checking catheter bags, record the fluid, and assessing the urine, looking at the urine to make sure it's a healthy normal colour.[373]

462. Dianne Power (AIN) gave evidence under cross-examination of dealing with catheter bags by emptying them and making sure that they're flowing properly. If she has any problems with them, she will connect and disconnect the bags that go on overnight. If she sees that there's a need for inserting anything she would call the RN. She is conscious to check if the urine is cloudy because if the urine is blocked, it can be very painful for the resident and may lead to infections and other complications.[374]

Administering medication—Lay Evidence Report [442]–[466]

463. Background document 1 (at [116.3]) recognises as apparently uncontentious that "*[t]here is an increase in the number and complexity of medications prescribed and administered.*"

464. The ANMF adopts Lay Evidence Report [442]–[466]. This refers to the evidence of (*inter alios*) Suzanne Hewson (EN) at [24(a)].

465. Ms Hewson's evidence at [21] is also relevant in assessing the changing nature of medication rounds for nurses:[375]

> "I cannot recall the last time I completed a medication round without an

372 Amended witness statement of Stephen Voogt, 9 May 2022 at [62] (tab 269 page 13402).
373 Cross-examination of Sheree Clarke at PN9976–PN9978.
374 Cross-examination of Dianne Power at PN9976.
375 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13420).

> interruption. There used to be a practice that nurses were not to be interrupted whilst undertaking a medication round to allow them to focus and avoid medication errors. Now, we are required to respond to multiple interruptions including call bells and phone calls. This not only delays the medication round and potentially the time that residents obtain their medication, but it is also distracting and can result in mistakes."

466. Also relevant in understanding the way in which medication rounds occur in modern times are [16]–[17] of Ms Knights's statement:[376]

> "It used to be that Registered Nurses (RNs) primarily administered mediation. More and more, however, the work of RNs came to be in the office rather than on the floor. I say more about this later. So, administering medication more and more became the job of an EN.
>
> Existing ENs did quite extensive additional education of about 220 hours (plus a two week placement) in order to undertake medications. New ENs (like me) transitioned from the Certificate IV in Nursing to a Diploma which incorporated the medication administration modules. We were known as Medication Endorsed ENs for about a decade when there were still many ENs who did not have the qualification. Now it is the reverse. The overwhelming majority of Enrolled Nurses are qualified to administer medications and are simply registered with AHPRA as Enrolled Nurses. Those without the qualification have an endorsement on their registration to say they cannot administer medications. That has been an enormous change."

467. Also relevant is [42]–[44] of Ms Knights's statement, which is in relation to the interrelationship between the shift to person-centred care (on the one hand), and the performance of structured tasks like medication rounds (on the other):[377]

> "42. Similarly, there is now a lot more consumer choice, especially under the new Aged Care Standards introduced in 2018. For example, some residents want to sleep until 10am or 11am each day. This means their morning medication is actually given at lunchtime. Then their lunchtime medication is given at 5pm.
>
> 43. That makes medications (as well as other care needs like toilets like personal care or meals) more complex. It used to be that you were able to structure your work or establish routines around the kinds of work that you would be doing at particular times. Now, you cannot do that — different work is required for different residents at different times, based on their preferences.
>
> 44. Again, that is a good thing for residents, and I support it. But it is less efficient for aged-care workers, and so involves more work."

468. Ms Knights gave further evidence concerning procedure in her cross-examination (PN9151–9165).

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376 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13440).

377 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13444).

469. Rose Nasemena (AIN) has undertaken a course "Assist Clients with Medication"[378] and started assisting residents with administering their medications in July 2013.[379] She describes the prospect of making a medication error as always hanging over her and adding to stress. She once made an error by providing the right medication but entered the wrong number into the computer. She says it is quite dangerous because while assisting with the meds she is still having to watch out for residents and can be called to do other tasks by the RN. [380]

470. Paul Sadler (CEO, ACSA) has observed that AINs / PCWs are involved in medication to a greater degree than they used to be, in that 15 years ago the work that they today perform would generally have been undertaken by an RN (at [84]).[381]

471. Mr Sewell's evidence is likewise that certain AINs / PCWs are now more involved with medications in residential aged care than used to be the case (at [124]).[382]

Relevance of this evidence to work value

472. The evidence before the FWC consistently identifies that the roles of direct care workers have expanded to include a wider range of duties, tasks and increased responsibilities. This has required direct care workers to learn and exercise new skills. This change has been dramatic and relates to many facets of the work performed.

473. The direct and immediate consequence of changes to the nature of aged care work discussed above (such as the increased acuity of residents and clients, changes to staffing levels and skill mix, changes to the philosophy and model of care and changes in accountability, regulation and residents' expectations) is a corresponding increase to the level of skill and responsibility involved in doing the work. Direct care workers are now required to exercise a greater breadth and depth of skills.

474. There is a greater requirement for AINs/PCWs, ENs and RNs to observe and assess residents and clients. The role of an AINs/PCWs has evolved from performing care "tasks" to the ever-increasing responsibility associated with making judgments about residents and clients. AINs/PCWs are now required to identify relevant changes to

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378 Amended witness statement of Rose Nasemena, 6 May 2022 at [10] (tab 267 page 13355).
379 Amended witness statement of Rose Nasemena, 6 May 2022 at [25] (tab 267 page 13357).
380 Amended witness statement of Rose Nasemena, 6 May 2022 at [26] (tab 267 page 13357).
381 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13593).
382 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14612).

residents and clients and report these to the registered nurse. Enrolled Nurses also actively observe residents and clients, exercise judgment and collect additional information and data. Registered nurses make assessment and decision about what needs to happen in the context in the context of the more challenging work environment and far greater demands on their time.

475. There is consistent evidence about the high level of interpersonal skills such as empathy communication, positive mental attitude, time management and the ability to handle criticism required by direct care workers. It is submitted that:

(1) The level of these skills required in aged care has increased as a result of other identified changes to the nature of the work; and

(2) These skills have historically been undervalued and include "hidden skills" as identified and discussed in the report of Hon Assoc Prof Junor, (considered later in these submissions).

476. There is also consistent evidence about the increased performance of, and requirement for, assistance to residents and clients with respect to falls, wound care, skin tears, bruises, interventions such as catheters and the administration of medication. The increased skills associated with this work can be observed across all direct care classifications. The increased prevalence of this work and reduced numbers of registered nurses and enrolled nurses has led to an increased requirement for AINs/PCWs to perform this work. Meanwhile, the registered nurse is directly involved in providing more complex clinical care and retains responsibility for care work delegated to others.

477. These increased skills and responsibility reflect the fundamental changes in the nature of the work performed and the conditions under which the work is done. The increased skills required, and responsibility involved in doing the work, also reflects a change in the nature of the work and the conditions under which the work is done. As such, the increased skills exercised by direct care workers amount to reasons justifying increased minimum rates for all three of the section 157(2A) reasons, not merely s 157(2A)(b) pertaining to the "*level of skill and responsibility involved in doing the work*".

E.6 Specialised knowledge and care— Lay Evidence Report Part D.6

478. Under this heading, the specific topics of dementia care and palliative care are addressed. It will have been observed that evidence in regard to this topic has been (at least) touched on in relation to other topics (*e.g.*, acuity, chemical restraint). Dementia, in particular, is a phenomenon that enhances the complexity of work in a variety of respects and so does not fit neatly into one only of the topics addressed in this Part E. The ANMF will seek to avoid duplication to the extent possible.

Agreement between interested parties as to this factor

479. The Consensus Statement at [2]–[3] recognises the importance of these two specialist areas of knowledge and care needs—dementia and palliative care:

> "The proportion of people with dementia and dementia-associated conditions receiving aged care services has increased.
>
> With an increase in the ageing population, the need for embedded and effective palliative care is now more prevalent than historically was the case."

480. Background document 1 (at [116.4] and [116.10) recognises as apparently uncontentious that

> "4. The proportion of residents and clients in aged care with dementia and dementia-associated conditions has increased.
>
> …
>
> 10. More residents and clients in aged care require palliative care" [footnotes omitted]

481. IRT submits that there has been a significant increase in the incidence of dementia and mental health issues among residents, and that employees need to be more highly skilled in order to meet the challenge associated with these conditions.[383]

482. UnitingCare Australia likewise submits that increased clinical support is required as a result of (*inter alia*) dementia.[384] It submits that there is a "*dementia epidemic*," and there is a need for "*more specialist psycho-geriatric care*."[385]

483. Evergreen Life Care submits that residential aged care facilities have shifted from a blend of low, medium, and high care residents, to a focus much more on *high care*

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383 Submissions of IRT (tab 128 page 1117).
384 Submissions of UnitingCare Australia (tab 129 page 1121).
385 Submissions of UnitingCare Australia (tab 129 page 1121).

residents and those living with dementia," which results in "*increased workload and stress for staff*," without increased wages commensurately.[386]

The Lay Evidence Report

Dementia Care

484. The ANMF adopts Lay Evidence Report [468]–[487]. There are extracts from, and references to, the evidence of (*inter alios*) Lisa Bayram (RN) at [60], Dianne Power (AIN / PCW) at [44]–[47], and Hazel Bucher (NP) at [45] and [49].

Palliative care

485. The ANMF adopts Lay Evidence Report [488]–[499]. There are extracts from, and references to, the statements of (*inter alios*) Hazel Bucher (NP) at [48], Stephen Voogt (NP) at [43]–[44], Wendy Knights (EN) at [82]–[83], and Maree Bernoth (RN) at [39].

Evidence of other Frontline Workers

Dementia Care

486. Linda Hardman (AIN / PCW) referred at [22(b)] to the observational skills required in relation to residents affected by dementia to mental illness: "*[o]ften, before a resident has problematic behaviours associated with mental illness or dementia, you can notice triggers or little changes in behaviour.*"[387] Ms Hardman also referred to the increased prevalence of physical or verbal aggression (at [48]–[49]), especially after the diminution in the use of anti-psychotics (at [50]).[388] This requires workers to be astute to recognising triggers or warning signs (at [51]), and the use of tactics like redirection or distraction (at [52]–[53]).[389]

487. Suzanne Hewson (EN) addressed dementia at [22]–[23] of her statement:[390]

> "22. … Ideally, all care staff would receive special training on these subjects [dementia and palliative care], but this would come at a cost to the facility. I receive no extra money for performing this role, nor do I have any extra time available to me, but it is important to me that I can assist in providing the best possible care for our residents.
>
> 23. Unfortunately, dementia in some residents can present significant

386 Submissions of Evergreen Life Care (tab 132 page 3129).
387 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13267).
388 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13271).
389 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13271).
390 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13421).

> aggression and violence towards staff and other residents. For example, one resident was required to attend hospital for three weeks recently as her behaviour had become unsafe and unmanageable. This resident had become a significant risk to staff members and residents and required significant sedation whilst at hospital. Situations such as this are not unusual. They are very challenging to manage and the skills required to deal with them are often not taught. They are learned from experience and, if you are lucky, good mentoring from colleagues. I do my best to mentor my colleagues, but it is difficult in the limited time available. It is always hard to find good new staff and keep them for a long period of time."

488. Ms Hewson's view is that residents with advanced dementia and challenging behaviours would be better off in a purpose-built facility, with a controlled environment, and staff who are all appropriately trained (at [24(c)]).[391] Of course, for the aged-care workers outside of such facilities (which is most of them—see the evidence of Kathryn Chrisfield at [493] below), or without such specialist training, the work is accordingly more complex and challenging.

489. Jocelyn Hofman (RN) says (at [41]) that the increased prevalence of dementia "*has resulted in the need for increased skills in diversion strategies and assisting residents when highly agitated*."[392] But, this intersects with recent changes in policy and practice rules relating to restrictive interventions. This has affected Ms Hofman's daily work, "*and made it more complex, more demanding and involving greater demands for professional judgement*."[393]

490. Wendy Knights (EN) describes (at [24]) being in charge of the dementia unit in her facility.[394] She had also completed a course in dementia through the University of Tasmania (at [20]).[395] Despite this, she still was not comfortable being in charge of the dementia overnight, due to the increased risk of residents becoming aggressive (see at [28]).[396] This is indicative of the level of difficulty involved in caring for residents affected by dementia.

491. From [49]–[54] of her statement, Ms Knights describes the changes to her work brought about increased prevalence of dementia. This is worth setting out in full:[397]

> "49. I mentioned above at paragraph 32 above that aged-care workers

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391 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13421–13422).
392 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13157).
393 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13157).
394 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13441).
395 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13440).
396 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13442).
397 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13445).

> encounter difficulties with dementia-related behaviours. There are a few aspects to this.
>
> 50. First, since people are entering aged care later and living longer, there are far more residents with dementia than used to be the case. Residents have greater needs due to being home longer in home care packages. There is often undiagnosed early Alzheimer's/dementia as they have been home in their familiar surroundings: when they come in they are taken from familiar surroundings and their behaviours and their frustrations compound. They have a particular routine and insist on it, but in an aged care setting often those expectations can't be met, because as much as we try we only have so many staff. The residents' care needs are greater than they were when I started in aged care.
>
> 51. Second, there are fewer physical constraints on residents than there used to be. For example, concave mattresses, which we use as a safety measure, are no longer allowed other than in exceptional circumstances. If dementia patients want to wander in the secure area they can. This is stressful because if they want to go outside, even though it is a secure area, I can't monitor them as I will often be busy doing other tasks or answering buzzers. Fall risks have increased as a result. We used to use concave mattresses as a safety measure.
>
> 52. Similarly, there has been a dramatic reduction in anti-psychotic medication after the Aged Care Royal Commission. I understand the concern of the Royal Commission was overmedication. That is a valid concern, but it does not apply across the board (does not apply in Princes Court, for example), and under-medication is also problematic.
>
> 53. There are residents whose behaviours without anti-psychotic medication are just atrocious. I think if they knew what they were doing, they would be mortified. Patients with dementia can get quite aggressive. They can get agitated, restless, or paranoid. Past memories are sometimes refreshed, so you might get residents insisting they have to pick their kids up or check on their parents. Residents wander. The late afternoon is a challenging time for these kinds of behaviours.
>
> 54. And, most aged-care workers are not trained as mental health nurses. That is why I do not feel safe working overnight, by myself, in the dementia ward. Aggression is a much bigger problem than it used to be. It can be triggered unpredictably.

492. Christine Spangler (AIN / PCW) likewise describes colleagues in the memory loss unit having had wrists broken or having been head butted (at [35]).[398]

Evidence of officials

493. As addressed in the evidence of Annie Butler, the Australian Institute of Health and Welfare ("**AIHW**") identifies that people with dementia tend to have higher care needs

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398 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13018).

than those without dementia.[399] Earlier, in 2008–09, the AIHW recorded that over half (53 per cent) of the permanent residents living in Australian Government subsidised aged care facilities who were appraised with an ACFI had a diagnosis of dementia.[400]

494. Andrew Venosta's evidence is that managing and caring for residents with dementia has been a constant but increasing challenge during his career in aged care. He describes an increasing prevalence of residents exhibiting aggressive and, at times violent, behaviour in recent years.[401]

495. Kathryn Chrisfield (Occupational Health and Safety Team Manager, ANMF) referred at [11] to shortcomings of existing buildings for psycho-geriatric care:[402]

> "… There are very few psycho-geriatric facilities that are purpose-built and have specialised staff to deal with aged mental health issues (for example), and they may be a significant distance from the resident's family, or may not have capacity to take the resident. Consequently, staff are left to continue attempting to provide care to residents in an inappropriate environment, with inadequately educated and experienced staff, to the detriment of the staff and often other residents."

496. Ms Chrisfield also gave evidence as to some of the occupational health and safety consequences of the increased prevalence of dementia (at [32]–[33]):[403]

> "Reports from members (supported by evidence from the Dementia Australia programs and website) indicate that residents with dementia or other altered mental states may become disorientated or defensive (or aggressive). Due to the increasing numbers of these residents within regular aged care facilities, aged care workers are required to have an understanding and knowledge about the particular condition of the resident, how it may be triggered and how it may present. These are complex, varied conditions that staff must be able to accommodate, without staff necessarily being provided education and training around how to recognise deterioration, what may trigger each resident, how best to de-escalate situations, how to protect other residents should a resident become aggressive etc.
>
> Whilst there are some specialist facilities, most aged care facilities also have residents with these conditions in their population. Members in aged care have reported that there is inadequate time and resources for these staff to provide the residents with the care they require, which can result in the residents becoming more unwell or violent. Aged care workers are required to attend to these residents, irrespective of their violence, and are regularly the subject of

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399 Australian Institute of Health and Welfare (2020), GEN fact sheet 2018-19: People's care needs in aged care, Australian Government; Amended Witness Statement of Annie Butler dated 2 May 2022 at [149].] (tab 181 page 9270).

400 Australian Institute of Health and Welfare (2011) Dementia among aged care residents: first information from the Aged Care Funding Instrument. See ANMF 100. pP. vi

401 Amended Witness statement of Andrew Venosta dated 3 May 2022 at [60] to [62] (tab 188 page 11136).

402 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10741).

403 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10745).

aggressive outbursts, which manifest in verbal and physical assault."

497. Stephen Voogt, (Nurse Practitioner in Gerontology) gives evidence of the prevalence of complex palliative care with aged care facilities. He says that it is a real struggle for nurses and carers to provide psychological support for them and their families–often with absolutely no extra resources. He also identifies that the ACQSC has promoted advanced care planning (ACP) and most residents choose to stay in the facility for their final weeks and so it falls back on the facility to provide for end of life care. Many of the GPs simply aren't available to attend the facility or provide an adequate resource for out of hours care and so the nurses on PM and night shift are the ones who have to make a call on how best to care for the resident.[404]

498. Andrew Venosta's evidence is that palliative care inevitably calls for a greater level of knowledge and responsibility from the nurses of the facility, who will not be able to rely on external support throughout the whole of the palliation process.[405] He says that the expectation for end-of-life care to be provided at the aged care facility contributed to what he observed to be higher levels of emotional stress for the nurses, and the PCWs who in most cases have not been provided with training and acquired the appropriate skills to deal with end-of-life care and the issues around death, grief, and providing emotional support to families and loved ones.[406]

Findings of the Royal Commission

499. This evidence referred to above is reflected in findings of the Royal Commission, including:

(1) at [IR.1.85], where the Royal Commission referred to an increased incidence of dementia in older ages, increasing the need for disability support;

(2) in figure 3.1 on [IR.1.86], showing an estimate of Australians with dementia having increased markedly between 2010 and the present day, and continuing to increase through to 2030;

(3) at [FR.3A.104], where it is stated that the number of older people living with dementia is expected to increase in line with ageing population, and that in 2019

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404 Amended witness statement of Stephen Voogt dated 9 May 2022 at [47] (tab 269 page 13399).
405 Amended Witness statement of Andrew Venosta dated 3 May 2022 at [120] (tab 188 page 11145).
406 Amended Witness statement of Andrew Venosta dated 3 May 2022 at [121] (tab 188 page 11145) .

just over half of the people living in permanent residential aged care, but it could be as high as 70 per cent; and

(4) *Recommendation 79: Review of certificate-based courses for aged care* recommends review the need for specialist aged care Certificate III and IV courses and the content of those courses. Commissioner Briggs considers the following competencies should be considered for inclusion in the content of Certificate III and IV courses:

> "personal care modules, including trauma-informed care, cultural safety, mental health, physical health status, wound care, oral health, palliative care, falls prevention, first aid, monitoring medication and dysphagia management quality of life and wellbeing, including the use of technology, interventions for older people at risk, and recognising and responding to crisis situations."

Palliative care

500. At [12] of her statement, Pauline Breen (RN) referred to the stress and upset associated with caring for palliative patients.[407]

501. At [24(e)], Suzanne Hewson (EN) states that GPs are reluctant for continuous administration of drugs to palliative patients. Accordingly, workers have to administer low doses of morphine, hourly. This results in a great deal of stress and pressure, given the shortage of resources for such a task.[408]

502. At [15], Jocelyn Hofman (RN) describes, at a high level, the tasks involved in palliative care as involving constantly assessing the efficacy of pain management, assessing whether residents are becoming agitated or distressed, addressing cultural requests, and "*guid[ing] families through the dying, death and grieving process*."[409]

503. Lisa Bayram (an RN) describes a scenario at a residential care facility involving three residents on morphine pumps in end of life care at the same time, creating a huge workload.[410] Separately, she says that staff struggle with palliative care to keep

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407 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13349).
408 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13422).
409 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13152–13153).
410 Statement of Lisa Maree Bayram, dated 29 October 2021[75]. at [75] (tab 262 page 13240).

residents comfortable in a timely manner.[411] She has been advocating for better palliative care management.[412]

504. Additionally, Dianne Power (an AIN / PCW),[413] Jocelyn Hofman (an RN),[414] Pauline Breen (an RN),[415] Rose Nasemena (an AIN / PCW),[416] and each describe being involved in providing palliative care to residents

Relevance of this evidence to work value

505. It is beyond dispute that:

(1) The proportion of people with dementia and dementia-associated conditions receiving aged care services has increased; and

(2) The prevalence of palliative care within aged care facilities has also increased.

506. The evidence establishes that the provision of dementia care and palliative care each require the utilisation particular advanced skill and involve significant additional responsibilities. Work involving dementia care and palliative care is more complex, more demanding and necessitates greater levels of professional judgment. The increased prevalence of dementia care and palliative care requires direct care workers to have and deploy those additional skills and take on that additional responsibility. Moreover, the provision of this care involves the utilisation of "*hidden skills*" identified and discussed in the report of Hon Assoc Prof Junor and considered later in these submissions.

507. All persons working with residents or clients with dementia must be cognisant of behaviours associated with dementia, how individuals present differently and how they display symptoms that are unique to them. Personal carers and nurses need to know how to find meaningful activities for each person. Increased levels of people with dementia and dementia-associated conditions also increases the prevalence of occupational violence and aggression, making the conditions in which the work is done more dangerous and challenging.

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411 Statement of Lisa Maree Bayram, dated 29 October 2021[87]. at [87] (tab 262 page 13242 – 13243).
412 Statement of Lisa Maree Bayram, dated 29 October 2021[85]. at [85] (tab 262 page 13242).
413 Statement of Dianne Power dated 29 October 2021 at [82] (tab 258 page 13113).
414 Statement of Jocelyn Hofman dated 29 October 2021 at [39] (tab 261 page 13156).
415 Statement of Pauline Breen dated 29 October 2021 at [12] (tab 266 page 13349).
416 Statement of Rose Nasemena dated 29 October 2021[46 at [46] (tab 267 page 13361).

508. The increased prevalence of palliative care in aged care arises from:

(1) The reduced length of stay in residential facilities; and

(2) More clients and residents choosing to remain in their home or residential facility (rather than be transferred to hospital) until they pass.

509. This work involves a broad range of skills, including:

(1) the provision of physical or clinical care to manage symptoms through medical and non-medical interventions;

(2) discussions with families and residents or clients to work through expectations, fears and desires;

(3) understanding the emotional needs of residents and clients and tailoring care appropriately; and

(4) the need to navigate resourcing issues and difficult ethical issues that may arise.

510. The importance of assisting the end of life process for residents and clients cannot be overstated. The provision of this care is a massive responsibility on the shoulders of direct care workers. The increased prevalence of palliative care in aged puts additional emotional stress on employees as is addressed further in the following part.

E.7 Impact of death of residents and clients on workers—Lay Evidence Report Part D.7

Evidence of other Frontline Workers

511. Further to the evidence extracted in the Lay Evidence Report, Pauline Breen (RN), at [12], referred to the stress and upset associated with going through the end-of-life process.[417] And, Wendy Knights (EN) said this at [82]–[83] (emphasis added):[418]

> "82. <u>There are now a far greater number of residents who spend their end stage at the facility rather than going to hospital</u>. That is usually specified in their Advanced Care Plan where they specify that they want to stay in the facility. I think that <u>dealing with end stage and death of a resident–who we treat as part of the family–requires skills and an advanced level of emotional competence.</u>
>
> 83<u>. Finding the balance between privacy for families, explaining what is happening for families, providing care and separating our own emotions is all</u>

417 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13349).
418 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13450).

> quite challenging. On top if that we often have to shepherd newer staff members through the process. Very rarely is a doctor present (except initially around medications or after death to sign the death certificate). An RN is always in the facility or contactable, but the comfort and care of the resident is usually in the hands of EN and/or carers."

512. Jocelyn Hofman (RN) gave evidence that it was her responsibility to notify families and doctors of the death of a resident (PN9652).

513. Rose Nasemena (AIN) gave evidence that it can be extremely draining when a resident passes away because she really bonds with many residents. She describes having to try and put it in the back of her mind and be there for the other residents. Over time, the stress has moderated for her and she mostly manages to treat it as part of the job. Ms Nasemena notes some carers can't handle this side of the job.[419]

514. This evidence of frontline of workers is given context by Kathleen Eager (Professor of Health Services Research and Director of the Australian Health Services Research Institute at the Faculty of Business and Law at the University of Wollongong) who identifies that there are 180,000 beds in the residential aged care centre. Every year 60,000 residents die and another 60,000 take their place.[420]

The Lay Evidence Report

515. The ANMF adopts Lay Evidence Report [500]–[511]. This part of the Lay Evidence Report extracts or refers to the evidence of (*inter alios*) Patricia McLean (EN) at [54], Sherree Clarke (AIN / PCW) at [77], Linda Hardman (AIN / PCW) at [73] and Dianne Power (AIN) at [84].

516. Further to Ms McLean's evidence at [54], she also describes having had clients in both residential care and community care who died while in her care. She says that she found this distressing and that she developed long-term professional relationships with most of her clients. She describes an occasion when a client fell and hit his head when letting her into his house. She administered first aid, called an ambulance, contacted his family and her employer. She was with him until the ambulance arrived and took him to hospital but he died a few days later. She says that she feels sad anytime a client of hers dies.[421]

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419 Statement of Rose Nasemena dated 29 October 2021, [47] (tab 267 page 13361).
420 Cross-examination of Kathleen Eager at PN8900.
421 Amended witness statement of Patricia McLean dated 9 May 2022 at [52]–[53] (tab 265 page 13311).

517. Further to Ms Power's evidence at [84], she also describes getting to know residents and their families. She says that she finds it very stressful and sad when those residents die. She likes to think she has made a difference in their life, made life happier and more comfortable for them. It is upsetting for her to see relatives come and clear out their loved one's belongings. Sometimes within two days the room will have been cleaned and a new resident will have moved in. She understands that it is necessary to keep rooms occupied for financial reasons, but describes this as hard because a resident might be in a room for six years, then after they die there will be a new resident in their room straight away.[422]

Evidence of employer witnesses

518. Mark Sewell (CEO, Warrigal) notes—in addressing the higher acuity of residents on entrance into residential aged care—that now, more so than two decades ago, Warrigal is seeing a "*much shorter length of stay in residential aged care*" (at [56]). The length of stay is a range of around 5 months to 22 months (at [56]). This means that assisting residents and their families with "*the process of managing the end stages of their life*" is required "*on a regular basis in aged care*" (at [57]).[423]

519. Craig Smith (Executive Leader Service Integrated Communities, Warrigal) likewise notes that consumers are staying for shorter periods in residential aged care. Whereas when he started in the industry, the length of stay could be 10 years or so, now the general length of stay is less than two years for consumers with higher care needs (at [64]).[424] Accordingly, Warrigal's turnover is 30 per cent (at [65]).[425]

520. Emma Brown (Special Care Project Manager at Warrigal) identifies an increase in consumers who need palliative care[426] in part due to residents having shorter stays in aged care facilities. She also identifies an increase in the number of residents who, through their advanced care plan specify that they wish to receive that palliative care within the facility.[427]

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422 Witness statement of Dianne Power dated 29 October 2021 at [83] (tab 258 page 13113).
423 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14602).
424 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14129).
425 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14130).
426 Statement of Emma Brown dated 2 March 2022 at [44(d)] (tab 290 page 13988) and cross-examination at PN13421.
427 Cross-examination of Emma Brown at PN13422–PN13423.

Relevance of this evidence to work value

521. As the average length of stay in aged care facilities reduces, there is an increase in frequency of direct care workers dealing with the death of residents. As identified above, more clients are now choosing to receive palliative care in their home or aged care facility. As such, although the nature of aged care work has always involved death of residents and clients, this is now more regular the impact of death on direct care workers is more direct.

522. Frontline workers in this proceeding have given honest and heartfelt accounts of the emotional impact of the loss of clients or residents. This is an emotionally difficult element related to the nature of the work performed by direct care workers.

523. In addition to the particular skills required to deliver palliative care, skill is also required to separate the emotional impact of the death of residents to allow aged care employees to continue to perform their the day to day work.

524. These changes are also related to nature of aged care work and the conditions under which the work is done and must be recognised when assessing the value of this work.

E.8 Physical and emotional aspects of working in aged care - Lay Evidence Report Part D.8

Agreement between interested parties as to this factor

525. At Consensus Statement [7], it was agreed that "*[t]he need for socio-emotional skills in addition to clinical and care skills is more apparent*." And, at [12], it was agreed that, "*[c]ommunication with consumers and their families requires skills in interpersonal communication and cross-cultural awareness.*"

526. As to physical demand, at Consensus Statement [13], it was agreed that, "*[t]he work demand of aged care workers is changeable and work is done to rigorous time and performance standards*."

527. IRT submitted (at [15]) that "*aged care work is more physically and emotionally taxing*" than work in the retail and hospitality sectors, but this is not reflected in current

rates of pay.[428] Evergreen Life Care submitted that increased acuity resulted in "*an increased workload and stress for staff*," which was not reflected in wage rises.[429]

The Lay Evidence Report

528. The ANMF adopts Lay Evidence Report [512]–[528]. As O'Neill C noted (at [512]), a large number of witnesses gave evidence that the provision of aged care was physically, mentally and emotionally taxing and stressful work. Extracted (or referenced) in this part of the Report was the evidence of (*inter alia*) Maree Bernoth (RN) at [57]–[62], Pauline Breen (RN) at [30], Hazel Bucher (NP) at [31], Sherree Clarke (AIN / PCW) at [71]–[77], Suzanne Hewson (EN) at [20], Jocelyn Hofman (RN) at [8], [18], Wendy Knights (EN) at [84]), Virginia Mashford (AIN / PCW) at [18], Irene McInerney (RN) at [45], and Rose Nasemena (AIN / PCW) at [16], [47].

529. Ms Breen's evidence is referenced rather than extracted. What she says at [30] is that staff become exhausted and dehydrated working in the heat, especially in the afternoon, given that many aged persons do not have air conditioning.[430] Also relevant is [12] of Ms Breen's statement, where she refers to being so busy that it is difficult properly to manage the clinical care needs of patients.[431]

530. And, further to Ms Bucher's evidence at [31], at [44(b)] she referred to work being more intense and complex than it once was, which imposes greater demands on staff and causes a sense of rushed care.[432]

531. Ms Hewson's evidence at [18]–[20] is that the workload is heavy and ever increasing, and gets more complicated with short-staffing, new or inexperienced workers, or agency staff. The job is stressful, and very physically and emotionally demanding.[433] Ms Hewson also says, at [31]–[32], that staff work extra hours without pay, physically and mentally exhaust themselves on a daily basis, and go out of their way to improve by doing extra training, but it is not recognised or valued. At the time that she gave that

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428 Submissions of IRT (tab 128 page 1118).
429 Submissions of Evergreen Life Care (tab 132 page 3129).
430 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13352).
431 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13350).
432 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13128).
433 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13420).

evidence she intended to move into another field of nursing on account of being burnt out.[434] She had, by the time of her oral evidence, actually so moved (PN8277–8288).

532. At [84], Ms Knights referred to the work as "*draining*," which was the reason why she had to take a break from aged care in 2019–2020.[435] Further to Ms Knights' evidence at [84], at [7] she says that she could find easier and less stressful work in other industries for as much or even more money (hence money is not why she does the work).[436] And, at [29] Ms Knights said this:[437]

> "Our overall staffing makes it tough to simply get through what needs to be done physically each day–meds, turns, personal care, feeding–without actually doing the emotional and social care that we need to. It also makes the work more draining and less rewarding than it should be."

Evidence of other Frontline Workers

533. Linda Hardman (AIN / PCW) refers (at [19]) to the work being challenging in that there is not enough time to meet residents', and residents' families', expectations.[438] At [29], Ms Hardman refers to the increased number of, and the increased physical demand of, transfers involving overweight and bariatric residents (who make up a larger proportion of residents than they used to).[439] The work associated with changing pads and attending to personal care (including checking for skin issues) is also more difficult (at [30]).[440]

534. Ms Hardman also says that higher-acuity patients need more help transferring into and out of bed, onto and off the toilet, to and from activities, and have a greater requirement for wound care (which means more lifting and transferring). All of this adds to the physicality of the work (at [31]–[33]).[441]

535. Ms Hardman also says that the work leaves her worn down (at [82]): "*people work long hours and do hard work. Often carers, including me, stay behind and work double shifts rather than leave other workers short staffed. It is tiring*."[442]

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434 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 pages 13423–13424).
435 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13451).
436 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13438–13439).
437 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13442).
438 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13266).
439 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13268).
440 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13268).
441 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13268–13269).
442 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13275).

536. Christine Spangler (AIN / PCW) says, at [15], that she has worked only night shift since February 2020. For 17 or so years prior to that, she only worked afternoon shift, but she found the workload too heavy and that it involved more mental fatigue.[443]

537. Patricia McLean (EN) describes the physical demands of visiting aged care clients in their home. Her evidence is that some clients do not having hospital beds or slide sheets which meant that attending to those clients in bed and moving these clients could be difficult.[444]

538. Ms McLean also identified a document titled "Critical Job Demands Analysis" prepared by her employer in relation to her work providing aged care in clients' homes.[445] Ms McLean confirmed that this document provides an accurate description of the demands of her tasks as at 2014 and the nature of the work she would perform after that time.[446]

539. Dianne Power (AIN) gives evidence of being a very fit person who competes in triathlons. Despite being physically and mentally strong, she says that she is often shattered after her shift in aged care.[447] She describes the work as very physically demanding. She sees other staff who are tired and struggling to cope. She sees staff getting burnt out and finding it difficult to cope with the workload. She identifies that there are high levels of absenteeism amongst staff at Regis Whitfield.[448]

540. Ms Power's evidence extracted above at [517] is again relevant, here.

Evidence of officials

541. It is worthwhile setting out in its entirety [33]–[39] of the evidence of Kathryn Chrisfield (Occupational Health and Safety Team Manager, ANMF), which refers to the physical and psychological effects of residents' and families' conduct on staff:[449]

> "33. Whilst there are some specialist facilities, most aged care facilities also have residents with these conditions [dementia or other altered mental states] in their population. Members in aged care have reported that there is inadequate time and resources for these staff to provide the residents with the care they

443 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13012).
444 Amended witness statement of Patricia McLean, 9 May 2022 at [49] (tab 265 page 13310).
445 Amended witness statement of Patricia McLean, 9 May 2022 at [51] and Annexure PM 2 (tab 265 page 13310 and 13323).
446 Amended witness statement of Patricia McLean, 9 May 2022 at [51] (tab 265 page 13310).
447 Witness statement of Dianne Power, 29 October 2021 at [38] (tab 258 page 13107).
448 Witness statement of Dianne Power, 29 October 2021 at [39] (tab 258 page 13107).
449 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 pages 10745–10747).

require, which can result in the residents becoming more unwell or violent. Aged care workers are required to attend to these residents, irrespective of their violence, and are regularly the subject of aggressive outbursts, which manifest in verbal and physical assault.

34. The ANMF OH&S Unit have had numerous reports of staff experience kicking, biting, scratching, punching, items being thrown at them, and regularly sexual assault, as well as verbal abuse denigrating them. Members report that this can be particularly offensive as there are often racist, sexist and sexual overtones to the abuse. In my experience few facilities have implemented adequate controls to deal with it and staff continue to suffer the consequences. These physical and psychological injuries suffered by staff at the hands of residents can be significant as is evident from some workers compensation matters and staff are on occasion blamed for their part in 'causing' the behaviour.

35. There are many examples. I remember a resident punched a staff member in the face at facility in Springvale in 2018. An ANMF member advised the affected staff member to fill out an incident report which management expressed extreme displeasure about. Although the affected worker did fill out the incident form our member who advised her to do so was subjected to a disciplinary process (the outcome–a warning - was eventually withdrawn).

36. Another example in 2019 was at a facility in Ferntree Gully where a carer/PCA went to relieve another worker for their meal break in the dementia unit. I was involved in representing the members around the health and safety systems in place. There were 18 residents with dementia and only one carer in the locked area. There were four residents sitting up in the lounge area just after midnight. A resident called out from their room and the carer found the resident dishevelled and soiled. When she attempted to clean the resident the resident became verbally and physically aggressive and punched and kicked at our member. Our member did her best to clean and make the bed and left the room after the bed was made. She couldn't call for help as she was in a locked area and had no duress system because it didn't function across the facility. She couldn't use her mobile as she was being punched. She couldn't write an incident report because carers/PCAs at that time weren't allowed to write progress notes or access computers. They had to tell the EN or RN who would then use their discretion about what was reported. The carer had had no training on occupational violence and aggression and a dementia care session was only held after ANMF made enquiries about training.

37. The second category of occupational violence and aggression is that perpetrated by residents or their family / visitors, where the behaviour is intentional. This is where the resident / visitor / family member deliberately verbally, physically or sexually assaults the staff member. Aged care facilities are a microcosm of society, and just as there are aggressive, intolerant members in society, so there are in the residents and visitors to aged care facilities. One distressing scenario was at a facility in Warrnambool in 2014 where there was an elderly resident in a wheelchair who would chase the staff in her wheelchair, hitting them, running into them, and assaulting them. The staff would hide under tables when she was coming to try to escape her.

38. In 2015 I dealt with a situation where there was a resident at a facility in Wheelers Hill who was known to ANMF members employed there to be sexually inappropriate with staff, and the employer implemented an 'intervention strategy' of the staff member having to tell the resident to stop

> when they engaged in these behaviours. The resident continued to sexually assault staff, unabated. When a member made a complaint, the employer refused to take action to prevent this from occurring, but also blamed the staff member who was subject to the behaviour and failed to support her when she sought assistance. There was no subsequent follow up, and the employer engaged in victim-blaming, with the member told that she should have 'pushed him off her' and to just 'stay away from him'. Our member was expected to continue to care for the patient following the incident but, due to the effects of the incident, subsequently took leave, and I believe submitted a workers compensation claim.
>
> 39. Aggression has also been reported to the OH&S Unit when family members are dissatisfied in the care that their loved one is being provided. They will express this in the form of verbal and sometimes physical abuse, or harassment, with constant questions, phone calls, questioning of what is occurring and how. This can be distressing for the staff, but also takes significant time away from their ability to provide care to residents whilst trying to appease the family member or members."

542. Further, at [40], Ms Chrisfield refers to workers being susceptible to mental injury due simply to the sheer volume of their work. Further (Ms Chrisfield says at [42]), workers experience undermining, backstabbing, exclusion, and other kinds of psychologically damaging behaviour from management and/or colleagues, which can result in devastating psychological injuries. Ms Chrisfield provides examples at [43]–[44].[450]

543. And, at [45], Ms Chrisfield refers to the mental toll that results from, "*the constant pressure and scrutiny of the work that they undertake and the care they provide*."[451] This comes from residents, family, organisations, media, and regulators (at [45]). Ms Chrisfield continues:[452]

> "45. … The volume of work is significant enough in itself. However, this is risk of stress and adverse mental health outcomes is compounded with the knowledge that everything that you do is going to be analysed.
>
> 46. The industry has large amounts of paperwork and reporting requirements to regulators in an attempt to ensure resident safety. A focus on 'resident-centred care', or 'resident first' has led to a scenario in a number of cases referred to the Unit where staff inadvertently subvert their own needs to comply with the expectations, to the detriment of their own psychological wellbeing."

544. At [47], Ms Chrisfield refers to the "*substantial work intensification*" caused by ongoing reduction in staffing levels combined with an increase (or constancy) in

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450 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10747–10748).
451 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10748).
452 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10748).

resident numbers and an increase in the acuity of residents. As Ms Chrisfield identifies:[453]

> "The residents require more intense care but there are fewer qualified staff to provide the care (as RN and EN numbers drop as a proportion of the workforce). Due to the reduction in the number of nurses, it means that the care workers are required to do more complex work which is often outside of their qualifications or experience. These workload pressures are present at all levels of the care staff and add to the concerns around completing their jobs."

545. At [48], Ms Chrisfield states that nurses and AINs / PCWs in aged care facilities frequently refer to their work as being "*emotionally charged work*."[454] This has been exacerbated during COVID-19—but that aspect of the work will be discussed separately, in Part E.16 below.

Evidence of employer witnesses

546. The evidence of Kim Bradshaw (General Manager at Warrigal's Stirling Facility) is that the AIN undertakes emotional and pastoral care of the resident as part of their role, although this is not an explicit task. She says that they also give the residents that may be feeling down, anxious or confused, emotional support and will be the first point of contact to help the resident and family.[455]

Relevance of this evidence to work value

547. There is a substantial body of evidence before the Full Bench establishing that the work performed by direct care workers is physically and emotionally demanding. The evidence also supports a finding that this work has become *more* demanding as the needs of clients and residents become more complex and as staffing levels are reduced. Staff working in aged care now have greater responsibility for complex and emotionally demanding situations. In this respect the nature of the work is changing, becoming harder and additional skills are required to perform the work.

548. In dealing with the emotional demands of the work, employees also utilise "*hidden skills*" identified and discussed in the report of Hon Assoc Prof Junor and considered later in these submissions.

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453 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10748).
454 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10749).
455 Statement of Kim Bradshaw dated 4 March 2022 at [32] (tab 294 page 14942).

E.9 Incidence of and strategies to deal with violence and aggression - Lay Evidence Report Part D.9

The Lay Evidence Report

549. The Lay Evidence Report identified that many witnesses stated that there was a real risk of violence when in the aged care setting (at [531]) and that witnesses commonly identified that they had learnt strategies, including their formal training, about how to deal with aggressive and dangerous behaviour (at [530]). The ANMF adopts Lay Evidence Report [529]–[558].

550. That part of the Report incorporates or refers to evidence in the statements of Lisa Bayram (RN) at [86], Maree Bernoth (RN) at [42]–[44], Dianne Power (AIN / PCW) at [81], Patricia McLean (EN) at [105], Christine Spangler (AIN / PCW) at [34]–[35], Rose Nasemena (AIN / PCW) at [28]–[31], [34], Pauline Breen (RN) at [29].

Evidence of other Frontline Workers

551. Linda Hardman (AIN / PCW) also gives evidence (at [51]–[52]) of occupational aggression and violence, as follows:[456]

> 51. … With my experience, I am pretty good at recognising the kinds of triggers that will lead to behaviours, aggression, or abuse. But, despite all of my training and experience sometimes I do not see the warning signs. Sometimes, you just have to leave a resident's room because you can see that the resident is about to get aggressive. I always make sure the resident is safe before I leave. I then re-approach several times. I use strategies such as changing staff, to see if that makes a difference. If none of that works, then I report it to the RN on duty and it is written up in the work logs.
>
> 52. Dementia and mental health issues also leads to wandering. Some residents wander into other residents' rooms, which can lead to conflict. Even if it does not, we spend time finding wandering residents and persuading them go back to their own room or in any event leave another resident's room. Sometimes we use strategies such as making a cup of tea, or finding an activity for the resident to undertake. At times I just have to make time to have a chat with the resident to reassure them or orientate them in time and place. This takes time, but it can prevent a resident becoming aggressive or intrusive into other residents' rooms."

552. Ms Hardman gave as instances of the kind of unsafe situations she had encountered from time to time when residents try to bite or kick her, or when she gets verbal abuse from a resident's family. On one occasion, the abuse was bad enough that she seriously thought about taking long-service leave (PN9876–9878).

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456 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13271).

553. Suzanne Hewson's (EN) evidence extracted above at [487] is relevant, here, as well.[457]

554. Jocelyn Hofman (RN) refers, at [31], in listing the skills that are required for an aged-care RN, "*the skills required to address aggressive or agitated behaviours*."[458]

555. Wendy Knights (EN) says as follows at [53]–[54]:[459]

> "There are residents whose behaviours without anti-psychotic medication are just atrocious. I think if they knew what they were doing, they would be mortified. Patients with dementia can get quite aggressive. They can get agitated, restless, or paranoid. Past memories are sometimes refreshed, so you might get residents insisting they have to pick their kids up or check on their parents. Residents wander. The late afternoon is a challenging time for these kinds of behaviours.
>
> And, most aged-care workers are not trained as mental health nurses. That is why I do not feel safe working overnight, by myself, in the dementia ward. Aggression is a much bigger problem than it used to be. It can be triggered unpredictably.

556. Ms Knights gives as contributing causes to the increased prevalence of aggression the increased prevalence of Alzheimer's / dementia and the stress to those residents associated with entering aged care (at [50]), there being fewer physical constraints on residents than there used to be (at [51]), and there having been a dramatic reduction in anti-psychotic medication (at [52].[460] Ms Knights says that, after the Royal Commission, there is more aggression in the dementia unit than there used to be (at [73]), and therefore that nurses and carers are informally learning new skills to de-escalate situations and calm or console residents (at [71]). Several staff have been injured as a result of interactions with residents (at [73]).[461] At [92], Ms Knights says that there is much more aggression and violence than there used to be in aged care.[462]

557. Dianne Power (AIN) says that she has learned strategies for managing behaviour, which means she is less likely to get hit by a resident or cause them to become agitated. Nevertheless, her evidence is that there are not many days when a resident does not become agitated and needs to be calmed down. Agitated behaviour can include screaming or hitting out. The strategies she uses include staying calm and avoiding distracting stimulation, like having the television on or too much noise. She says that

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457 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13421).
458 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13154).
459 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13445–13446).
460 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13445).
461 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13448).
462 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13452).

speaking calmly and distracting them helps, or taking them away from other residents that may be upsetting them.[463]

558. Under cross-examination Sheree Clarke (AIN) gave evidence about situations where she said it was not possible to follow protocol or procedure to de-escalate an unsafe situation. Specifically, she identified a situation where a resident is aggressive and going towards another vulnerable older person. In that situation she said that you couldn't just walk away if they're turning, taking a swing at you and going back for that person. Her evidence was that "*[y]ou've got to do whatever you can to get the attention back on you, away from the more vulnerable person*."[464]

559. Virginia Mashford (AIN) describes that there is sometimes both physical and verbal aggression in her work environment. Her work involves violence, residents hit her and verbally abuse her. From her experience, this aggression is often it is about communicated needs not being met, as well as workers being rushed to try and complete tasks.[465]

560. The evidence of Irene McInerney (RN) is that there is always the potential for violence from unpredictable residents who have mixed mental health diagnoses (including dementia). She describes the need to know what triggers residents toward unexpected and potentially dangerous behaviours and notes that these triggers can vary between residents. She says that all staff need to have good communication skills and need to judge when to press and when to back off.[466]

561. Camilla Sedgman (home care AIN / PCW) described (at PN5225–5234) a situation of being present at a client's house, with the client's son, who—out of the blue—screamed and yelled at her to a degree that she personally felt unsafe and had to leave the residence. She was affected to the point of shaking and crying. She went home, had a cup of tea, and carried on working in the afternoon. This captures the unpredictability of the work, the risk involved in being, without support, in another person's private residence, and the resilience required to carry on working despite having been subjected to an act of serious aggression.

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463 Witness statement of Dianne Power, 29 October 2021 at [72] (tab 258 page 13112).
464 Cross-examination of Sherree Clarke at PN10044–PN10049.
465 Amended Witness Statement of Virginia Mashford, dated 6 May 2022 at [55].] (tab 271 page 13435).
466 Witness Statement Irene McInerney dated 10 May 2022 at [52] (tab 260 page 13149).

562. Jennifer Wood (home care AIN / PCW), said (PN5616) that she always kept her car keys in her pocket because you never knew when you might have to exit in a hurry. She also did not park in the driveway (in case an ambulance was required), and did park facing the direction she would leave so that, again, she could leave in a hurry (PN5616). This captures, in addition to the risk, the awareness on the part of the worker of being at risk, and the need to plan to reduce that risk (but never eliminate it).

563. A memorable piece of evidence, which could really be put in many of the headings of this part, was that of Judith Clarke (AIN / PCW) at PN12068–12073. Ms Clarke described that she had made one medication mistake in 48 years of aged-care work, which resulted in no harm to any resident, which occurred because a resident was beating Ms Clarke over the back of the head with a shoe, but which was so distressing for Ms Clarke that she never went back to administering medication. This is relevant to (at least) exposure to violence, degree of responsibility, and the mental and emotional toll of the work.

Evidence of officials

564. Kathryn Chrisfield (Occupational Health and Safety Team Manager, ANMF) has an entire part of her statement dedicated to occupational violence and aggression (see at [31]–[39]). That has been quoted at [541] above and will not be repeated, but is relevant here as well. Further, Ms Chrisfield said in cross-examination that around once per month she or her team would have occasion to call Safe Work Victoria because of a safety incident in an aged care facility, a majority of which calls were in relation to occupational violence or aggression risks that are not being managed (PN3829–PN3831).

565. The incidence of occupational violence has remained a consistent and growing problem in the sector. This problem was also reflected in the results from the 2019 ANMF National Aged Care Survey discussed in the evidence of Robert Bonner (Director, Operations and Strategy of the Australian Nursing and Midwifery Federation (SA Branch)).[467]

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467 Witness Statement of Robert Bonner dated 29 October 2021 at [120] and "RB 4" – Australian Nursing and Midwifery Federation (2019). ANMF National Aged Care Survey 2019–Final Report, p. 2424 (tab 187 page and 11052).

566. In January and February 2020, the ANMF (Victorian Branch) also conducted a survey of Victorian aged care members, receiving responses from 1476 RNs, ENs and AINs/PCWs. As discussed in the evidence of Paul Gilbert (Assistant Secretary of the Victorian Branch of the ANMF) participants were sked whether certain events had occurred in the past week because of insufficient staffing or a lack of time in your workplace.[468] The responses included that:

(1) 28.99 per cent of respondents (365) said that a resident has been injured because of aggression by another resident; and

(2) 38.13 per cent of respondents (480) said that a nurse or carer has been injured because of aggression by a resident.

Findings of the Royal Commission

567. At FR.3B.522, the Royal Commission noted "*incidents of assault and abuse can have a significant effect on aged care workers*". Similarly, [IR.1.6] refers to a "*major quality and safety issue[]*" being "*a high incidence of assaults by staff on residents and by residents on other residents and on staff*."

Relevance of this evidence to work value

568. The conditions under which aged care work is done involves the increasing prevalence of occupational violence and aggression. Direct care workers attend to residents with dementia or other altered mental states which can lead to them being kicked, bitten, scratched, punched, being subjected to sexual assault and verbal abuse. Direct care workers can also be subjected to violence and aggression perpetrated by residents or their family / visitors, where the behaviour is intentional. This can lead to physical and psychological injuries.

569. The evidence supports a finding that occupational violence and aggression is increasing with:

(1) The increased prevalence of dementia or other altered mental states; and

(2) The reduced use of physical and chemical restraints.

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468 Amended Witness Statement of Paul Gilbert dated 3 May 2022 at [60] "Survey of aged care members" at 15-16. (tab 186 pages 10789 – 10790).10785–10786).

570. As such, the nature of the work and conditions under which the work is done have become more challenging and dangerous.

571. Likewise, direct care workers must now exercise greater levels of skills and responsibility to identify, prevent and de-escalate violence and aggression.

E.10 Supervision - Lay Evidence Report Part D.10

Agreement between interested parties as to this factor

572. At [15]–[16] of the Consensus Statement, the following was agreed between the parties to that statement:

> "Since 2003, there has been a decrease in the number of nurses, both Registered Nurses (RNs) and Enrolled Nurses (ENs), as a proportion of the total workforce employed in aged care. RNs are the clinical leaders in residential aged care and have experienced an increase in managerial duties (including co-ordinating and supervising and delegating) and/or administrative responsibilities. Expectations of RNs have increased markedly (along with a shift from residents with lower to higher social and clinical needs). Nurses are required to detect changes in resident health status, identify elder abuse and anticipate medical decision-making. Overall, there are more demands upon nurses due to workforce structures and meeting governance requirements. They develop care plans and oversee their implementation and review.
>
> Again since 2003, there has been an increase in the proportion of PCWs and AINs (care workers) in aged care with less direct supervision. PCWs are being required to perform duties that were traditionally undertaken by nurses (such as peg feeding and catheter support) after receiving relevant training and/or instruction. Care workers in both residential care and home care are performing increasingly complex work along with the increasing complexity of the needs of residents entering care. There are more expectations of care workers to detect changes in resident or client condition, identify elder abuse and assist with medications and other treatments."

573. This central proposition—fewer nurses means more and different work for both nurses and AINs / PCWs—is confirmed by other evidence in the case.

The Lay Evidence Report

574. The ANMF adopts Lay Evidence Report [559]–[577]. In those paragraphs, O'Neill C referred to Consensus Statement [15]–[16] and said that, "*[t]he evidence from the lay witnesses is consistent with this, giving evidence that there is little direct supervision*" (at [559]). Thereafter, O'Neill C extracted or referred to the evidence of (*inter alios*) Wendy Knights (EN) at [90].

Evidence of other Frontline Workers

575. In Pauline Breen's (RN) statement at [23], she says that there are fewer RNs working in home care than when she started, and that when RNs retire they are often not replaced by another RN.[469]

576. Hazel Bucher (NP) says at [31] that supervising staff and understanding the resident has become more important while attending to clinical tasks.[470] But, supporting very new and clinically inexperienced RNs is not particularly easy given language barriers and cultural differences. The responsibility of supporting new RNs falls to more-senior RNs (at [33]).[471] At [43(a)], Ms Bucher says that a change since 2010 is that there are fewer RNs and ENs, and an increased proportion of carers (and a reduction in the hours of care staff). This has resulted, Ms Bucher says at [44(a)], in:

> "[t]he devolution of responsibilities and tasks from senior and experienced RNs to less experienced (and fewer) RNs, an increased role for ENs, especially in the area of medication, and a substantial change in the role of carers in delivering direct care."

577. At [63] of the statement of Linda Hardman (AIN / PCW), she says that when she started in aged care twenty years prior, there were at least four RNs on each shift, but that now there are often only two. The result is that their workload is high, and when they are in-charge of the facility they have to deal with staffing issues on top of the clinical workload.[472] Ms Hardman continues (at [65]) to say that there are not enough RNs, ENs, or AINs / PCWs.[473]

578. Jocelyn Hofman (RN) says at [24] that there has been a reduction in RN numbers over the last twenty years, but despite this the workload and allocation of responsibilities is increasing.[474] The results of fewer RNs include that some tasks are delegated to AINs / PCWs, including in relation to medication—which concerns Ms Hofman (at [33]).[475]

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469 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13351).
470 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13123).
471 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13124).
472 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13272–13273).
473 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13273).
474 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13153).
475 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13155).

579. Ms Hofman explains at [34] that a further consequence of reduction in RN numbers is increased scope and extent of responsibility for remaining RNs. It requires increased exercise of judgement in prioritising demands.[476]

580. Wendy Knights (EN) describes at [26]–[27] that RNs are much more involved in administrative work than they used to be. Though, they are still required on the floor when, for example, ENs or PCWs ask for assistance or evaluation or if there is a fall.[477]

581. Christine Spangler (AIN / PCW) describes at [28] that there is usually an RN or EN on each ward, but not always. If there is no EN, then the RN has to do the medication round and other tasks that would ordinarily fall to an EN.[478]

Evidence of officials

582. The evidence Annie Butler (ANMF Federal Secretary) is that AINs and PCWs work under the supervision of RN and also direction from ENs. More experienced and qualified AINs and PCWs can provide 'on the ground' supervision and direction to other AINs and PCWs.[479] The EN provides nursing care, working under the direction and supervision of the registered nurse.[480]

Evidence of employer witnesses

583. Paul Sadler (CEO, ACSA) accepted in cross-examination that an effect of RNs being diverted into more paperwork is that RNs are providing less direct care themselves (PN12314), and that there is less ability to maintain direct supervision by RNs of direct care work (PN12315).

584. Mark Sewell (CEO, Warrigal) also stated that the role of the RN has changed in that the role is now more administrative in nature: "*RN's [sic] are now spending more time undertaking duties such as compiling reports, conducting audits of documentation and completing care plans*" (at [113]).[481]

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476 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13155).
477 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13441–13442).
478 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13016–13017).
479 Amended Witness Statement of Annie Butler dated 2 May 2022 at [174].] (tab 181 page 9274).
480 Amended Witness Statement of Annie Butler dated 2 May 2022 at [173].] (tab 181 page 9274).
481 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14610).

585. The result is that AINs / PCWs are now working, "*under the general supervision of RN's rather than alongside the RN*" (at [115]).[482] Though, Mr Sewell goes on to emphasise that RNs are available when they are needed (at [116]).[483]

586. In cross-examination, Mr Sewell said that care workers are performing more of the direct care work than had previously been the case, and with less direct supervision (PN12921–PN12922). Warrigal was instead relying on indirect or general supervision (PN12923), a result of which was that care workers have to have the skills and knowledge and experience to identify the types of issues that may be of concern and need to be raised at the level of the RN or clinical manager (PN12924).

587. Under Cross Examination Sue Cudmore (who has operational control of Alliance Community) described Alliance Community providing community care to elderly clients with high care needs. She said that such work involves a RN supervising or delivering the program.[484] However, Ms Cudmore also acknowledged that in home care, employees won't be receiving direct supervision most of the time.[485]

Findings of the Royal Commission

588. Commissioner Briggs echoes Ms Cudmore's observation about home care workers, stating at [FR.3A.404] "*Home care workers require a level of confidence to deal with new, challenging and unpredictable situations while operating at a distance from supervisors and managers*."

Relevance of this evidence to work value

589. The Consensus Statements at [15] – [16] identifies that since 2003:

(1) there has been a reduction of RNs ENs as a proportion of the total workforce employed in aged care;

(2) RNs have experienced an increase in managerial duties; and

(3) there has been an increase in the proportion of PCWs and AINs (care workers) in aged care with less direct supervision.

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482 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14610).
483 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14610).
484 Cross-examination of Sue Cudmore at PN13544.
485 Cross-examination of Sue Cudmore at PN13589.

590. PCWs and AINs working with less direct supervision are required to exercise additional skills and a higher level of responsibility in performing their work.

591. The evidence also identifies additional supervisory duties being performed by ENs and other staff (also requiring additional skills and responsibility).

592. Finally, in addition to their critical role in providing direct care to residents and clients, RNs now exercise additional skill and bear additional responsibilities as managers.

E.11 Technology - Lay Evidence Report Part D.11

Agreement between interested parties as to this factor

593. Background Document 1 (at [116.15]) recognises as apparently uncontentious that "[t]*here is expanded use and implementation of technology in the delivery and administration of care"* [footnote omitted].

The Lay Evidence Report

594. The Lay Evidence Report identified evidence about the changing use of technology (at [578]) and how this affected the work of employees in aged care (at [580]), noting that the evidence broadly was that there had been an increased use of technology, with mixed views about whether this had made the job easier (at [580]).

595. The ANMF adopts Lay Evidence Report [578]–[591]. This refers (*inter alia*) to the evidence of Suzanne Hewson (EN) at [50], and Sherree Clarke (AIN / PCW) at [61]–[62].

596. In addition to her evidence at [50], Sherree Clark says (at [33]) that "*[s]ome residents require two-person handling*."[486] Despite that hoists and slide sheets are regularly used (see at [61]),[487] it remains that Ms Clark is "*constantly manual handling residents, some of whom may weigh between 100–170kg and who may be physically resistive to being handled by me*." She has been injured via the use of hoists themselves.[488]

Evidence of other Frontline Workers

597. Maree Bernoth (an RN) states that technological change happens quickly in regard to standards, funding tools, education, tele-health, care plans, and medications, which

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486 Statement of Sherree Clark dated 29 October 2021 at [33].
487 Statement of Sherree Clark dated 29 October 2021 at [61].
488 Statement of Sherree Clark dated 29 October 2021 at [72]–[73].

requires staff to develop the skills and expertise in using these devices.[489] Further, staff are required to trouble-shoot technology when it malfunctions.[490] New reporting requirements require additional technological skills.[491]

598. Dianne Power (an AIN / PCW) also describes the additional work involved in dealing with electronics including for residents.[492] Linda Hardman (AIN / PCW) wrote notes on paper during the day, and then wrote them again, electronically at the end of her shift (PN9839–9841).

599. Wendy Knights (an AIN / PCW) describes (at [39]–[40]) how a particular computer program, MedSig, makes the dispensation of medications harder than simply recording on paper, especially together with IT and connectivity issues.[493] She also refers (at [45]) to the need to fix residents' technology or assist them in connecting video calls.[494] In cross-examination, Ms Knights said that some records were paper-based, and others were electronic, and that varied from doctor to doctor (PN9213–9214).

600. Lisa Bayram (an RN) states that, despite whatever mechanical aids now exist, it remains that "*many residents at Grossard Court require a two person lift*."[495] Dianne Power (an AIN / PCW) says the same.[496]

601. Linda Hardman (an AIN / PCW) states (at [29]) that there are a lot more overweight and bariatric patients than previously, so that some tasks require three rather than two staff. This increases the workload, both in terms of the number of transfers in which a PCW is involved, and the physical demand of those transfers.[497] Wendy Knights (an AIN / PCW also describes (at [33]) two-person lifts.[498]

602. Associated with the evidence of the impact of technological developments upon aged care work, there was a substantial amount of evidence pertaining to the built form of residential facilities, including purpose built facilities. For example, Lisa Bayram (an RN) says that more-private and more-spacious facilities are better for residents, but

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489 Statement of Maree Bernoth dated 29 October 2021, [55]–[56].] (tab 264 page 13285).
490 Statement of Maree Bernoth dated 29 October 2021, [55]–[56].] (tab 264 page 13285).
491 Statement of Maree Bernoth dated 29 October 2021, [37].
492 Statement of Dianne Power dated 29 October 2021 at [48] (tab 258 page 13109).
493 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13443–13444).
494 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13444).
495 Statement of Lisa Bayram dated 29 October 2021, [87].] (tab 262 page 13242 13243).
496 Statement of Dianne Power dated 29 October 2021, [19] (tab 258 page 13104).
497 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13268).
498 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13442).

make work harder for carers, ENs, and RNs. This, she says, is because carers, ENs, and RNs cannot easily see and monitor each resident in that resident's room, in comparison with a ward-type setup.[499] This is in circumstances where residents spend more time in their rooms, given increasing acuity.[500]

603. Hazel Bucher (a NP) states (at [31]) that "*creating a home like environment but providing clinical grade service is challenging*,"[501] and (at [44(c)] that "*a home like environment and older facilities present difficulty and dangers in delivering care to frail, obese or cognitively impaired residents*."[502]

604. Virginia Mashford (an AIN / PCW) draws attention to the clutter of individual rooms, the presence of cords and other tripping hazards, and the difficulty manoeuvring people into and out of beds in small rooms.[503]

605. In any event, the Commission could not safely make any finding about the prevalence of purpose-built newer facilities, in comparison with non-purpose-built or older facilities. For example, Suzanne Hewson (an EN) describes (at [15]) that Labrina Village was a police station, then retirement accommodation, and now a residential aged care facility (and is not well suited to that final purpose).[504]

Evidence of officials

606. The evidence of ANMF officials is such that the Commission could not safely make any finding about the prevalence of mechanical aids. Kathryn Chrisfield (Occupational Health and Safety Unit Coordinator, ANMF) notes (at [15]) that built-in safety features are not mandatory and hence are often cut from budgets.[505] She also said that there was sometimes inadequate staff safely to operate a lifting machine (PN3845), and sometimes the machines were not adequately maintained (PN3846). In any event, even where such features exist, they are not consistent and sometimes cannot be used where (for example) access is obstructed as a result of poor design (see [16]).[506] In home care

499 Statement of Lisa Bayram dated 29 October 2021, [89].] (tab 262 page 13243).
500 Statement of Lisa Bayram dated 29 October 2021, [89].] (tab 262 page 13243).
501 Statement of Hazel Bucher dated 29 October 2021(tab 259 page 13123).
502 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13128)
503 Statement of Virginia Mashford dated 29 October 2021 at [53]–[54].] (tab 271 page 13434 — 13435).
504 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13418).
505 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10742).
506 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10742).

settings, there is often a lack of appropriate resident handling equipment and an inappropriate physical environment in which to undertake care (see [59]).[507]

607. Mr Bonner describes an explosion of clinical technology in the sector in recent years as acuity has increased. This includes PEG feeds, infusion pumps, falls mats and mechanised and lifting equipment.[508] The industry has seen a significant increase in the use of resident documentation and related technology, communication and other technology particularly over the last 20 years.[509]

608. With respect to built form, the evidence of frontline workers identified above is confirmed by that of Kathryn Chrisfield. Ms Chrisfield says (at [13]) that there has been focus on aesthetics, but not on functionality or safety.[510] Individual rooms and attractive common areas make the facility more appealing for residents, but increase difficulty for staff.[511] More time is spent walking down hallways between rooms before staff are able to provide care; and if that care involves physically assisting residents down the same hallways then that, again, enhances the physical demands of the work (at [13]–[14]).[512]

609. Further, as Ms Chrisfield notes at [20], an increase in privacy for residents means a decrease in safety for workers, who are required to attend to residents alone, with no visibility to others in the event of an incident.[513] This the case for home care workers, who are, Ms Chrisfield notes at [59], "*[l]one worker[s] in potentially vulnerable situations with no means of assistance*."[514]

610. Especially where there is no consultation about design features, Ms Chrisfield notes (at [17]–[18]) that designs that increase the attractiveness of a building might give rise to access issues, trip/slip issues, poor flooring choices, or sub-optimal facilities for staff.[515]

611. And, consistently with Virginia Mashford's evidence, Ms Chrisfield notes (at [28]) that the "*home-like environment*" that is sought to be created in some residential aged care

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507 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10752).
508 Witness Statement of Robert Bonner dated 29 October 2021 at [133].] (tab 187 page 10820).
509 Witness Statement of Robert Bonner dated 29 October 2021 at [136].] (tab 187 page 10820).
510 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10741).
511 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10741).
512 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10741–10742).
513 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10742–10743).
514 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10751).
515 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10742).

facilities results in inability to access lifting equipment, and otherwise creates hazards.[516]

Evidence of employer witnesses

612. Paul Sadler (CEO, ACSA) stated that, while staff do require training in the use of new technologies, they generally make work easier (at [98]).[517] Similarly, he referred to "*physical overhauls of the work environment to adapt to the changing needs of consumers*," in that new and retrofitted facilities are now "*more purpose built to suit the current needs of the consumer*" (at [62]–[64]).[518]

613. Mr Sadler accepted in cross-examination that not all technology did in assist workers and some technologies created inefficiencies (PN12436). And, it may be that even where technology might work well, in practice inefficiencies were introduced because of (for example) a shortage of computer terminals (PN12437). And, it happens often enough that there is duplication of labour in that workers write notes on paper, before then inputting that information into a computer, including "*because pen and paper are actually [sometimes] the simplest way to get some information at the bedside*" (PN12438).

614. Mr Sadler accepted in cross-examination that there is a greater need for the use of such aids, because of the increasing levels of immobility and frailty amongst residents (PN12341). Mr Sadler also accepted (in regard to home-care workers) that, while the home-care environment has always been variable, there is an increasing number of home care consumers who have difficulty caring for themselves on account of age, frailty, acuity, *etc.* (PN12345, PN12346), and an increasing need for home care workers to be attuned to environmental and physical risks in the home (PN12347).

615. Mark Sewell (CEO, Warrigal) gave similar evidence—that "*most residential aged care facilities are now more purpose built to meet the needs of residents during the later stages of their lives*" (at [59]).[519] There has also been an expansion in the availability

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516 Statement of Kathryn Chrisfield dated 29 October 2021 (tab 184 page 10744).
517 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13595).
518 Statement of Paul Sadler dated 01 March 2022 (tab 289 page 13590).
519 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14602).

of mechanical aids such as lifters (at [60]).[520] Mr Sewell refers to the use of technology systems for paperwork and records (at [84]–[87]).[521]

616. Mr Sewell accepted in cross-examination that what for some people would be straightforward tasks—like toileting, showering, eating, *etc*.—can be very complex for people with complex health needs, particularly if combined with cognitive difficulties (PN12955). Moving residents with severe mobility issues can be a complex task (PN12956), and the use of mechanical aids does not obviate the need for care workers to communicate and negotiate with residents to use those devices (PN12958), which carry with them a risk of injury (PN12959). This is even more complex if dementia or other cognitive issues are involved (PN12960) (which, as submitted elsewhere, is increasingly the case).

617. Mr Sewell also accepted that the change to single rooms with ensuites involved more walking for nurses and AINs / PCWs (PN13093), that it was more difficult for nurses and AINs / PCWs to keep all residents under observation (PN13094), and that it was more difficult for nurses and AINs / PCWs to themselves be under observation should some difficult situation arise (PN13095). Not surprisingly, Mr Sewell accepted that while some technology was good, other technology may be less easy to use (PN13097), that hardware shortages might create inefficiencies (PN13098), and that it was very common for workers to write a set of paper notes and then write those notes a second time electronically in a record system (PN13099).

618. Craig Smith (Executive Leader Service Integrated Communities, Warrigal) likewise refers to a change away from multi-bed rooms and hostel accommodation towards the majority of rooms being single rooms with ensuites.[522]

619. Emma Brown (Special Care Project Manager at Warrigal) describes her observations at Warrigal of the following forms of technology being integrated into facility systems and practices:

(1) Online of app based internal training;

(2) Apps (Ento) for rostering;

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520 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14603).
521 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14606).
522 Statement of Craig Smith dated 01 March 2022 (tab 291 page 14130).

(3) Electronic visitor management systems;

(4) Laptops for the nurses' station; and

(5) iPads for medication and wound management.[523]

Findings of the Royal Commission

620. Pursuant to the recommendations of the Royal Commission, the use of technology to record data and assist with care management is likely to increase. For example, *Recommendation 68: Universal adoption by the aged care sector of digital technology and My Health Record*, will if fully adopted, require every provider to use a digital care management system, including an electronic medication management system. In addition, every person receiving aged care services will be asked to provide consent to their care records being made accessible on My Health Record, and if consent is given, the provider must keep the record up to date [FR.3A.323].

Relevance of this evidence to work value

621. The use of new technologies such as mechanical aids, smart phones, ipads and software programs used for documentation, compliance, reporting and training have required direct care workers to develop new skills and take on additional responsibilities. Likewise, the operation of new equipment such as PEG feeds, infusion pumps and falls mats have also required a level skill and responsibilities. These new technologies are also related to changes to the nature of the work and conditions in which the work is done. Accordingly, each of the work value reasons identified by s 157(2A) justify an increase to the applicable award minimum wages.

622. The increased prevalence of mechanical aids such as sling lifters and stand-up aids have reflected increased levels of immobility and frailty amongst residents. Despite these aids, direct care workers continue to handle (sometimes obese) residents manually, for various reasons, including because of inadequate staff safely to operate them or because they are not adequately maintained. That is, to the extent that some new technologies many make aspects of aged care work easier, those new technologies are not sufficient to set off other factors such as increased resident and client acuity, changes to staffing

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523 Statement of Emma Brown dated 2 March 2022 at [82] (tab 290 page 13995).

levels and skill mix, changes to the philosophy and models of care and changes in accountability, regulation and resident's expectations.

623. The construction of purpose-built facilities reflects a change to the condition under which the work is done. Individual rooms can provide increased privacy for residents but a decrease in safety for workers who are required to attend to residents alone, with no visibility to others in the event of an incident. Individual rooms also involve more time being spent walking down hallways between rooms before staff can provide care. Designs that increase the attractiveness of a building might give rise to access issues, trip/slip issues, poor flooring choices, or sub-optimal facilities for staff.

624. With respect to built form:

(1) at least in large part the evidence suggests that those changes were made with residents', not workers', interest in mind;

(2) the Commission is not in a position to find that such changes are sufficiently widespread as to meet the general trend of increased acuity; and

(3) even where changes in built form and availability of technology have the capacity to make work physically easier, this is (more than) offset by the increased need to use such technologies compared with the past (when residents were generally more ambulant), and the increased skill involved in using (say) lifting technologies in regard to (say) bariatric patients.

E.12 Qualifications and training - Lay Evidence Report Part D.12

Agreement between interested parties as to this factor

625. At [21], the Consensus Statement sets out examples of the proposition that, "*[t]he changes in, and changes sought to, the qualifications and training of direct care workers reflect changing care needs*." The examples given are these:

> "(a) The addition of a reference to the care of older people to the Registered Nurses Accreditation Standards 2019
>
> (b) The skills considered necessary to be added to current training for the Certificate III in Care Support, as follows:
>
> (i) Person-centred behaviour supports
>
> (ii) Providing loss and grief supports
>
> (iii) End of life and palliative care

(iv) Dementia care

(v) Management of anxiety and adjustment to change

(vi) Supporting relationships with carers and families

(vii) Falls-prevention strategy

(viii) Assisting with monitoring and modification of meals

(ix) Working with people with mental health issues

(x) Providing or assisting with oral hygiene and recognising and responding to oral health issues

(xi) Effective care for members of diverse population groups including aboriginal and Torres Strait Islander people

(xii) Use of information technology."

626. Additionally, Background Document 1 (at [116.11]) recognises as apparently uncontentious that "*[e]mployers in in the aged care industry increasingly require that PCWs and AINs hold Certificate III or IV qualifications* [footnote omitted]".

627. Reference is made below, in Part E.13, to the disparity between the wages paid to direct care workers and their qualifications, in comparison with the relationship of qualifications and wages in other areas (*e.g.*, lower wages than acute care work despite similar qualifications, lower wages than retail despite aged-care workers often having significantly greater qualifications). That evidence will not be repeated here.

The Lay Evidence Report

628. The Lay Evidence Report identified that many lay witnesses who were personal carers had a Certificate III in Individual Support (Ageing) or a related field. The Lay Evidence Report recognised evidence of differing views about the sufficiency and necessity of holding a Certificate III or Certificate IV qualification and that some witnesses emphasised that they had developed additional skills through working in their roles beyond the Certificate III level training.

629. The ANMF adopts the contents of the Lay Evidence Report addressing this theme at [592]–[605]. Further, the ANMF adopts Appendix A to the Lay Evidence Report, in which O'Neill C set out the qualifications and competencies of the lay witnesses.

Evidence of Frontline Workers

630. In addition to what is set out in the Lay Evidence Report, it may assist the Commission to have some evidential references to the qualifications outlined by various of the ANMF's lay witnesses.

631. Pauline Breen (RN) says at [9] that, in addition to her qualifications as an RN, she has completed a lot of further clinical training in relation to wound care, stoma care, women's health, and aged care.[524]

632. Hazel Bucher (NP) sets out her (many) qualifications and work history from [5]–[16]. These include, in addition to her basic qualifications for registration, a Master of Nursing Science (Nurse Practitioner), a Grad. Dip. Nursing Aged Care, a Grad. Dip, Mental Health, a Grad. Cert. (Geriatric Rehabilitation).[525]

633. Linda Hardman (AIN / PCW) has a Cert III in Aged Care, a Cert IV in Aged Care, and a Cert IV in Mental Health. She got these because she felt the aged care system was changing and it was good for her to keep upskilling (see at [11]–[14]).[526] Ms Hardman says (at [54]) that there is an expectation, which did not previously exist, that staff would have a minimum of a Cert III in aged care or be working to that qualification.[527] She thinks this is a good thing, as Cert III teaches people "*basic skills*" (at [56]).[528] Her motivation in completing the certificates was to become more competent in her job (PN9802).

634. Suzanne Hewson (EN) has a Cert III in Aged Care, and also a Diploma of Nursing.[529]

635. Jocelyn Hofman (RN), in addition to the qualifications leading to registration as an RN, has completed training in areas including palliative care, wound care, psychotropic medication, COVID-19, emergency fire training, dementia management, falls prevention, and work health and safety (see at [8]–[10]).[530] She, like Ms Hardman, says (at [22]) that there is an expectation that AINs / PCWs will have a Cert III.[531]

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524 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13348).
525 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13118–13119).
526 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13266).
527 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13272).
528 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13272).
529 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13418).
530 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13152–13153).
531 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13153).

636. Wendy Knights (EN) gives evidence as to the abilities of AINs / PCWs with Cert III qualifications. In her view, they "*are given broad training but it isn't sufficiently in depth to identify or question certain care needs like wounds, dementia, diabetes and continence*" (see [14]). That is why, before she became an EN, she completed a Cert IV to assist her in her work as an AIN / PCW (at [13]–[14]).[532] Ms Knights also says (at [17]) that the overwhelming majority of ENs are now qualified to administer medication, which has been an enormous change since 2000 (see [15], [17]).[533] Mr Knights has completed courses in dementia and palliative care (see [20], [22]).[534]

637. In cross-examination, Ms Knights explained that she thought Cert III training was insufficient to identify when there had been changes in a resident in order for their care to be upgraded, and for dealing with dementia (PN9141). She felt more confident in dealing with palliative patients having completed a separate course in that discipline (PN9173–9175). There was no de-escalation training for dementia patients when Ms Knights did her Cert III, and it was not until she started doing her EN diploma that she got hands-on training in that regard (PN9218)

638. As noted in the Lay Evidence Report at [600], Christine Spangler (AIN / PCW) has completed around 42 in-house courses, mapped against the Aged Care Quality Standards (see [8]).[535] Unlike Ms Hardman and Ms Hofman, Ms Spangler's experience has been that, whereas she had been asked whether she had a Cert III or intended to do on, these days that question is no longer asked (at [30]).[536] In cross-examination, Ms Spangler expressed the view that Cert III training was required to do the job properly (PN8645).

639. In addition to the Pain Advocacy Nurse in Aged Care training identified in the Lay Evidence Report, Lisa Bayram (RN) has completed additional training in:

(1) Occupational Health and Safety;[537]

(2) Dementia Essentials through Dementia Training Australia;[538]

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532 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13439–13440).
533 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13440).
534 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13440, 13441).
535 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13009–13011).
536 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13017).
537 Statement of Lisa Bayram dated 29 October 2021, [9].] (tab 262 page 13227).
538 Statement of Lisa Bayram dated 29 October 2021, [10].] (tab 262 page 13227).

(3) Comprehensive Assessment of the Older Person in Aged Care;[539] and

(4) Palliative care through a course with Gippsland Palliative Care Consortium.[540]

640. Sheree Clarke (AIN) has a Diploma in Community Services as a Youth Worker and has undertaken extensive additional training in aged care as set out in her witness statement at [18].

641. Patricia McLean (EN) has a Certificate IV in Aged Care, Certificate IV in Workplace Health and Safety and a Diploma of Nursing.[541] Additionally, she has completed a number of Blue Care courses including continence and safety coaching. She has done a lot of courses in dementia and driver safety training including.[542]

Evidence of officials

642. As noted by Annie Butler (ANMF Federal Secretary), the 2020 Census Report identified that 66 percent of PCWs held a Certificate III or higher in a relevant direct care field, and another two percent were studying for a Certificate III or higher. Of the balance, facilities reported 26 per cent as without a response and are assumed not to hold or be studying for Certificate III. The remaining 7 per cent were reported by the employer as unknown.[543]

643. As discussed by Ms Butler in her evidence, the 2020 Census Report identifies the number of providers that report having direct care workers with formally obtained specialist skills across 22 different areas in residential aged care,[544] HCPP[545] and CHSP.[546]

644. Robert Bonner (Director, Operations and Strategy of the Australian Nursing and Midwifery Federation (SA Branch)) describes the Certificate III in Individual Support

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539 Statement of Lisa Bayram dated 29 October 2021, [12].] (tab 262 page 13227).
540 Statement of Lisa Bayram dated 29 October 2021, [13].] (tab 262 page 13227).
541 Amended witness statement of Patricia McLean dated 9 May 2022 at [23]–[25] (tab 265 page 13305).
542 Amended witness statement of Patricia McLean dated 9 May 2022 at [26]–[28] (tab 265 page 13305 - 13306).
543 2020 Census Report, 17; Amended Witness Statement of Annie Butler dated 2 May 2022 at [89].] (tab 181 page 9255).
544 2020 Census Report, 52, A.4.1, Amended Witness Statement of Annie Butler dated 2 May 2022 at "AB 3"." (tab 181 page 9295).
545 2020 Census Report, 54, A.4.3, Amended Witness Statement of Annie Butler dated 2 May 2022 at "AB 4"." (tab 181 page 9296).
546 2020 Census Report, 56, A.4.5, Amended Witness Statement of Annie Butler dated 2 May 2022 at "AB 5"." (tab 181 page 9297).

(CHC33015) qualification as the principal qualification for preparation to work in the aged care sector. He says that it provides entry level training for a care worker in the provision of care and support such as that related to the activities of daily living, emotional support and skills related to communication and observation, including the need to refer to health professionals particularly to registered nurses. It introduces care workers to the aged care sector and care delivery. It involves a mix of required knowledge and skills coupled with workplace experience, including workplace placements which amount to a total of 120 hours.[547]

645. The Statement of Julianne Bryce (Senior Federal Professional Officer, ANMF), is almost entirely concerned with the training and qualifications of nurses in particular (but also AINs / PCWs). Salient points include these:

(1) (at [15]–[18]) the accreditation process for nurses, and monitoring by the Australian Nursing and Midwifery Council on behalf of the NMBA, ensure that nurses have completed an accredited and approved program of study leading to registration or endorsement with the NMBA under the National Law. This ensures that graduates of accredited and approved programs of study have undertaken the necessary theoretical content and clinical practice required and have been assessed as meeting the national NMBA standards for practice.[548]

(2) (at [20]) there is a national Professional Practice Framework, which includes standards for practice for NPs, RNs, and ENs, codes of conduct and ethics, decision-making frameworks and frameworks for assessing standards of practice for RNs and ENs, guidelines in regard to registration and professional practice, and safety and quality guidelines.[549]

(3) (at [20]) there are Registration Standards in regard to criminal history, English language skills, continuing professional development, recency of practice, professional indemnity insurance, endorsement as an NP, and endorsement for Scheduled medicines for RNs.[550]

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547 Witness Statement of Robert Bonner dated 29 October 2021 at [88].] (tab 187 page 10812– –10813).
548 Statement of Julianne Bryce dated 29 October 2021 (tab 189 page 11152–11153).
549 Statement of Julianne Bryce dated 29 October 2021 (tab 189 page 11153).
550 Statement of Julianne Bryce dated 29 October 2021 (tab 189 page 11153).

(4) (at [21]–[26]) registration as an RN requires completion of a three-year Bachelor of Nursing degree in the university sector; enrolment as an EN requires completion of an 18-month Diploma of Nursing in the VET sector.[551]

(5) (at [27]–[37]) maintaining registration requires meeting registration standards (outlined above—criminal history, professional indemnity insurance, recency of practice, and continuing professional development). There is a disclosure requirement for criminal conduct. There is an obligation to maintain professional indemnity insurance. Nurses need to declare at renewal that they have practised for a period equivalent to a minimum of 450 hours, within the past five years. Nurses are required to complete 20 hours of CPD each year, and nurses who are dual-registered require 20 hours for each profession, each year. NPs must complete a further 10 hours in relation to prescribing and administering medicines, diagnostic investigations, consultation, and referral.[552]

(6) (at [38]–[48]) nurses are "*responsible for making professional judgements about when an activity is within their scope of practice and, when it is not, for initiating consultation and collaboration with, or referral to, other members of the healthcare team*" (at [39]). Further, RNs are required to make decisions concerning the scope of appropriate delegation.[553]

646. In cross-examination, Ms Bryce explained that one of the differences in training as between RNs and ENs was that RNs were taught more by way of critical thinking and higher-level skills including decision-making and delegation (PN3735). Only RNs are entitled to set a plan of care, and the most complex nursing tasks (*e.g.*, caring for a chest tube, removing cardiac sutures) would only be done by RNs (PN3738).

647. The evidence of Paul Gilbert (Assistant Secretary of the Victorian Branch of the ANMF) is that prior to about 2016, Enrolled Nurses who were educated to the satisfaction of the NMBA to administer medications became "Endorsed" Enrolled Nurses on the register of Enrolled Nurses. In about 2016, the number of "endorsed" ENs far outnumbered the "unendorsed" ENs and the NMBA revised the way this was

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551 Statement of Julianne Bryce dated 29 October 2021 (tab 189 page 11154).
552 Statement of Julianne Bryce dated 29 October 2021 (tab 189 page 11154–11155).
553 Statement of Julianne Bryce dated 29 October 2021 (tab 189 page 11156–11157).

recorded, simply making a notation against an Enrolled Nurse's registration if they were not so educated and able to administer medications (at [58] to [63]).

Evidence of employer witnesses

648. Mark Sewell (CEO, Warrigal) states that there has been an increase in the number and type of mandatory training required due to regulatory changes and changes in the current work environment (*e.g.*, COVID-19) (at [91]).[554] Warrigal prefers its employees to have at least a Cert III (at [92]),[555] but Mr Sewell says that a Cert III "*cannot teach the attitude and maturity required of the role that we are looking for personal carers*," which he says requires around three years (at [93]).[556] Mr Sewell was cross-examined (see PN12994 ff) in regard to this "*attitude and maturity*" aspect of his evidence, showing that really what he meant was that workers develop valuable skills over this period—this is discussed in Part F below at [826] to [831].

649. As far as Warrigal was concerned, Mr Sewell estimated that there are about 30 per cent of frontline carers with Cert IIIs, and he would want that to be about 80 per cent (PN12990).

650. Craig Smith (Executive Leader Service Integrated Communities, Warrigal) says that there are fewer and fewer employees coming in at the non-qualified entrant level—*i.e.*, more and more with some form of qualification (Cert III, *etc.*) (at [99]–[101]).[557]

651. Anna-Maria Wade of ACSA stated that, over the last decade, there has been an increased in providers requiring AINS / PCWs to have a Cert III in individual support (at [46]).[558] This gives a base line understanding of care principles, but experience is more important (at [47]).[559]

652. The additional evidence from employer witnesses regarding qualifications and training includes that:

554 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14607).
555 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14607).
556 Statement of Mark Sewell dated 01 March 2022 (tab 292 page 14607).
557 Statement of Craig Smith dated 01 March 2022 (tab 291 page 15191).
558 Statement of Anna-Maria Wade dated 01 March 2022 (tab 296 page 15201).
559 Statement of Anna-Maria Wade dated 01 March 2022 (tab 296 page 15201).

(1) Buckland prefers that its carers are certificate III qualified and undertakes regular mandatory training;[560]

(2) The home care provider KinCare requires its employees to undertake mandatory training run quarterly and involving 12 hours training per year.[561] Nurses at KinCare also conduct medication training for home care employees;[562] and

(3) For the past 10 years Warrigal has provided mandatory training for all employees.[563] Warrigal also prefers personal care workers commence with a Certificate III in Individual Aging (or equivalent).[564] Warrigal Stirling also engages external experts to conduct training such as dementia care and wound management.[565]

Findings of the Royal Commission

653. The Royal Commission found at [FR.3A. 406] "*Aged care workers need to have good quality, and easily accessible, ongoing training and professional development opportunities available to them.*"

654. The level of mandatory training for direct care workers is likely to increase based on the following recommendations of the Royal Commission.

(1) *Recommendation 80: Dementia and palliative care training for workers* [FR.3A.405] recommends that it be a condition of approval of aged care providers that all workers involved in direct contact with people seeking aged care services undertake regular training about dementia care and palliative care.

(2) *Recommendation 81: Ongoing professional development of the aged care workforce* [FR.3A.407] recommends development of short courses, skill sets and micro-credentials for the aged care workforce designed to improve opportunities for learning and professional development and upgrade skills, knowledge and capabilities of the existing workforce.

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560 Statement of Johannes Brockhaus 3 March 2022 at [14] and "JB-01" (tab 293 pages 14829 and 14849ff).

561 Statement of Cheyne Woolsey dated 4 March 2022 at [28] to [29], "CW02" and "CW03" (tab 297 page 15716 – 15717 and 15727 – 15728).

562 Statement of Cheyne Woolsey dated 4 March 2022 at [31], "CW04" (tab 297 page 15717 and 15729).

563 Statement of Emma Brown dated 2 March 2022 at [65] (tab 290 page 13991).

564 Statement of Emma Brown dated 2 March 2022 at [69] (tab 290 page 13991). See also Statement of Kim Bradshaw dated 4 March 2022 at [23] (tab 294 page 14940).

565 Statement of Kim Bradshaw dated 4 March 2022 at [24] (tab 294 page 14940).

(3) *Recommendation 82: Review of health professions' undergraduate curricula* [FR.3A.409] recommends that in conducting their regular scheduled reviews of accreditation standards, the relevant accreditation authorities should consider any changes to the knowledge, skills and professional attributes of health professionals so that the care needs of older people are met.

Relevance of this evidence to work value

655. Registered nurses and enrolled nurses have minimum educational and accreditation requirements as well as ongoing professional obligations to maintain their registration. For RNs, this includes the completion of a three-year Bachelor of Nursing degree in the university sector. For EN, this includes completion of an 18-month Diploma of Nursing and educational preparation for medication administration. The evidence establishes that RNs and ENs undertake ongoing education and training specific to their work in aged care and beyond the requirements of their registration. This education and training is related to the nature of the work and the level of skill and responsibility involved in doing the work. The value of these qualifications and training must be adequately recognised by the applicable minimum wages. At present it is not.

656. Many employers now at least prefer AINs and PCWs working in aged care to hold a Certificate III in Individual Support (Ageing) or a related field. This is reflected in the fact that at least 66 per cent of AINs and PCWs hold a Certificate III or higher in a relevant direct care field.

657. Employers regularly conduct and/or require aged care employees to complete annual mandatory training. ANIs and PCWs, like ENs and RNs, gave evidence of a multitude have also undertaken a multitude of additional training and received various certificates to assist them in their day to day work. This reflects the agreed matter identified in the Consensus Statement, namely that the changes in, and changes sought to, the qualifications and training of direct care workers reflect changing care needs. That is, the changes to the nature of the work performed by direct care workers requires workers to have additional qualifications and training.

658. Finally, it is recognised by witnesses called by the employer interests and by unions that formal training and qualifications provide only part of the broad range of skills used in the performance of aged care work. Other skills used by direct care workers reflect personal attributes and skills developed through work in the industry. The

identified syllabus of Certificate III in Individual Support (Ageing) does not purport to cover the types of "*hidden skills*" identified and discussed in the report of Hon Assoc Prof Junor and considered later in these submissions.

E.13 Attraction, retention, workload, wage rates - Lay Evidence Report Part D.13

Agreement between interested parties as to this factor

659. A separate part of the Consensus Statement is dedicated to attraction and retention of workers, on page 5. The parties to the statement agreed to the following:

> "Wages in aged care need to be competitive to attract and retain the number of skilled workers needed to deliver safe and quality care.
>
> Minimum award wages of nurses are significantly lower than in the acute health sector, making aged care a less attractive choice for nurses. Minimum award wages of PCWs are significantly lower than for disability support workers
>
> Providers of both aged care and disability support would benefit from alignment of wage levels to support the mobility and the aggregate supply of staff in both sectors.
>
> Similar challenges are faced in the attraction and retention of support staff, who are an integral part of aged care functional teams."

660. Other aged-care employers (including State Governments) made submissions to the effect that wages increases were required, in some cases directly linking this to attraction and retention of workers.

661. BaptistCare submits that its staff "*deserve a significant increase to the relevant Awards that apply to aged care provision*, for reasons developed at [23]–[25].[566]

662. IRT submits that it is finding it increasingly difficult to attract and retain employees, resulting in staffing shortages, particularly in regional areas. This, it says, is primarily the result of low rates of pay, given that employees can earn significantly more in the acute health sector or the disability sector for similar (or even less demanding) work.[567] Accordingly (it says at [21]), it strongly supports increasing minimum wages in the aged care sector (subject to funding).[568]

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566 Submissions of BaptistCare (tab 126 pages 877–878).
567 Submissions of IRT at [13]–[15] (tab 128 page 1118).
568 Submissions of IRT (tab 128 page 1119).

663. UnitingCare Australia likewise supports that award rates should be substantially increased.[569]

664. Uniting (a different entity) also says that aged care workers are not paid commensurate with the value of the work they perform,[570] and supports aged care workers having a "*significant wage increase*," subject to funding.[571] Uniting also spends several pages of its submissions speaking about its difficulties in attraction / retention. Salient points include that it has experienced a huge shortage of aged care workers, that it is experiencing a spike in employee turnover the drivers of which are wage rates, overwork, burnout, *etc.*, and that its strategy in responding to shortages includes maintaining wage rates at the highest rates possible.[572]

665. Nevertheless, its critical staff shortages are "*directly due to low wages rates which impacts the ability for [it] to attract workers from other sectors and retain those already in the sector*."[573] Less skilled and emotionally challenging work is either equally or better remunerated so people are reluctant to work in aged care—this disparity being evident in comparing the wages of disability workers to aged care workers.[574]

666. Evergreen Life Care submits that current wages are "*by no means a fair reflection of the work our staff do*," but that they cannot afford to fund more, and hence support an increase subject to funding.[575] Evergreen Life Care also refers to staff shortages, in part due to staff moving to the acute sector (or even roles in, *e.g.*, retail), which an increase in award wages would help address.[576]

667. MercyCare supports a significant increase to the aged care award rates, subject to funding. It does this for reasons including easing staff shortages.[577]

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569 Submissions of UnitingCare Australia (tab 129 page 1121).
570 Submissions of Uniting (tab 131 page 3122).
571 Submissions of Uniting (tab 131 page 3123).
572 Submissions of Uniting (tab 131 page 3124–3125).
573 Submissions of Uniting (tab 131 page 3125).
574 Submissions of Uniting (tab 131 page 3125).
575 Submissions of Evergreen Life Care (tab 132 page 3129).
576 Submissions of Evergreen Life Care (tab 132 page 3130).
577 Submissions of MercyCare (Tab 138 page 3193).

668. The State of Queensland shares the unions' concerns that work performed under the affected awards has been undervalued,[578] and noted the range of evidence "*supporting widespread undervaluation of work in the aged care industry*."[579]

669. The State of Victoria supports an appropriate increase (or series of increases) to minimum award rages, funded by the Commonwealth.[580] It submits that an appropriate increase to minimum wages is justified by work value reasons and necessary to achieve the modern awards and minimum wages objectives, because of the inherent value of the work, more-recent changes to the nature of the work (including to complexity, skill, responsibility, and judgment), and work conditions.[581]

The Lay Evidence Report

670. The Lay Evidence Report identified that witnesses gave a range of evidence to the effect that low pay made it hard to attract workers, that there is high staff turnover, that it is a female-dominated industry (noting that this is separately addressed in Part E.14 below), that the workload means staff are often working over-time, and that quality of care is affected by this time-pressure (at [606]). The ANMF adopts Lay Evidence Report [606]–[625].

671. In the Lay Evidence Report there are extracts from, and references to, the evidence of Maree Bernoth (RN) at [65], Wendy Knights (EN) at [95], Sherree Clarke (AIN / PCW) at [76], Jocelyn Hofman (RN) at [24], and Stephen Voogt (NP) at [64].

672. There are also references to the evidence of witnesses who "*gave evidence about their involvement in enterprise bargaining and the difficulties they faced in attempting to negotiate improved wages and conditions with their employers*."[582] This is addressed separately in regard to the modern award objective, at Part G.4 below.

Evidence of other Frontline Workers

673. In addition to the witnesses mentioned in the Lay Evidence Report, Pauline Breen (RN) refers to out-of-pocket expenses incurred by home care workers, including notably petrol (at [31]), and says that "*[m]any of these additional issues are not factored int our*

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578 Submissions of Queensland (tab 133 page 3131).
579 Submissions of Queensland (tab 133 page 3131).
580 Submissions of Victoria (tab 134 page 3142).
581 Submissions of Victoria at [48] (tab 134 page 3144).
582 See Lay Evidence Report fn 829.

wages or the time that is allocated for us to do our work" (at [32]). She says that the community is generally not aware of the work that aged care workers do, until they have a loved one in home care. She is considering retiring soon, but is more likely to delay doing so were wages to increase (at [33]).[583]

674. Hazel Bucher (NP) refers at [36] of her statement to the "*transient nature of the workforce*."[584] In her experience, new graduate nurses move after a few months working in aged care into acute care, or see aged care as a second job with a contract in acute care as a preferred focus (at [37]).[585] Ms Bucher's view is that an increase in the minimum wage would hopefully encourage carers and nurses to prioritise their work, so as to have better retention and provide improved care (at [55]).[586]

675. Further, at [45], Ms Bucher says as follows in relation to the acute care sector drawing workers away:[587]

> "My ideal RACF would consist of all carers who have completed additional qualifications in dementia care and all senior nurses would hold post graduate qualifications in aged care. The two areas in which I consider RACFs should do better are in dementia and palliative care. I have observed high levels of burn out of inexperienced staff in a complex clinical field, with associated high turnover of staff where the attraction to the acute sector and better wages draws nurses away. My ideal is a long way from being realised."

676. Linda Hardman (AIN / PCW) says that, despite working 75 hours per fortnight (at [4]), she is not certain that her current income will meet her future living expenses and retirement (at [5]). Hence, she works both weekend days to get loadings and penalties. If she worked only weekday shifts, her income would be significantly less (at [6]).[588]

677. Ms Hardman does not think that the pay is adequate for the work that is done (at [71]). She does not do the work because it pays well; she does it "*because [she feels] like an AIN in [her] heart. [She] enjoy[s] caring for people*" (at [72]). She thinks that people who are not actually on the floor do not know or care about how difficult the work

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583 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13352–13353).
584 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13124)
585 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13125).
586 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13129).
587 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13128).
588 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13265).

actually is (at [72]).[589] She thinks that an increase in the minimum rate would make working in aged care more attractive (at [79]).[590]

678. Suzanne Hewson (EN) says (at [7]–[8]) that she is fortunate to have a partner with a higher salary than hers, so that they do not have to rely on her income alone. If they did, her income would not be enough to meet expenses. Her pay has not gone up with the cost of living. She was (at the time of writing her statement) completing further study, to leave aged care and earn more money. As she explains at [32], she was (then) studying a Cert IV in Mental Health to move to another field of nursing.[591] She has, in fact, now done so (PN8277–8278).

679. Jocelyn Hofman (RN) says (at [6]–[7]) that her income is probably not sufficient to enable her to retire, which she intended on doing in about five years. She takes additional measures, like working evenings and weekends, to get loadings and penalties.[592]

680. Wendy Knights (AIN / PCW) says (at [6]–[7]) that her income barely meets her current expenses, and that is in a circumstance where she is paid above the award rate. If she were on the award rate, she would not be able to work in residential aged care. She does not do it because the money is good; she could find easier and less stressful work in other industries for as much or more money. She does it because she finds, "*helping residents and their families both challenging and immensely rewarding*," and she likes the sense of responsibility and camaraderie.[593]

681. At [85], Ms Knights refers to the fact of working unpaid overtime.[594] And, at [94]–[95] she says as follows:

> "94. For the most part, I feel that my work is valued by residents and families. I do not feel as though it is valued as it should be by the community at large. I do not think the community realises what work goes into good quality aged care. Lots of people seem to think that you are just making cups of tea.
>
> 95. My observations is that level of wages means it is difficult to retain staff. Nurses are often talking about workloads and pay rates. The work is hard and demanding, and sometimes dangerous. You are sometimes abused by residents, or families. You are exposed to bodily fluids and waste. But you

589 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13274).
590 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13275).
591 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13424–13425).
592 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13151).
593 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13438–13439).
594 Statement of Wendy Knights dated 29 October 2021 (tab 272 page 13451).

> could earn as much or more doing a job that did not have any of these difficulties. At the moment, it seems to me that the people that tend to be retained in aged care are people who really have a passion for caring work"

682. Irene McInerney (RN) says as follows at [45]:[595]

> "The work day leaves me feeling there isn't enough of me to go around; it is that simple. But I do get the reward from achieving a difference in the residents' day. Many staff decide it is too hard on them mentally (as well as physically) and they leave the Aged Care sector. They leave as the pay isn't attractive enough for a difficult of work environment."

683. Christine Spangler (AIN / PCW) works 70 hours per fortnight, but her wages are not enough to retire on (see [5]–[6]). When she was paying off a loan, it was very difficult financially; she and her husband are just managing now (at [6]).[596] At [36], Ms Spangler refers to a lack of staff being a constant problem.[597] And, at [41], she says that an increase in wages would attract more staff—and would cause her to continue to work in the sector for longer than might otherwise be the case.[598]

684. Dianne Power (AIN) describes having seen a lot of girls start out in aged care, get their EN qualification and then go into something else like working in hospitals or disability care where they are paid better.[599]

685. Sheree Clarke (AIN) describes being unable to save a deposit to get a loan to buy a house or unit because of her limited hours and rate of pay in aged care and is not confident of having enough income each fortnight to pay rent on a house or unit. She lives in a caravan park so that if she gets evicted, she will not end up with a bad rental history.[600] She has now started permanent-part work for the Queensland Nurses and Midwives' Union, working 8 days a fortnight.[601]

686. Rose Nasemena (AIN), relies on penalty rates to earn enough to pay bills and her rent. She would not be able to manage and support herself if she didn't work afternoon shifts

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595 Statement of Irene McInerney dated 29 October 2021 (tab 260 page 13147–13148).
596 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13009).
597 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13018).
598 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13019).
599 Witness statement of Dianne Power, 29 October 2021 at [93] (tab 258 page 13115).
600 Witness Statement of Sheree Clarke dated 29 October 2021 at [14]–[16].] (tab 268 page 13366– –13367).
601 Witness Statement of Sheree Clarke dated 29 October 2021 at [17].] (tab 268 page 13367).

and on weekends.[602] Ms Nasemena resigned from her position as PCA from 7 May 2022 to take time out. She had worked in that role for 13 years.[603]

687. Patricia McLean (EN) resigned from her employment as a EN in community care in July 2021.[604] Prior to her resignation, her income working in aged care did not meet her living expenses. Since that time, she has been working one day a week for the Queensland Nurses and Midwives' Union.[605]

Evidence of officials

688. The evidence of Annie Butler (ANMF Federal Secretary) notes that the 2020 Census Report identifies that between November 2019 and November 2020:

(1) 29 per cent percent of all workers in direct care roles in residential aged care had left their employment.[606]

(2) 34 per cent percent of all workers in direct care roles in HCCP had left their employment; and[607]

(3) 26 per cent percent of all workers in direct care roles in CHSP had left their employment.[608]

689. The 2020 Census Report presents data on vacancies in direct care roles at the time of the Census in residential aged care, CHPP and CHSP. This data is summarised in the Amended Witness Statement of Annie Butler at [126] to [129]. In summary, this data identified that as at 2020:

(1) 7% of Registered Nurse positions in residential aged care facilities were vacant;

(2) 10% of Registered Nurse positions within HCPP providers were vacant;

(3) 6% of Registered Nurse positions within CHSP providers were vacant;

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602 Amended witness statement of Rose Nasemena, 6 May 2022 at [15] (tab 267 page 13356).
603 Amended witness statement of Rose Nasemena, 6 May 2022 at [4] (tab 267 page 13354).
604 Amended witness statement of Patricia McLean, 9 May 2022 at [6] (tab 265 page 13303).
605 Amended witness statement of Patricia McLean, 9 May 2022 at [10] (tab 265 page 13304).
606 2020 Census Report, 23; Amended Witness Statement of Annie Butler dated 2 May 2022 at [91] and [123].] (tab 181 page 9256 and 9264–9265).
607 2020 Census Report, 35; Amended Witness Statement of Annie Butler dated 2 May 2022 at [123].] (tab 181 page 9256).
608 2020 Census Report, 35; Amended Witness Statement of Annie Butler dated 2 May 2022 at [123].] (tab 181 page 9256).

(4) 5% of Enrolled Nurse positions in residential aged care facilities were vacant;

(5) 14% of Enrolled Nurse positions within HCPP providers were vacant;

(6) 9% of Enrolled Nurse positions within CHSP providers were vacant;

(7) 5% of personal care worker roles in residential aged care facilities were vacant;

(8) 11% of personal care worker roles within HCPP providers were vacant; and

(9) 11% of personal care worker roles within CHSP providers were vacant.[609]

690. In 2016, the NILS Report identified that 88.2 per cent of the residential aged care direct care workforce were employed on a part time or casual basis.[610] Despite this, 44 per cent of this workforce was identified as working 35 hours per week or more.[611] As at 2020, 93 per cent of the total direct care workforce in permanent positions (full-time and part-time positions) were part time positions and 20.2 per cent of the residential aged care direct care workforce employed as casual/contractor on payroll.[612]

691. Just 11.9 per cent and 11.2 per cent of the direct care workforce across are employed full time in residential and community care respectively. This may be contrasted to the 62 per cent of the broader Australian workforce who are employed full time.[613]

692. Including in this context, Ms Butler said as follows at [197]–[202], [205]:

> **"**197. The first of these is the Productivity Commission 2011 report, Caring for Older Australians (**ANMF 26**). The report notes:
>
> > 'While most aged care providers will support skill development, current remuneration and working conditions are considered strong disincentives to entering and staying in the sector. Registered nurses and allied health professionals will also be in greater demand. As is the case for personal care workers, the key to attracting and retaining these workers will also be to offer fair and competitive remuneration and satisfying working conditions.'
>
> 198. On the question of remuneration, the report states:

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609 2020 Census Report, 22, 35 and 45; Amended Witness Statement of Annie Butler dated 2 May 2022 at [127] (table 26), at [128] (table 27) and at [128] (table 28).) (tab 181 page 9265 - 9267).

610 NILS 2016, 25; Amended Witness Statement of Annie Butler dated 2 May 2022 at [76].] (tab 181 page 9253).

611 NILS 2016, 26; Amended Witness Statement of Annie Butler dated 2 May 2022 at [77].] (tab 181 page 9253).

612 2020 Census Report, 11 (table 2.2); Amended Witness Statement of Annie Butler dated 2 May 2022 at [86].] (tab 181 page 9255).

613 NILS 2016, 25 (table 3.16) and 84 (table 5.16); Amended Witness Statement of Annie Butler dated 2 May 2022 at [106]–[107].] (tab 181 page 9259 – 9260).

> 'The relatively low remuneration of aged care workers is consistently raised as a key issue in attracting and retaining workers. There are a number of factors that have kept wages relatively low, including:
>
> • Inadequate price setting and indexation of care subsidies
>
> • Poor bargaining positions of highly feminised, part time workforce which has limited success in raising wages significantly above the relevant industry awards.'

199. The Productivity Commission recommended:

> RECOMMENDATION 14.1 The Australian Aged Care Commission, when assessing and recommending scheduled care prices, should take into account the need to pay fair and competitive wages to nursing and other care staff delivering approved aged care services and the appropriate mix of skills and staffing levels for the delivery of those services.

200. The next substantial report that focussed on workforce in the aged care sector was A Matter of Care- Australia's aged care workforce strategy (**ANMF 27**). This report developed a range of strategies to enhance, promote and develop sustainable growth of the aged care sector workforce to meet the demands of a growing sector in both the short and long term. The report notes:

> 'There are pay deficiencies, particularly for PCWs (residential and home care) and nurses. Korn Ferry Hay Group analysis undertaken for the taskforce highlights these roles, on average, are being under-rewarded by 15 per cent against the midpoint.'

201. The Aged Care Workforce Strategy Taskforce recommended that the 'industry develop a strategy to support the transition of PCWs and nurses to pay rates that better reflect their value and contribution to delivering care outcomes'.

202. The Taskforce commissioned a report from the Korn Ferry Hay Group titled 'Reimagining the Aged Care Workforce' (**ANMF 28**).

…

205. With respect to nurses, the report found a key factor in recruitment and retention of nurses to the aged care sector was the disparity in wages and conditions with the acute care sector."

693. The ANMF National Aged Care Survey 2019[614] discussed in the evidence of Robert Bonner (Director, Operations and Strategy, ANMF) identified workloads to be the main factor that hindered efforts to recruit and retain staff. Analysis of in-depth responses indicated that many participants could not identify only one single factor, but highlighted that many related factors contributed to why nurses and care staff leave or do not want to work in aged care. One of the three main themes to emerge from

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614 Witness Statement of Robert Bonner dated 29 October 2021, "RB 4" – Australian Nursing and Midwifery Federation (2019). *ANMF National Aged Care Survey 2019–Final Report*. Australian Nursing and Midwifery Federation (Federal Office), Melbourne, Victoria. (tab 187 page 11037).

qualitative analysis was that participants were 'undervalued, under recognised, not respected', 'unable to provide quality/good care', and the 'culture of blame'.[615]

694. Mr Bonner went on to say as follows at [51]:

> "This combined with less attractive conditions and fewer career opportunities makes it difficult to recruit and retain qualified staff in the sector. Research commissioned by the Aged Care Workforce Strategy Taskforce identified that nurses and PCAs employed in aged care earn between 10-15 per cent less than their similarly employed counterparts in the acute health and sector."

695. The ANMF collects and collates wage data relating to the pay rates of nurses, midwives and PCWs/AINs, including a comparison of public sector wages and private residential aged care wages. Information relating to private residential aged care wages is created through a process of identifying agreements in the non-public residential aged care sector and reporting average wages data based on rates of pay extracted for key classifications in the aged care agreements. It publishes this and other wage information quarterly in a document titled *Nurses and Midwives' Paycheck*.[616]

696. In her second statement, Kristen Wischer (Senior Federal Industrial Officer, ANMF) sets out highly-salient information as to the growing divergence between aged-care wages and public-sector nursing wages. This is most clearly seen at [26], and in the chart that follows it. In 2002, pay under the Nurses Award, pay under enterprise agreements covering aged care, and pay for public-sector nursing were very similar (just under $800/week for the former two; just over $800/week for the latter). Now, however, for RNs, public-sector nursing pay approaches $1800/week (see also [32]), whereas bargained outcomes in aged-care are at about $1500/week (see also [33]), and the Nurses Award rate is about $1200/week (see also [34]) (*i.e.*, about two thirds of public sector pay).

697. The disparity is slightly less pronounced in percentage terms for ENs and AINs / PCWs, but this does not deny its meaningfulness in dollar terms. For ENs, the public-sector pay is around $1300/week (see [38]), the bargained aged-care pay is around $1150 per week (see [39]), and the Nurses Award rate is just under $1000 per week (at [40]). For

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615 Witness Statement of Robert Bonner dated 29 October 2021, at [45]–[47] and "RB 4" – Australian Nursing and Midwifery Federation (2019). *ANMF National Aged Care Survey 2019–Final Report*. Australian Nursing and Midwifery Federation (Federal Office), Melbourne, Victoria, 10. (tab 187 page 10804 – 10805 and 11038).

616 Amended (Further) Witness Statement of Kristen Wischer dated 9 May 2022 at [8]–[10] and "KW 1".

AINs / PCWs, the public sector pay is about $1100 per week ([45]), the bargained aged-care pay is about $950/week ([46]), and the Nurses Award rate is about $900 per week.

698. In short, there is a clear financial incentive to RNs, ENs, and AINs / PCWs to work in the public health sector rather than the aged care sector.

699. Kevin Crank (Industrial Officer, ANMF) gave unchallenged evidence as follows, at [21] of his statement:

> "The 2020 Aged Care Workforce Census Report of the Commonwealth Department of Health says at p.9 "At the time of the Census there were an estimated 22,000 vacancies in direct care roles across the (aged care) sector." Based upon my discussions with members and upon my experience, including as an Industrial Officer with the ANMF, I believe that those vacancies are likely to be significantly fewer if the Award wages were very substantially higher and consequently the quality and safety of the care delivered would be enhanced."

700. And finally, Paul Gilbert (Victorian Assistant Secretary, ANMF) said as follows at [70] and [77]:

> "70. The Royal Commission concluded, aged care nurses and carers are overworked, understaffed and undervalued. They found (volume 1 page 75):
>
> > We have found that Australia's aged care system is understaffed and the workforce underpaid and undertrained. Too often there are not enough staff members, particularly nurses, in home and residential aged care. In addition, the mix of staff who provide aged care is not matched to the needs of older people. Aged care workers often lack sufficient skills and training to cater for the needs of older people receiving aged care services. Inadequate staffing levels, skill mix and training are principal causes of substandard care in the current system. The sector has difficulty attracting and retaining well-skilled people due to: low wages and poor employment conditions; lack of investment in staff and, in particular, staff training; limited opportunities to progress or be promoted; and no career pathways. All too often, and despite best intentions, aged care workers simply do not have the requisite time, knowledge, skill and support to deliver high quality care.
>
> These conclusions by the Royal Commission are reflective of the answers to our survey, which was one of a number conducted before and during the Royal Commission hearings.
>
> This is the environment in which carers and nurses have been working over the last 20 years. Aged care was never a perfect system, but the dramatic changes I have observed in the last 15 or more years have meant that the system is far worse than it was.
>
> From the late 90s to about 2012 changes to the system made working and caring extremely difficult in residential aged care. These changes include the reduction in numbers of staff per resident, the hollowing out of the workforce

> (the decrease in nurses compared to the increase in carers/PCWs as a proportion of the workforce), the increasing acuity and frailty of those entering residential aged care, the changes to the layout and design of buildings that has made monitoring residents harder and workload even heavier, increases in regulation and changes to models of care (consumer directed care and consumer choice for example). Some of these changes are to be welcomed. However, from my perspective the combined effect has been to make aged care nursing and care today harder, more complex and more stressful than it was in 2000.
>
> 77. CEDA make a number of recommendations (pages 21-23) which echo those of the Royal Commission, including that unions, employers and the Federal Government should collaborate to increase award wages in the sector. They conclude that:
>
> > At a bare minimum, wages should be comparable to those in adjacent industries such as health and disability. This would ensure that workers choose a career based on their skills and attraction to the sector, as opposed to the higher salaries of other caring sectors. However, this is unlikely to be enough to attract and retain quality workers. Wages should also rise as workers gain more skills and responsibility. There needs to be clearer paths to career progression, with commensurate increases in pay.
> >
> > Experience overseas also suggests that wage increases lead to improved retention, attraction and longer tenure, but must be properly funded and regulated, or they can lead to lower working hours or increased workloads for staff. Increasing wages by 25 per cent would entail significant cost, but as outlined earlier, the enormous challenge to boost retention and attract new staff requires a substantial wage increase. Available analysis suggests a wage rise of 25 per cent for personal-care workers would cost $2.2 billion over four years at current staffing levels.
>
> I agree with the Royal Commission and with CEDA that there needs to be a major boost to wages across the aged care sector to attract and retain staff as well as make it the fulfilling career choice that it once was. Increased wages are part of the matrix of improvements–along with better staffing, career progression, better education and training, more professional management–that is needed to produce a workforce capable of delivering first rate care."

Evidence of employer witnesses

701. In cross-examination, Paul Sadler (CEO, ACSA) was taken to some statements made by the Australian Aged Care Collaboration. That is a legal entity which advances public positions on behalf of aged-care employer organisations including ACSA, LASA, and the four faith-based peak bodies for the Anglicans, Catholics, Uniting, and Baptist Churches (PN12222–PN12224). Amongst other things, that organisation expressed the view that the key to fixing or solving the crisis of difficulty in attracting and retaining sufficient and appropriate staff in both residential and home aged care is pay (PN12375). Mr Sadler continued to say as follows:

> "The Australian Aged Care Collaboration has been very clear for many, many months now that there is a need for this Fair Work Commission work value case to proceed for it to make a determination of how wages should be adjusted to reflect the work value of our aged care workforce, that we believe that that will require an increase in wages for aged care staff, and that it is very important then that the Federal Government, whoever that is post 21 May, actually fully funds the outcome of that decision that the Fair Work Commission will make."

Findings of the Royal Commission

702. A fair and powerful summary of the conditions of aged-care work appears at [IR.1.89] (emphasis added) (see also [FR.2.213]):

> "*We have heard about an aged care workforce under pressure. Intense, task-driven regimes govern the lives of both those receiving care and those delivering it. While there are exceptions, most nurses, carer workers and allied health practitioners delivering care are doing their best in extremely trying circumstances where there are constraints on their time and on the resources available to them. This has been vividly described by the former and current aged care staff who have given evidence*.
>
> *The aged care sector suffers from severe difficulties in recruiting and retaining staff. Workloads are heavy. Pay and conditions are poor, signalling that working in aged care is not a valued occupation. Innovation is stymied. Education and training are patchy and there is no defined career path for staff. Leadership is lacking. Major change is necessary to deliver the certainty and working environment that staff need to deliver great quality care*."

703. It is not surprising, the Royal Commission found, that "*staff leave the sector because of dissatisfaction with remuneration, income insecurity, and excessive and stressful work demands*." This is in circumstances where nurses and AINs / PCWs in the aged-care sector earn 10 or 15 per cent less than their colleagues in other sectors (including acute health) ([IR.1.229], see also [FR.1.128]).

704. These findings reflect the evidence of ANMF witnesses, many of whom say (as outlined above) that they work in aged-care not because of the pay (which is dismal) but because of their passion for the work. Pay that accurately matched work value of particular work would attract more than just those persons who are intrinsically drawn to that work. Instead, including due to the paucity of pay, "*[d]ifficulties arise in identifying, recruiting, training and retaining suitable skilled staff*" ([IR.1.186]).

705. A similar finding appears at [IR.1.218], noting also the estimated need for the aged care workforce to double by 2050 in order to accommodate the need for aged care services. More reference to difficulties in attraction and retention appears at [IR.1.221]. Not at

all surprisingly, the Royal Commission received evidence that lifting wages to acute-sector levels assisted in attracting more staff ([FR.2.214]).

706. The evidence outlined in these submissions echoes the findings of the Royal Commission at [IR.1.230], including that "*aged care workers often experience excessive work demands and time pressure to deliver care*." For care workers, "*inadequate staffing levels mean that they are overworked, rushed and generally under pressure*."

707. At [FR.1.40], the Royal Commission observed that, "*[a]ged care is a worthy profession, and it needs to be appreciated as the key means to keep the aged care system safe and of high quality*." Evidence from ANMF witnesses to the effect that they do not feel appreciated (except, in some cases, by their colleagues and aged care residents themselves) has been summarised above. Their work is not respected. This is in part because low wages cause society (wrongly) to regard aged-care as a low-status occupation ([FR.2.214], see also [FR.1.125]).

708. "*The staff in aged care are poorly paid for their difficult and important work*" ([FR.1.124]). There is a gap between their wages and the wages paid to colleagues in acute health ([IR.1.229], see also [FR.1.128]). Successive governments have made several failed attempts to address that gap by providing funds to providers in the hope they would be passed on to workers by way of increased wages, but they were not passed on ([FR.1.128], see also [FR.3A.414]). An Aged Care Workforce Strategy Taskforce recommended that "*industry develop a strategy to support the transition of personal care workers and nurses to pay rates that <u>better reflect their value</u> and contribution to delivering care outcomes*," but this did not work either ([FR.3A.414]).

709. Aged care is understaffed and the workforce underpaid ([FR.2.211]). These are not new issues ([FR.2.211]). After the removal of an obligation to spend a particular proportion of funding on direct-care staffing, many aged-care providers contain labour costs by replacing nurses with AINs / PCWs ([FR.2.211])—the result of which, as appears from ANMF witnesses' evidence, is that fewer nurses are carrying the burden of nurse's work between them, and AINs / PCWs are performing work that would formerly have been performed by nurses (increasing the value of all of their work).

710. As stated at the outset of these submissions, so significant was this problem seen to be that it was the subject of two recommendations. The Royal Commission opined that in its view, "*the Australian Government, providers and unions must work together to improve pay for aged care workers*" ([FR.1.128]). Elsewhere, it said that "*the Australian Government and providers have a responsibility to lift the employment conditions and the status of aged care workers*," rather than relying on the commitment and goodwill of workers to build the aged care workforce ([FR.2.214]).

711. Whether there exist work value reasons justifying an increase in the award rates payable to direct care workers is the ultimate issue for the FWC. However, were it to accept that such an increase were justified it would not be alone. At [FR.3A.371], the Royal Commission opined, based on the "*extensive evidence before [it] about the work performed by personal care workers and nurses in both home care and residential care, … all three of the section 157(2A) reasons may well justify an across-the-board increase in the minimum pay rates under the applicable awards*" ([FR.3A.416]).

712. "*A Matter of Care–Australia's Aged Care Workforce Strategy*" (2018)[617] describes the aged care workforce as being significantly underpaid and undervalued for their work for reasons that include gender and the inherent lack of value of caring roles.[618] Comparative pay analysis undertaken for the taskforce confirms the comparatively low-paid status of nurses and PCWs employed in aged care.[619]

Relevance of this evidence to work value

713. The evidence and material before the FWC is abundantly clear. Wages in aged care are not high enough to attract and retain the number of skilled workers needed to deliver safe and quality care. Minimum award wages of nurses are significantly lower than in the acute health sector, making aged care a less attractive choice for nurses. Minimum award wages of PCWs are significantly lower than for disability support workers.

714. Workforce participants are conducting their own assessment of the work value of direct care work. As submitted at [256] above, labour supply constraints that exacerbate staff shortages and inadequate skill mix increase the intensity and work requirements of

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617 A Matter of Care Australia's Aged Care Workforce Strategy, Aged Care Workforce Strategy Taskforce, June 2018 (ANMF 27) ("**A Matter of Care**").

618 A Matter of Care at p. 5, 18 and 90.

619 A Matter of Care at p. 91.

existing staff. These are matters "*related to*" the nature of the work, the responsibilities involved and the conditions under which the work is performed. The evidence supports a conclusion that work intensity has been affected by staff shortages and that "*working up*" in relation to greater responsibility and increased skill demands has been a major and transformative feature of the changes in work and work requirements in recent years.

715. As a result, direct care workers are leaving the industry and new entrants are choosing to pursue careers elsewhere. The increase in the minimum wages sought by the ANMF is justified by work value reasons and necessary to attract and retain the number of skilled workers needed to deliver safe and quality aged care.

E.14 Gendered nature of the workforce - Lay Evidence Report Part D.14

716. The gendered nature of the aged-care workforce was a subject of the ANMF's expert evidence. Rather than deal with the import of that evidence here, this Part E.14 will largely be limited to setting out the evidence establishing the (uncontroversial) fact that women are the overwhelming majority of the workforce, and the submissions of some of the parties as to the salience of that fact. The expert evidence will be addressed separately, in Part F below.

717. Uniting, in its submission, submits that there has been an "*inherent under-valuing of caring roles and roles undertaken by female workers*," which "*no doubt contribute to the pervasive acceptance by many key stakeholders of lower wages in the sector*."[620]

718. The State of Victoria notes that the direct care workforce is one of the largest and fastest growing sectors in the State, that it is largely female, and that there is a substantial gender pay gap.[621]

719. The Lay Evidence Report identified evidence to the effect that the workforce in aged care, in both residential facilities and home care settings is overwhelmingly female (at [626]). The ANMF adopts Lay Evidence Report [626]–[637]. This contains extracts from, or references to, the evidence of (*inter alios*) Linda Hardman (AIN / PCW) at

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620 Submissions of Uniting (tab 131 page 3122).
621 Submissions of Victoria at [42] (tab 134 page 3143).

[68]–[70], Rose Nasemena (AIN / PCW) at [56], Wendy Knights (EN) at [94], and Jocelyn Hofman (RN) at [17].

720. Kevin Crank (Industrial Officer, ANMF) set out in Annexure KC-3 to his statement a list of enterprise agreements approved by the Commission since 18 October 2019 with a table containing some demographic information in regard to the employees covered (see also at [20]).[622] The unchallenged evidence of Mr Crank is that 88 per cent of employees in relevant workplaces were female (at [20]), and a high proportion were casual. Review of Annexure KC-3 bears this out: there are some (smaller) workplaces where literally every employee covered by the agreement is female;[623] larger workplaces are still overwhelmingly female;[624] it is not unusual for a quarter or even a half of workers to be casual, and in some cases an overwhelming majority of workers are casuals.[625]

721. In 2016, the NILS Report identified that 87 percent of the residential aged care direct care workforce were female. By occupational group at that time:

(1) 87.6 per cent of RNs were female;

(2) 91.4 per cent of ENs were female;

(3) 86.2 per cent of AINs / PCWs were female.[626]

722. The 2020 Census Report identified that 86 per cent of the aged care workforce in direct care roles identify as female.[627]

723. The 2016, the NILS Report also identified 89 per cent of the direct care workforce in home and community aged care was female.[628]

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622 Statement of Kevin Crank dated 29 October 2021 (tab 185 page 10759).

623 Jimbelunga Nursing Centre, Karuna Hospice Service.

624 See, *e.g.*, Regis Aged Care, Lutheran Services (Qld), Wesley Mission Queensland, Ozcare.

625 An example of this latter category is Pine Lodge, where 45 out of 52 covered employees were casuals, and the remaining seven were part-timers. At Laura Johnson Home, 31 out of 52 employees were casuals, and 15 of the remaining 21 were part-timers.

626 NILS 2016 at 127 (figure 3.4) and Amended Witness Statement of Annie Butler dated 2 May 2022 at [72].] (tab 181 page 9252).

627 2020 Census Report, 15; Amended Witness Statement of Annie Butler dated 2 May 2022 at [87].] (tab 181 page 9255).

628 NILS 2016, 74; Amended Witness Statement of Annie Butler dated 2 May 2022 at [103].] (tab 181 page 9259).

Findings of the Royal Commission

724. The Royal Commission [FR.2.29] identified that as at 2016, 87 per cent of direct-care workers in residential aged care, and 89 per cent in home care, were women.

Relevance of this evidence to work value

725. The direct care workforce is predominantly and overwhelmingly female. Moreover, the nature of the work, level of skill and responsibility and conditions under which the work is done reflect what is historically seen as "*women's work*".

726. Numerous frontline workers express the opinion that their work is undervalued, in part, because of the gendered nature of the workforce. That evidence is supported by the expert evidence contained in the Smith/Lyons Report and in the Junor Report as are discussed further below.

E.15 Inherent value of the work - Lay Evidence Report Part D.15

The Lay Evidence Report

727. The Lay Evidence Report identified evidence from lay witnesses about why they love working in the aged care industry even though they believe the wages to be too low (at [638]). Evidence was also identified of residents not having visitors and employees providing care and support and human contact which was relied upon heavily by residents and community care clients (at [639]).

728. The ANMF adopts Lay Evidence Report [638]–[648]. This part of the report includes extracts from and references to the evidence of (*inter alios*) Dianne Power (AIN / PCW) at [37], and Rose Nasemena (AIN / PCW) at [41].

Evidence of other Frontline Workers

729. In a similar vein to the evidence extracted in the Lay Evidence Report, Pauline Breen (RN) described (at [13]) her satisfaction in seeing patients achieve better health outcomes.[629] She feels that her work is valued by patients and families, but not her employer (at [28]).[630] Her work is not understood by the community at large (at [32]).[631]

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629 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 10349).
630 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 10352).
631 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 10352–10353).

730. Hazel Bucher (NP) did not feel that her role was yet valued by health professionals who generally do not understand it (at [51]). She further considered that there is a lot of social rhetoric about the value of older people, but there is then less commitment from Government in terms of actually spending the necessary money to improve their worlds (at [52]).[632]

731. Linda Hardman (AIN / PCW) said as follows in regard to the community's understanding (or lack thereof) of aged care work, at [68]–[69]:

> "68. The community doesn't really understand aged care work. It isn't until a community member has a relative or friend in aged care they realise the deficiency in the system. They often do not know that until they have a family member in aged care or they end up being a resident in aged care.
>
> 69. I do not think that the community understands what goes into properly-performed aged care. Even families that come into the facility have an expectation that it should be possible for their mother or father to be brought to, say, the dining room straight away. They do not know that, for example, someone might have had a fall, someone needs to be put onto a hoist, someone needs to be taken off the toilet, or similar. If when someone comes to visit there are three or four people on the toilet, then we have to attend to that before we can walk another person down to the dining room. There are too few AINs to do all of these things at once. Sometimes we get verbal abuse from families. This, of course, causes upset and stress. Based on the things that have been said to me by families, I think this comes from a lack of understanding about the aged care sector and the workload, and sometimes from unrealistic promises made by management"

732. Ms Hardman went on to say, at [73], that she does feel valued by residents, and at [75] that she feels valued by other aged-care workers—who know what the job is like.[633] Ms Hardman also said this, in regard the public perception of aged care (at [76]):[634]

> "I, and other aged care workers with whom I've spoken, feel a little let down by the Royal Commission. I had hoped that it would come through more in the media coverage what it is like to be on the floor in terms of the work pressure and time pressure. We are working our guts out to provide quality care, and we were hoping that would come out, and maybe some recognition that we are undervalued and underappreciated. Instead when you see aged care in the media, it is usually negative."

733. Suzanne Hewson (EN) said (at [30]–[32]) that she started working in aged care because she wanted to make a difference to people, but sometimes feels like a cog in a machine, as though she is taken for granted and undervalued. It is constantly demanded that aged

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632 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13129).
633 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13274).
634 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13274).

care workers do more with less. Staff work extra hours without pay, physically and mentally exhaust themselves, and go out of their way to improve by doing extra training. This is to better assist residents, but none of it is recognised or valued.[635]

Findings of the Royal Commission

734. Staff who are "*succeeding*" within this context are doing so "*due to their own passion and dedication*," where the aged care system "*provides no incentive or encouragement for these achievements*" ([IR.1.9]). At [IR.1.229], the Royal Commission found that, "*an intrinsic interest in caring for older people is a common motivator for many people working in aged care*," but that many workers see it as a stepping stone to the acute health sector.

735. Commissioner Briggs, in her overview of the findings of the Royal Commission, says at [FR.1.40] "*Aged care is a worthy profession, and it needs to be appreciated as the key means to keep the aged care system safe and of high quality*. And at at [FR.1.40] "*The community as a whole needs to reflect upon the value of aged care workers and the essential nature of the work they do, and to pay them accordingly."*

736. Chapter 12 "The Aged Care Workforce" [FR.3A.437] concludes with the following:

> "We reflect on the words of the late Commissioner Tracey, following evidence given by four aged care workers:
>
> > *We are enormously grateful to you for bringing us stories from the coalface and giving us a better understanding of what it is like to provide quality care to the aged in this community. And the dedication that you display on a day-to-day basis is something that this community must be exceedingly grateful for.*
>
> We agree. Gratitude must mean something in real terms. It must mean that the work of caring for older people is valued."

Relevance of this evidence to work value

737. The nature of the work performed by direct care workers is such that they have a profound effect on the lives of residents and clients *every day*. The evidence establishes that direct care workers make incredible contributions to the physical and emotional wellbeing of vulnerable recipients of aged care. They perform important services for *human* beings, not objects, and provide a benefit to community broadly. These are

635 Statement of Suzanne Hewson dated 29 October 2021 (tab 270 page 13423).

matters related to the nature of the work. The significance of the nature of this work cannot be overstated.

738. The value of this work must be recognised. The industry should not (and cannot) simply rely on employees who perform the work because of their own passion and dedication.

E.16 COVID-19

The Lay Evidence Report

739. The Lay Evidence Report noted that there was also a great deal of detailed evidence from lay witnesses about the impact of the COVID-19 pandemic on the employees and their workplaces. This included evidence about the additional stress it placed on staff, residents and clients, the difficulties of working in PPE, the higher emotional toll and the additional pressure felt by care staff assisting residents and clients who were distressed and more isolated than usual. However, the Lay Evidence Report did not develop this theme in circumstances where it was said that the extent to which these matters would be ongoing was not yet known (at [3]).

740. The ANMF's submission is that this evidence <u>is</u> relevant to work value, for basically two reasons. *First*, COVID-19 is not a temporary event. As at the date of writing this submission, it has been a material reality in Australia for more than 2.5 years. The Commission could take notice of the fact that daily cases are once again on the rise in various Australian States, that new variants are emerging several times each year, that COVID-19 outbreaks continue to occur in aged-care facilities, and that whey they do they result in serious illness and sometimes death.

741. *Second*, and relatedly to this last point, the evidence before the Commission establishes that COVID-19 has caused permanent changes in the way that infection prevention and control is dealt with in aged care. This is detailed below.

Evidence of officials

742. Unlike in other sub-parts of this Part E, it is convenient to start with the evidence of union officials, and in particular with the evidence of Kathryn Chrisfield (Occupational Health and Safety Team Manager, ANMF). At [51]–[58], Ms Chrisfield says (*inter alia*) the following:

(1) that there has been a substantive increase in the focus on infection prevention and control ("**IPC**") throughout COVID-19, whereas pre-COVID-19 there had been little consideration of prevention of outbreaks and scarce consideration to learnings from outbreaks;

(2) that there have been various industry stakeholder groups for a COVID-19 response, including Victorian Government groups;

(3) that IPC practices have had to be quickly and efficiently improved during COVID-19, and requirements to maintain currency of knowledge around IPC principles;

(4) that each aged care facility is now required by the Aged Care Quality and Safety Commission to have an IPC lead within their service, whose role is to maintain oversight of IPC practices at the facility together with other matters;

(5) that this role will continue to be required post-COVID-19, and will hopefully reduce the level of gastroenteritis and influenza outbreaks in aged care.

743. This last notion—that changes in the approach to infection prevention and control will remain a part of aged care practice even if an era is reached that can be described as post-COVID (the current time not being that era)—is supported by the evidence of Mark Sewell:

> "PN12900
>
> Would you also agree, is it also the case that from your experience at Warrigal at least that the pandemic has taught lessons in relation to infection control procedures generally in aged care, outside of COVID specifically?---Yes, all our staff are now required to be infection control aware and follow the expertise of the infection control advisors.
>
> PN12901
>
> Those are lessons which you, Warrigal at least, would wish to incorporate into the general provision of aged care services going forward, irrespective of what happens with COVID in coming years?---I think, yes, definitely."

744. Andrew Venosta's evidence is that infection control has always been a part of aged care and that the regulatory focus, compliance requirements, documentation, reporting and training around infection control and outbreaks have increased markedly in the last 20

years. This is especially so now as a result of the COVID-19 pandemic.[636] Since the onset of the COVID-19 pandemic, he has witnessed the challenges of infection control coming to a head with an even greater need for specific training regarding advanced PPE and lockdown procedures, screening of staff and visitors, workforce management issues, and extraordinary pressure and stress on staff. He describes supporting members of the ANMF working in the aged care sector in his role as an Industrial Officer on many occasions with respect to issues such as unavailability of PPE in the workplace, inadequacy of infection control training, single site employment arrangements, underpayment of dual employment subsidies, and issues related to suspected exposure to COVID-19.[637]

Evidence of other Frontline Workers

745. Pauline Breen (RN) says (at [27]) that the work is more hazardous as a result of COVID-19 including now needing to use PPE such as masks, gloves, and sanitiser for wound care and to attend to catheters.[638]

746. Hazel Bucher (RN) said (at [50]) that COVID-19 has increased the isolation of residents, and increases the difficulty of dealing with residents affected by dementia, since such residents rely heavily on facial expressions for communication.[639]

747. Linda Hardman (AIN / PCW) said (at [74]) that the emotional demands of the job are heightened as a result of COVID-19. It has been harder for families to visit, which means that, in order to provide proper care, she spends an extra five or ten minutes with residents. Sometimes they cry and need "*some TLC*." That is harder to fit in with other work.[640]

748. Jocelyn Hofman (RN) (at [44]), like Ms Breen, refers to the changed PPE requirements, and the additional work (*e.g.*, taking temperatures) which places her under time pressure. Like Ms Bucher, Ms Hofman notes that wearing masks affects her ability to communicate with residents with hearing impairment and cognitive issues. Social

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636 Amended Witness statement of Andrew Venosta, dated 3 May 2022 at [77] (tab 188 page 11138).
637 Amended Witness statement of Andrew Venosta, dated 3 May 2022 at [75]–[76] (tab 188 page 11138).
638 Statement of Pauline Breen dated 29 October 2021 (tab 266 page 13352).
639 Statement of Hazel Bucher dated 29 October 2021 (tab 259 page 13129).
640 Statement of Linda Hardman dated 20 October 2021 (tab 263 page 13274).

interaction with families are affected, so more time is spent communicating with families.[641] Ms Hofman is responsible for COVID-19-screening visitors (PN9623).

749. Wendy Knights (EN) says (at [74]–[75]) that there is now much more focus on infection control, hand hygiene, and documentation, especially since the on-set of COVID-19. This is good practice, but slows down each assessment and task. At [80]–[81] (see also [93), Ms Knights refers to the need to perform daily health checks and temperature testing, and to increased PPE requirements. Ms Knights, like others, refers to the need for aged-care workers to provide emotional support to residents. They need to make time in shifts to give people attention because activities are not as frequent.[642]

750. Christine Spangler (AIN / PCW) (at [37]–[39]) refers to the difficulties in communication caused by masks, to it being hard on visitors and families (especially during lockdowns), and to families becoming upset (and sometimes conflicts occurring), which has added to the mental toll on staff.[643]

751. Lisa Bayram (RN) described the introduction of significant infection control measures at her facility as a result of COVID-19.[644] She said that the COVID-19 requirements have added extra tasks for all staff.[645] She describes that during the 2020 COVID-19 lockdown her facility had five or six people in isolation at any given time because of new admissions, residents returning from hospital or residents showing symptoms. When entering the rooms of a resident in isolation, staff were required to put on full PPE. Two residents who were going off site for dialysis during this period were in isolation at all times. Any resident who got a cold was required to be treated as a suspected COVID case. Ms Bayram said that his meant a lot more layers of process to get the same work done and a much higher level of understanding of the risks and the need to do it 100 per cent right, especially among the EN and AIN / PCW group.[646]

752. Ms Bayram also gave evidence that COVID-19 presented a large challenge for the provision of social support. She says that for residents who were cognitively intact, the lack of family contact had significant impact on their life and that staff were trying to

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641 Statement of Jocelyn Hofman dated 29 October 2021 (tab 261 page 13158).
642 Statement of Wendy Knights dated 29 October 2021 (tab 272 page13450).
643 Statement of Christine Spangler dated 29 October 2021 (tab 257 page 13018–13019).
644 Witness Statement of Lisa Bayram dated 29 October 2021 at [54].] (tab 262 page 13235).
645 Witness Statement of Lisa Bayram dated 29 October 2021 at [55].] (tab 262 page 13235).
646 Witness Statement of Lisa Bayram dated 29 October 2021 at [57].] (tab 262 page 13236).

fill that gap. She described staff, especially the PCAs, getting emotionally closer to the residents which created its own issues. She also describes the need for PCAs to manage the remote contact as well as the increased emotions of window visits, noting that there is sometimes an increased emotional response that residents have after having had remote contact or window visits.[647]

753. Ms Bayram says that a result of COVID-19, there has been a significant increase in infection control training and that this is ongoing.[648]

754. The evidence of Sheree Clarke (AIN) is that she feels that the need to spend time with residents is greater now due to COVID-19 where because of COVID-19, residents have had less family interaction. She describes her observations of residents needing human interaction[649] of residents in more distress which she believes to be a result on the restrictions on visitors.[650]

755. Virginia Mashford (AIN) gave evidence that she noticed that residents wanted to spend more time with staff during COVID-19 lockdowns when residents didn't have interaction with families. She describes that sadness and withdrawal among the residents became more obvious.[651]

756. Rose Nasemena (AIN) describes many residents as depressed where they haven't seen their families regularly during COVID-19. Her evidence is that they would often cry but became more used to very few visitors and to talking on the computer at an allocated time. Her evidence is that everyone in the team has had to deal with a lot more of the emotional side of residents and psychological ups and downs associated with COVID-19.[652]

757. The evidence of Ms Nasemena is that COVID-19 has made the work harder because everyone is so tired and has their own issues and health problems to deal with as well.

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647 Witness Statement of Lisa Bayram dated 29 October 2021 at [64].] (tab 262 page 13237).
648 Witness Statement of Lisa Bayram dated 29 October 2021 at [79].] (tab 262 page 13241).
649 Witness Statement of Sheree Clarke dated 29 October 2021 at [78].] (tab 268 page 13376).
650 Witness Statement of Sheree Clarke dated 29 October 2021 at [82].] (tab 268 page 13376).
651 Amended Witness Statement of Virginia Mashford, dated 6 May 2022 at [60].] (tab 271 page 13435–13436).
652 Amended witness statement of Rose Nasemena, 6 May 2022 at [42] (tab 267 page 13361).

She says that if someone has an infection and is a suspected COVID, or comes back from the hospital, staff need to don and doff PPE properly in the right order.[653]

758. The evidence of Dianne Power (AIN / PCW) is that COVID-19 has been difficult for everyone. She describes stages where staff had to wear PPE at all times in the facility. She describes a lot more instances of residents being confined to their rooms because they had a runny nose because residents with COVID-19 symptoms were required to be put into quarantine. She says that all staff are required to wear full PPE to see a resident in quarantine. This involves wearing a gown, gloves, mask and eye shield. These have to be put on and taken off and disposed of in a specific order. This, she says, is a lot to go through just to take a resident a cup of tea.[654]

759. During lockdowns, Ms Power noticed that residents became more emotionally reliant on her and her colleagues. Residents expected staff, especially AINs, to become more like their family. She says that this put pressure on AINs and impacted on residents' mental health.[655]

760. Stephen Voogt, (Nurse Practitioner in Gerontology) has identified a lot more isolation of residents from families and social supports arising from COVID-19. He says that the increased need for psychological support of residents particularly during the pandemic has fallen onto all levels of staff within the facility.[656]

761. Mr Voogt gives evidence about his involved in the management of COVID-19 outbreaks within residential aged care facilities. He identifies some aspects of these experiences have been identical, namely:

(1) the working environment is extremely stressful, being the most stressful he has experienced;

(2) there has been severe human resource depletion and availability; and

(3) the outcomes have been heart breaking for residents, family and staff.[657]

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653 Amended witness statement of Rose Nasemena, 6 May 2022 at [49] (tab 267 page 13361).
654 Witness Statement of Dianne Power, 29 October 2021 at [85] (tab 258 page 13114).
655 Witness statement of Dianne Power, 29 October 2021 at [86] (tab 258 page 13114).
656 Amended witness statement of Stephen Voogt, 9 May 2022 at [63] (tab 269 page 13402).
657 Amended witness statement of Stephen Voogt, 9 May 2022 at [67] (tab 269 page 13402).

762. However, Mr Voogt has also observed the work by nursing and care staff in those conditions, identifying:

(1) The stress of having to look after acutely/severely unwell residents with limited resources;

(2) Continual lack of/short staffing, working 12 hours days in full PPE with minimal breaks;

(3) Some of the RNs working 5 days straight 12 hours;

(4) Staff having to endure the negativity from government departments, the media and the public about COVID-19 and criticism of residential aged care facilities; and

(5) In the 2020 outbreak there were no vaccines and still little known about COVID-19, staff put themselves in harm's way, risking their own health for the residents where staff in residential aged care facilities are less well-resourced than the acute public health sector.[658]

Evidence of employer witnesses

763. Mark Sewell (CEO, Warrigal) agreed that, as far as aged care was concerned, concerns about the COVID-19 pandemic were as critical as they have been (PN12897). He observed that, as the community relaxes its restrictions, the restrictions in aged care arguably could become even tighter (PN12897). Warrigal's PPE and infection control procedures remain as stringent as they have been throughout the past few years (PN12898), and Mr Sewell thought that these procedures would certainly not change for the remainder of this year (PN12899).

764. Further, Mr Sewell explained, Warrigal's experience in the pandemic has taught lessons in relation to infection control generally, outside of COVID-19 specifically (PN12900), which Warrigal would wish to incorporate into the general provision of aged care going forward, irrespective of what happens with COVID-19 (PN12901).

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658 Amended witness statement of Stephen Voogt, 9 May 2022 at [69] (tab 269 page 13403).

Findings of the Royal Commission

765. In response to the COVID-19 pandemic and its impact on residential aged care, the Royal Commission produced an additional report "Aged care and COVID-19: a special report" The report describes the impact on the aged care workforce as a result of working throughout the pandemic [SR.1]

> "We heard evidence of the effect of the pandemic on those working in aged care. The Interim Report noted that the aged care workforce is under-resourced and overworked. It is now also traumatised. Care workers develop close relationships with residents. Many are grieving for residents who have died after contracting COVID-19. Others are anxious about bringing the virus into their work place or home to loved ones."

Relevance of this evidence to work value

766. COVID-19 has had a substantial impact on the nature of the work performed by direct care workers, the skill and responsibility involved in doing that work and the conditions under which that work is done. Some of that impact arises as a result of permanent changes resulting from COVID-19 protocols. Whilst other aspects of this impact are directly tied to the continuation of COVID-19, the pandemic currently remains on foot with outbreaks continuing to occur in aged-care facilities.

767. The nature of work in aged care during COVID-19 has been, and continues to be more difficult, more stressful and more dangerous. It is more difficult where workers are required to perform additional tasks and wear PPE. This also makes the work more stressful, as does the need to perform this work short staffed and the additional emotional needs of residents. It is more dangerous in circumstances where the risk of contracting COVID-19 has been magnified for care workers whose work involves close contact with residents and clients and the unavoidable exposure to bodily fluids.

768. Work thorough COVID-19 has involved, and will continue to involve, greater levels of skills and responsibility with respect to IPC. Additional skills are also required in dealing with the heightened emotional needs of clients and residents and other challenges, such as communicating with clients whilst wearing PPE.

769. The conditions under which the work is done now involve the more stringent IPC, including the requirement to weal PPE.

F. The ANMF's expert evidence

770. The ANMF advanced two expert reports: the Amended Report of Assoc Prof Smith and Dr Michael Lyons dated 2 May 2022 and the Amended Report of Hon Assoc Prof Anne Junor filed 5 May 2022.

771. The ANMF's case is, of course, that the rates of pay for aged-care workers do not reflect the work value of the work that they perform. It will assist the FWC in reaching that conclusion of undervaluation to understand why (at least in part) the work is undervalued. This is addressed in the Smith/Lyons Report and in the Junor Report.

772. At a very high level, in the Smith/Lyons Report the authors outline the gender pay gap ("**GPG**") and gender-based undervaluation of work in Australia, and the factors that contribute to each of these. They describe the barriers to proper assessment of work values in female-dominated industries in Australian industrial tribunals. They discuss matters relevant to whether there is a gender-based undervaluation of aged-care work covered by the Aged Care Award and the Nurses Award.

773. And again at a very high level, the Junor Report helps to explain why there is a gender-based undervaluation of this aged-care work. Dr Junor identifies that there are particular skills—associated with female-dominated work—that have not traditionally been recognised as skills bearing upon the value of work performed—"*invisible skills*." How this is done and the opinions Dr Junor expresses are detailed below.

774. These reports, in that light, assist the FWC to come to conclusions urged upon it by the ANMF. Why (as the ANMF asserts) do current pay rates fail to reflect work value? For reasons including that there has been a gender-based undervaluation of that work, as outlined in the Smith/Lyons Report. Why has there been a gender-based undervaluation of that work? For reasons including that certain of the skills brought to bear in female-dominated industries (like aged care and care more generally) are invisible in the sense that they have not traditionally been recognised as valuable skills.

775. Below appears a more-detailed summary of each of the Smith/Lyons Report and the Junor Report.

F.1 The Smith/Lyons Report

776. In overview, the authors of the Smith/Lyons Report express the following opinions.

777. There is a GPG in Australia, the measurement of which varies depending on what dataset is used (see table 1, page 4), but which is persistent ([10]). A common dataset is adult full-time ordinary time average weekly earnings (AWOTE), which yields a GPG of 14.2 per cent (table 2, page 5).

778. Scholarly approaches to identifying the contributing factors to the GPG can broadly be divided into the "*standard*" / "*orthodox*" approach (on the one hand), and the "*institutional*," "*sociological*," or "*heterodox*" approach (on the other hand) ([16]). The former assumes that women make a "rational choice" to work in lower-paying occupations ([16]); the latter suggests that there is an array of organisational, social, and labour-market forces that affect women's occupational choices ([16]).

779. The authors prefer the institutional approach, but note even "*orthodox*" approaches which allow that there is a GPG, the most-significant contributing component of which is gender discrimination ([24]). Another significant contributing factor is gender segregation as between occupations (*i.e.*, as between female-dominated occupations and male-dominated occupations) (see, *e.g.*, [32]–[33]).

780. Further, the authors are of the view that there has been and continues to be an "*undervaluation of feminised work and skills*" (see at [36], [39], [41]). This is "*influenced by social expectations and gendered assumptions about the role of women as workers*" ([56], see also [59], [60]). Undervaluation can happen in a number of ways (see at [45]–[46]), but in particular (and relevantly to Hon Assoc Prof Junor's evidence) because of the "*invisibility*" of skills which have historically not been differentiated from "*social behaviour required to relate to other humans outside the workplace, especially children, or the ill, infirmed or aged*" ([46]). For example, undervaluation may be based on a "*failure to recognise*" problem-solving, anticipation of conflict situations and other problems, and acting before they occur ([47]). Another significant factor is "*sex-based stereotyping*" and devaluing of work that is "*intrinsically 'feminine' in nature*," such as care-giving, manual dexterity, human relations, and working with children ([52]).

781. Importantly, undervaluation based on these kinds of considerations develop into "*social norms*," being attitudes or values that shape behaviour and perceptions in a given context ([51]). Norms and regulation are in an overlapping, or mutually-reinforcing, relationship ([61]).

782. The authors of the Smith/Lyons Report then turn to consideration of the regulatory aspect, and in particular approaches by legislators and industrial tribunals to the question of equal remuneration and work value ([68] ff). In summary, from 1972 to the present day, legislation and/or the approach of industrial tribunals in each of the four "*epochs*" of regulation (see [71]–[83]) have constituted barriers to addressing or reducing gender-based undervaluation of work in female-dominated industries (see [84]–[87] in particular, see also [184]). In relation to work value assessments in particular, one such barrier is (and Dr Junor's evidence goes to this as well) the "*invisibility*" of particular skills when assessing work value in female-dominated industries ([93]).

783. Now, to the particular awards here in question—the Aged Care Award and the Nursing Award. In relation to PCWs covered by the Aged Care Award, the authors of the Smith / Lyons Report opine as follows: the workers are low paid workers ([113]–[118]); that low pay cannot be explained by work value reasons ([119]–[123]), in particular because the award classification descriptors do not reflect the work and work value of contemporary employees ([120]); there has been no work value assessment undertaken since the Aged Care Award was promulgated ([132]–[134]); this despite there having been significant changes in the work value of aged care employees ([135]–[143]); the kinds of "*social and emotional*" skills that are traditionally overlooked or "*invisible*" include such things as interpersonal skills, emotional skills, caring, compassion, empathy, honesty, patience, respect, emotional labour, dementia care, diversity awareness, elder abuse awareness, falls risk, infection prevention and control, medications, palliative care, and wound care ([136], [140]).

784. In relation to RNs, ENs, and AINs covered by the Nurses Award, the authors of the Smith / Lyons Report opine as follows: while the classification descriptors are better than in the Aged Care Award ([149]), there has not been a work value assessment attempted in relation to the Award ([151]); again, this is despite work value having changed over that time ([153]–[157]); the work involves stress and high workloads, emotionally-draining work, application of social skills and emotional labour, time management, conflict resolution, and formally-obtained specialist skills ([155], [157]).

F.1.1 Cross-examination of Assoc Prof Smith

785. Assoc Prof Smith was not shaken in cross-examination. She expressed the opinion that "*women's work*" has struggled to be identified as skilled work. Skills can be "*overlooked or discounted in the worker*" (PN3286). This aligns perfectly with Hon Assoc Prof Junor's evidence, as discussed below.

786. Otherwise, Assoc Prof Smith was asked to explain certain parts of her opinion, to assist the Commission, and she did so in a way that demonstrated her clear expertise in relation to the subject matter.

F.2 The Junor Report

F.2.1 Overview of approach and structure

787. Hon Assoc Prof Junor's main research field is skill identification, particularly in the growing and feminised service and care sectors ([5]). She was asked to apply her "*Spotlight Tool*" to the work performed by RNs, ENs, and AINs / PCWs working in aged care, to express opinions in relation to whether those workers brought to bear "*invisible skills*" ([2]). She analysed work activity descriptors prepared by the aged-care workers, interviewed those workers, coded the available data, and analysed the data for the purpose of expressing her opinions ([6]).

788. The Spotlight Tool aids in identifying, naming, and classifying invisible skills used in service work processes. "*Invisible*," in this context, means "*hidden*", "*under-defined*", "*under-specified*" or "*under-codified*" ([10], [138]–[140]). A skill might be *hidden* because it is diplomatically kept unnoticed or downplayed because it is "*behind the scenes*" ([33], [140(a)]). A skill might be *under-defined* because it is hard to pin down in words, is non-verbal, or is applied in rapidly-changing situations ([33], [140(b)]). A skill might be *under-specified* because it is "*soft*" or "*natural*" and is misdescribed as something innate and personal rather than as a skill ([33], [140(c)]). A skill might be *under-codified* because it is integrative, or involves interweaving one's own activities with others' activities ([33], [140(d)]).[659]

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659 Further description of what is meant by each of these kinds of invisibility appears in Annexure 8 at [16]. Examples of each kind of invisibility, separated out into classification, are also in Annexure 8—at [21]–[40] for RNs, [41]–[59] for ENs, and [60]–[74] for AINs / PCWs.

789. The Spotlight Tool is designed to reduce unwitting gender bias ([7]). It measures the content and level of skills ([8], [67]–[72]). It is particularly relevant to care work, which has five key criteria ([72]): (1) contribution to physical, mental, social, and/or emotional well-being; (2) a primary labour process based on person-to-person relationships; (3) a degree of dependency on the part of care recipients based on age, illness, or disability; (4) contribution to a human infrastructure that cannot be adequately produced through unpaid work or unsubsidised markets; and (5) a predominantly female workforce. The tool's development and its previous use in expert evidence is described at [11]–[13], [73]–[77], and in Annexure 3.

790. Hon Assoc Prof Junor compiled data to which to apply the Spotlight Tool from two sources: *first*, interviews in which open-ended questions about the characteristics of a job are asked and answered and the associated transcripts ([16] and [61]); *second*, the completion of workbooks by the workers, in which the workers identify whether and to what extent they are required to bring particular skills to bear in their employment ([17] and [61]). In addition, optional written answers to generic open-ended questions were used for follow-up interview purposes ([61]). That data—Primary Material—is set out in Annexures 5–8 of the Junor Report. The detail in regard to the preparation of the Primary Material is at [82]–[93].

791. Responses were coded to activity descriptors that, in Hon Assoc Prof Junor's opinion, were thought likely to be applicable to the work of aged-care workers ([18]). On the basis of the coded data, Hon Assoc Prof Junor produced "*skill profiles*." The skill profiles were visualised in the form of "*heatmaps*" ([20]).

792. The heatmaps show the relative incidence, importance, and contribution to work value of activities performed by the aged-care workers ([23]). They indicate the relative incidence, importance, and contribution to work value of activities utilising each Spotlight skill, and document instances of each skill ([96], Annexure 5).

793. The skills that are "*invisible*" are identified in Annexure 8A. Hon Assoc Prof Junor's annexures also show collaboration across classifications and clustering of skills ([23], Annexure 6), evidence of increasing responsibility and effort, compared with decreasing conditions of work ([23], Annexure 7]).

F.2.2 Identification of skills

794. Using the Spotlight Tool, Hon Assoc Prof Junor identified three "*skill sets*," into which were organised nine skills, as follows ([26], Table MR-2 page 22):

A: Contextualising: Building and shaping awareness

A1. Sensing contexts or situations

A2. Monitoring and guiding reactions

A3. Judging impacts

B: Connecting — Interacting and relating

B1. Negotiating boundaries

B2. Communicating verbally and non-verbally

B3. Working with diverse people and communities

C: Coordinating

C1. Sequencing and combining activities

C2. Interweaving own activities smoothly with those of others

C3. Maintaining and/or restoring workflow.

795. There were 300 countable instances of the utilisation of such skills per individual in relation to RNs, 264 for ENs, and 224 for AINs / PCWs ([102]). Examples of the use of these kinds of skills in an aged-care setting can be found in Tables MR-3–MR-5 on pages 28–30. Division of these skills into "*hidden*," "*under-defined*," "*under-specified*," and "*under-codified*", for each of RNs, ENs, and AINs/PCWs, appears from [144]–[185].

796. One also sees this in Tables MR-3–MR-5 on pages 28–30. Each of the example skills identified in the tables has after it parenthetical abbreviations: "UC," for "*under-codified*," "UD," for "*under-defined*," "US," for "*under-specified*," and "H," for

"*hidden*."[660] As Hon Assoc Prof Junor states (Annexure 5, [10]), the types of invisibility and their relationship with gender are then explained in Annexure 8.

797. Hon Assoc Prof Junor's overall conclusion is as follows ([186]):

> "My overall conclusion is that the work of RNs, ENs and AINs / PCWs is of very high impact and social value. It requires the substantial depth and range of skills that have been brought to light using the Spotlight framework. I consider that the Primary Material, analysed through the evidence set out in Annexures 5-8, contains evidence of the pervasive, intensive, and extensive use of complex skills that are incompletely visible, as well as evidence of under-recognised and undervalued skill, effort and responsibility."

798. Each of these skills is exercised at one of five levels ([27]): 1. Orienting; 2. Fluently performing; 3. Solving new problems as they arise; 4. Sharing solutions/deploying expertise; 5. Creating a system.

799. Hon Assoc Prof Junor found that these skills were exercised intensively, extensively, and a high level of proficiency—predominantly at the level of solution-sharing in the case of RNs and at the level of problem-solving for ENs and AINs / PCWs ([28], [97]–[100]). Particular clustered applications of skills were in relation to the particular challenges of morning, evening, night and community shifts, working with culturally and linguistically diverse residents and colleagues, and in working with dementia, co-morbidities and palliative care ([29]), [106]–[108]).

800. Aged care work is founded on the "*fluent and practised deployment of all nine 'Spotlight' skill elements, and their intensive application in problem-solving and collaborative solution-sharing activities requiring a very substantial depth and range of skills*" ([105]).

801. Importantly, nearly all of the skills that Hon Assoc Prof Junor identified were: (1) likely to be required at relevant classification levels; but (2) not referenced in the classification descriptors (see [31], tables thereunder, as well as [123]–[124] and Tables MR-3). Table MR-6 (page 32) contains a list of skills that are brought to bear by aged-care workers but which are not reflected in existing classification descriptions. And Table MR-7 (pages 33–34) identifies where in the existing classifications the skills rendered visible by the application of the Spotlight tool might sit.

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[660] On a few occasions the letters "C" and "R" appear without a "U" in front, but these are to be understood as meaning "UC" or "UR."

F.2.3 Reason for invisibility of skills

802. Dr Junor gives three reasons for skills being invisible: *first*, under-recognition and under-valuation on a gender basis; *second*, biasing factors in the way that skills are described; *third*, under-development of qualification structure and pathways, and under-recognition and under-utilisation of skills ([36], see also especially [201]–[212]). A fundamental explanation, in short, for the invisibility and under-recognition of the skills is that the work is done predominantly by women ([192]). Hon Assoc Prof Junor identifies ways in which the use of skills could be made visible ([37], [198]).

803. The connection between each kind of invisibility and gender is explained in Annexure 8 starting at about [77], and is helpfully summarised in Table A8-3, which is set out below for ease of reference:

Table A8-3 Summary: Why gender-based skill invisibility results in undervaluation

Nature of invisibility: Skill is:	Source of under-recognition	Link to under-valuation	Link to gender
Hidden	• Involves: • Unseen work "behind the screens" • Diplomatic influence "behind the scenes" • Social status gap	• Taboo on mentioning • Visibility would undermine effective performance • Cultural, age and gender difference	• Body-work • Silence • "Supporting" role • Social status • Self-effacement • Indirect influence
Under-defined	• Dynamic, fleeting • Sensory e.g. tactile • Unofficial knowledge • Practised fluency • Aesthetic impact • Non-verbal	• Hard to name • Not expressed in words • Situated, context-specific	• 'Second nature' through experience • Managing impressions • Bodily and contextual perceptiveness/ knowledge

Under-specified	• Failure to unpack concepts of "emotional labour", "communication skills"
	• Seen as personal attribute ("sense of humour")
		• Taken for granted
		• Seen as natural, unlearned
			• Care seen as soft:
			  • service,
			  • care,
			  • empathy,
			  • interpersonal

Under-codified	• Organising • Thinking while doing • Multi-tasking	• Performed in the gaps • Integrative -Provides unseen links among codified skills • Second-order • Mental not physical • Multi-tasking	• Holding processes together • Social 'glue' • Getting things done • Rapid task-switching, refocusing • Contingency management, patching up
Under-recognised	• Any or all of above • Low job status • Non-credentialling of training • Non-recognition of experience	• Informal labour market • Low occupational status • Indicia: gender segregation, insecurity, small workplaces, high turnover • Inadequate job analysis	• Low pay • Limited return to qualifications. in-service, experience • Flat career path • Work intensity through invisibility of true job size

F.2.4 Whether current pay rates reflect underlying work value and changes thereto

804. Hon Assoc Prof Junor opines that there is significant undervaluation of the work of RNs, ENs, and AINs/PCWs, based on under-recognition of job size, and under-recognition of very intensive, extensive and clustered use of under-recognised skills at high levels of complexity ([40], [213]–[214]). She also opines that the work is performed under difficult and demanding conditions, which are set out in [41].

805. The evidence leads Hon Assoc Prof Junor to express the view that there have been "*significant changes in work value*" ([42]), and "*[s]ignificantly increased levels of knowledge, technical, social and organisational skill are also required as a result of the increase in numbers of residents with serious co-morbidities or in the late stages of their life journey and moving towards palliative care*" ([43]). Details of the skills that are brought to bear and the intensity of their use appears in particular in Tables MR-8–MR-10 (page 57), and Table MR-11 (page 59).

806. Annexure 7 describes an increased prevalence of higher-acuity residents with increased co-morbidities, an increased proportion of residents living with dementia, and an increased concentration of residents approaching end of life, and requiring palliative care. Interacting with increased levels of acuity and dependency have been the impacts of regulatory, policy and funding changes on staffing levels ([111]). Changes in work value are considered based on the primary material and secondary material from [234]–[243].

807. These are some only of the matters that lead Hon Assoc Prof Junor to the opinion that, "*the current rates of pay for RNs, ENs and AINs/PCWs, both as set out in the Award and as agreed through enterprise bargaining, are significantly below underlying work value*" ([45]).

F.2.5 Whether undervaluation is based on gender

808. Drawing on secondary material (which is reviewed and/or referenced in Annexure 9 to the Junor Report), Hon Assoc Prof Junor expresses the view that gender segregation leads to a lack of visibility and under-recognition of some skills, as a result of lingering perceptions of care work as an altruistic vocation ([48], [251] ff). Hon Assoc Prof Junor summarises the effect of the growth of "*care*" work as follows ([251]):

> "*The growth of care work reflects social trends that have contributed to the creation of low-status but skilled service jobs, mostly performed by women who have been recruited on the basis of skills acquired outside the labour market or formal training system. As a result, the skills in question have tended not to be defined as such, but to be "naturalised" to women, perhaps on the basis of earlier gender-specialised education and life and prior work experience.*"

809. The Spotlight methodology was designed to identify skills that are invisible for gender reasons ([49]). Since gender-based under-recognition is the basis of invisibility and the result is under-valuation, Hon Assoc Prof Junor concludes that gender-based under-recognition processes have resulted in gender-based undervaluation, so that the skills are undervalued on that ground ([49], [257]–[261]).

810. How it is that gender concentration or segregation leads to undervaluation, in the particular context of care work, is explained at [248] ff, by reference to the five "*Vs*"—visibility (women's skills may not be visible), valuation (women's skills are often not valued), vocation (women's skills are often treated as "*natural*," and deriving from their "*essence*" as mothers and carers), value added (women's work is more likely to be labour-intensive, but there may be a tension between "*quality*" and "*productivity*"), and variance (male work is the "*norm*," so women's work which diverges therefrom may be less valued) (Table MR-13, page 66.

811. In particular, the linkages between the nature of the invisibility of a skill (whether "*hidden*," "*under-defined*," "*under-specified*," and "*under-codified*"), the source of its non-recognition, the link to its under-valuation, and its link to gender, is helpfully summarised in Table MR-14 (pages 69–70).

F.2.6 Cross-examination of Hon Assoc Prof Junor

812. Hon Assoc Prof Junor was not disturbed in cross-examination. It was put to her, and she accepted, that one of the grounds on which a skill might be under-recognised is gender (PN3209). She expressed the (unchallenged) opinion that a more intensive and extensive use of complex skills has occurred in the past 20 years in aged-care work (PN3224). She expressed the (unchallenged) opinion that aged-care work was low paid in comparison with the distribution of wages generally, in comparison with the national minimum wage, in comparison with hospital nursing, and inherently in comparison with the size of the job (PN3229–3231).

813. In re-examination, Hon Assoc Prof Junor expressed the opinion that interview participants were doing a wider range of things in a more intensive way, which is to say that their work was more complex, more dense, more intense, and more clustered than it had been (PN3240).

F.3 Use to be made of the expert evidence

814. The ANMF submits as follows:

(1) the Commission would act on its preliminary view that the wages in the awards the subject of this application have never been properly fixed;

(2) it is not strictly necessary to make any positive finding that the absence of proper fixation was caused by any specific matter (*i.e.*, it need not be found, for example, that any fixation, or non-fixation, was the product of gender bias);

(3) but, in order to avoid double-counting, the Commission may wish to feel satisfied that any uplift in wages it grants now does not double-count on any previous uplift.

815. There are, then, two sure ways that the Commission can reach that last-mentioned state of satisfaction. *First*, double-counting is avoided where an uplift is based on increases in the value of work over time, which increases have not been matched by commensurate increases in ages. Much of the purpose of the lengthy Part E above is to set out the evidence of precisely such changes, in circumstances where the Commission knows that over the period covered (roughly, say, 20 years, or even fewer in many cases) that there have not been increases in wages linked with changes in work.

816. *Second*, double-counting is avoided where an uplift is based on the taking into account of skills that have not been taken account of before, because those skills are "*hidden*" or "*invisible*" within the meaning of Hon Assoc Prof Junor's analysis.

817. Or, expressed differently, Assoc Prof Smith (and the HSU's expert witnesses) provide the Commission with a basis on which to find that, historically, "*women's work*" has been (and continues to be) undervalued. Hon Assoc Prof Junor's evidence provides:

(1) a partial explanation for such undervaluation—that skills that are exercised in "*women's work*" are wrongly treated as non-skills; and

(2) a basis for identifying what those skills are (*i.e.*, the Spotlight tool).

818. The Spotlight Tool provides that basis in two major ways. The first is Hon Assoc Prof Junor's analysis within the Junor Report. As outlined above, Hon Assoc Prof Junor applied her Spotlight Tool to questionnaires completed by aged-care workers, and to the product of interview of those workers, and found concentrations of the use of such skills in each skill element, at each level (and in particular at higher levels of those skills), and for each of RNs, ENs, and AINs / PCWs.

819. This is captured in Tables MR-8–MR-10, which are set out overleaf for ease of reference:

Table MR-8 Spotlight skill profile — Registered Nurse

Incidence of reported activities reflecting Spotlight skills Skill element	1. Orienting	2. Fluently performing	3. Solving new problems as they arise during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising: Building and shaping awareness	13.0	23.0	33.5	36.0	9.5	115.0
Total B: Connecting — Interacting and relating	12.5	14.0	24.0	33.5	8.0	92.0
Total C: Coordinating	11.5	16.5	28.5	28.0	9.0	93.5
Overall incidence	37.00	53.50	86.00	97.50	26.50	300.5

Table MR-9 Spotlight skill profile — Enrolled Nurse

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently performing	3. Solving new problems as they arise during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising: Building and shaping awareness	12.0	20.0	30.0	27.0	4.7	93.7
Total B: Connecting — Interacting and relating	9.3	14.7	25.3	21.3	5.7	76.3
Total C: Coordinating	10.7	20.7	31.0	27.3	4.7	94.3
Overall incidence	32.00	55.33	86.33	75.67	15.00	264.33

Table MR-10 Spotlight skill profile — Assistant in Nursing/Personal Care Worker

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently performing	3. Solving new problems as they arise	4. Sharing solutions/A pplying expertise	5. Expertly creating a system	Totals
Total A: Contextualising: Building and shaping awareness	10.7	24.7	27.3	17.3	2.3	82.3
Total B: Connecting — Interacting and relating	13.0	16.7	22.0	16.0	3.7	71.3
Total C: Coordinating	14.3	16.7	21.3	17.0	1.0	70.3
Overall incidence	38.00	58.00	70.67	50.33	7.00	224.00

820. To illustrate what is to be drawn from this table, it assists to take an example. Registered Nurses completed questionnaires and were interviewed about the nature of their work. Their responses were compared against the nine skill elements, across five levels, which are summarised in Table MR-3. Skill elements B1–B3, are set out below, for example:

Table MR-3 Selected activities illustrating use of Spotlight skills — Registered Nurses

Skill element	1. Orienting	2. Fluently performing	3. Solving new problems	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
B1. Negotiating boundaries	3.5	4.0	8.0	12.5	4.0
L4 Consistently advocate for staff and residents in a way that retains goodwill (H, US)					
L4 Constructively provide upward and downward feedback in unequal power situations (H, US)					
L4 Gently manage unrealistic family expectations (US)					
B2. Communicating verbally and non-verbally	5.0	7.0	8.5	14.0	3.5
L4 Use a quietly authoritative and caring communication style that gains trust and cooperation (US)					
L4 Help staff reflect on language use, adapting to resident & family understanding & sensitivities (H, US)					
L5 Help build a consistent, respectful, aesthetic and ethical communication style for the organization ((UD)					
B3. Working with diverse people and communities	4.0	3.0	7.5	7.0	0.5
L3 Anticipate and act to minimise problems created by intercultural and disability barriers (H, US)					
L4 Appropriately incorporate elements of the cultures of staff, residents & families into work practices					

821. Table MR-8, then, is to be understood as showing that RNs exercise the skill elements, "*Negotiating boundaries*," "*Communicating verbally and non-verbally*," and "*Working with diverse people and communities*," at each of the five skill levels, but with particular concentration at the levels of "*solving new problems*," and "*sharing solutions, applying expertise*."

822. Dr Junor gives examples of the responses that, in her view, fell into the various skill complexes for RNs from [144]–[158]. And, the real bulk of the analysis is contained in Annexure 5. Examples of the work activities that utilise Spotlight skills are set out in Annexure 5 [15] ff. For example, and staying with skill elements B1–B3, one of the various examples set out for skill element B2 for an RN is at Annexure 5 [27]:

> "… especially with staff who don't know families, and don't know how they might respond, using a different set of words can fix things really quite easily. (Bron)
>
> Nurses just do this .... you do have to change the way you interact, the way you speak, the words you use, the way you behave for everybody, not just for groups of people. (Amy)"

823. Hon Assoc Prof Junor's analysis was not challenged in cross-examination, and no evidence contradicts hers. The Commission may safely accept her evidence and find not only that these kinds of "*hidden*" or "*invisible*" skills are brought to bear by aged-care workers; but also that they are "*hidden*" or "*invisible*" in that they have not, historically been identified as skills having economic value. These conclusions are all supported by the Smith/Lyons Report, which likewise was not meaningfully challenged.

824. It was said at [818] above that the Spotlight Tool provides two bases for identifying skills not previously recognised in a wage-setting exercise. The first (which has been outlined already) is the application of the Spotlight Tool to primary material undertaken by Hon Assoc Prof Junor herself.

825. The *second* is described in Annexure 1 to these submissions. Another source of primary material was identified—the evidence given by witnesses in this proceeding, both in statements and in oral evidence. Descriptions by workers of their work were then compared with the Spotlight descriptors to identify tasks performed by aged-care workers that involve application of Spotlight skills. If none had been identified, that might have called into question the validity of Hon Assoc Prof Junor's analysis of the primary material that she analysed. But the reverse is true: the evidence of the lay witnesses in this proceeding provides ample further examples of each of the spotlight skills being brought to bear, in each classification (RN, EN, AIN / PCW) and within each skill element (A1–A3, B1–B3, C1–C3). This, then, provides further support for the proposition that aged-care workers do, in fact, bring to bear the skills identified by Hon Assoc Prof Junor in the Junor Report.

826. The final point to be made is that a very neat encapsulation of the whole thesis of the Junor Report arose in the course of the evidence of Mark Sewell (CEO and Company Secretary of Warrigal). Mr Sewell had expressed the view, at [93] of his statement, that a Certificate III could not "*teach the attitude and maturity*" that made a quality aged care worker. In cross-examination by the HSU, when asked about this, he gave the following evidence (PN12997–13000) (emphasis added):

> "PN12997
>
> … Certificate III is a terrific training course to give the background and teach technical skills but it requires personal attributes of customer service and resilience and kindness that can't be taught so much but they're attributes and

> often they develop in people through a long-term commitment to older people and their needs and we estimate that about three years people become very, very good at explaining why they do what they do and love what they do and we use them to talk to other people, new incoming staff who are considering a career in aged care.
>
> PN12998
>
> Just two aspects of that. One is you referred to matters of perhaps relationship - relational skills, that is, how to relate to the residents, communicate effectively with the residents as matters which are improved over time?---Yes.
>
> PN12999
>
> I understood that correctly?---Yes.
>
> PN13000
>
> I take it you also - that the skills in terms of conducting particular activities, whether it be showering or toileting or the kind of medication processes and the like that care workers are involved in also improve over time in dealing with frail and residents with complex needs?---Yes, I think so. Any technical skill would improve over time definitely."

827. In cross-examination by the ANMF, Mr Sewell was asked whether the type of "*personal attribute*" he was referring to included:

(1) the ability to piece together resident information, past traumas, for example, to better understand present behaviour (PN13100);

(2) developing a fine-tuned knowledge of a resident's idiosyncrasies and preferences to support smooth patterns of hygiene, meals, sleeping (PN13101);

(3) being alert to co-workers' emotional pressures, strengths and need (PN13102);

(4) quickly picking up early warning signs of impending disturbances or an approach that isn't working (PN13103);

(5) observing, responding to, reporting even very slight changes in residents (PN13104);

(6) adapting one's voice, tone, body language to knowledge of how it is that residents would best respond (PN13105);

(7) dealing increasingly with residents from different language groups and ensuring that residents either within the same language group or between language groups are able to interact (PN13106);

(8) assessing the urgency and importance of simultaneous calls on the worker's attention (PN13107);

(9) smoothly switching back and forth between work that is individualised to one particular resident and then work within a team (PN13108).

828. Mr Sewell accepted that each of those fell within what he had in mind when referring to personal attributes that distinguished better from less-good aged care workers. He agreed that he could think of many other attributes that care workers and nurses would have that might fall into the category of characteristics or descriptors of the work that they perform which improve over time (PN13109).

829. Each of those characteristics that was put to Mr Sewell was a descriptor from the Junor Report: to be precise, from Table MR-5, and in order A1/L3, A2/L2, A2/L4, A3/L3, A3/L3, B2/L2, B3/L3, C1/L3, and C2/L2.

830. The point is this: Mr Sewell has more familiarity with aged-care work than most or many; Mr Sewell clearly did not intend to deprecate the skills brought to bear by aged-care workers in describing them as "*personal attributes … that can't be taught*;" he freely, when he was asked to, accepted descriptions of the kinds of attributes of which he spoke in terms that were clearly descriptors of skills.

831. In a similar way, Dr Susan Kurrle, whose expertise was apparent, used in her evidence the shorthand, "*born carer*" (PN3654). As Dr Kurrle went on to say, that phrase was not the right way to capture the "*attributes*" of skilled carers, whose attributes included things like, "*engender[ing] confidence in the person they're caring for*" (PN3655). This, of course, is a skill; it is valuable; it is desirable in an aged-care worker. That is precisely Hon Assoc Prof Junor's point: well-meaning, knowledgeable people can still (innocently) mis-identify as inherent characteristics things that are actually valuable skills, which should be recognised and compensated.

G. Modern Award Objective and Minimum Wages Objective

832. The FWC can be satisfied that the variation is necessary to achieve the modern awards objective and the minimum wages objective because, *inter alia*:

(1) the current award minimum rates for all Nursing Assistants and Enrolled Nurse classifications under the Nurses Award and AIN / PCW classifications under the Aged Care Award are currently close to, or below the "*low paid*" threshold.[661] The ANMF's evidence is that direct care workers face uncertainty about whether their current aged care income will be sufficient to meet their future living expenses and retirement;[662]

(2) enterprise bargaining has not (and will not) solve the low-wages problem in the aged care industry. Current minimum wages are a disincentive to collective bargaining;

(3) the Award Minimum Wages Variations would promote social inclusion through workforce participation by:

(a) a greater ability to attract and retain staff;

(b) an incentive for career progression for workers in the industry;

(c) accordingly, higher-quality care and quality of life for aged-care residents.

This is especially so in circumstances where 86 per cent of the direct care workforce in aged care identify as female and where increased wages would promote further workforce participation and retention.

(4) a correction of the historical undervaluation of the work values of aged care employees would promote the principle of equal remuneration for work of equal or comparable value.

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661 Having regard to the definition of "low paid" employees as being are those award-reliant employees who receive a rate of pay that (as a full-time equivalent) would place them below two-thirds of median (adult) ordinary time earnings; see *Annual Wage Review 2013-14* [2014] FWCFB 3500 at [359] and the *Annual Wage Review 2020-21* [2021] FWCFB 3500 at [137].

662 See Part E.13 above.

833. The current minimum rates of pay for direct care workers in aged care under the Nurses Award and Aged Care Award, do not provide a *fair and relevant minimum safety net of terms and conditions*, nor a safety net of fair minimum wages.

834. The national minimum wage is currently $21.38 per hour or $812.60 per week. The minimum rate of pay under the Nurses Award for an Assistant in Nursing, 1st year, is currently $23.25 per hour or $883.40. The minimum rate of pay under the Aged Care Award for an Aged care employee—level 2 (personal care worker grade 1) is $895.50 per week ($23.57 per hour).

835. The evidence available to the FWC establishes that the work value of an Assistant in Nursing, 1st year, justifies a minimum rate far greater than $1.87 per hour above the national minimum wage. Likewise, the work value of a personal care worker grade 1, justifies a minimum far greater than $2.19 per hour above the national minimum wage.

836. In its opening submissions, the ANMF set out the principles concerning the modern award objective (see [44]–[47], and in particular [46]). There is no meaningful inconsistency between these paragraphs and the Commission's Background Document 1 at [79]–[88]. Further, as raised by Question 10 in Background Document 1 the ANMF does not contest any of the observations in [89]–[107] concerning the specific elements in section 134(1)(a)–(h).

837. There are four aspects of this case involving the application of the modern award objective that require further brief attention:

(1) the significance of the expression "*fair and relevant*" in the circumstances of the particular awards, the variations proposed by ANMF and the evidence before the Full Bench;

(2) the relevance of the evidence in respect of attraction and retention of RNs, ENs, and AINs / PCWs;

(3) the relevance of funding arrangements applying in the aged care sector; and

(4) the significance of bargaining in relation to section 134(1)(b).

G.1 Fair and Relevant

838. In relation to the question of the expression "*fair and relevant*," attention is drawn to the following factors:

(1) a determination to vary the wages in the awards concerned can only be made if it is "*necessary*" to achieve the Modern Award Objective (Background Document 1 [78];

(2) the Modern Award Objective is to provide "*a fair and relevant minimum safety net of terms and conditions*" taking into account the matters particularised in section 134(1);

(3) the list of considerations to which the Commission is required to have regard under section 134(1) is not exhaustive of the matters the Commission might consider relevant to the determination of a fair and relevant minimum safety net (Background Document 1 [83]);

(4) the assessment of what is a fair and relevant minimum safety net may properly involve the "*contemporary circumstances in which an award operates*" (Background Document 1 [84]);

(5) what is "*necessary*" involves a question of judgement and includes considerations such as the circumstances of the particular modern award concerned, the terms of any proposed variation, and the submissions and evidence (Background Document 1 [88]).

839. The ANMF submits that the wage rates are neither fair nor relevant, including because:

(1) the rates do not reflect the work value of the employees concerned (which has been the subject of submissions above);

(2) the rates of pay are out of step with community expectations as reflected in the work and findings of the Royal Commission and the other public enquiries referenced by ANMF's witnesses;

(3) the context in which the awards operate have been the subject of analysis by a Royal Commission, which has concluded that the rates are inadequate for the purpose of securing the delivery of high quality care;

(4) the rates are inconsistent and out of step with those applying in other sectors for equivalent work (again, as has been submitted above); and

(5) the evidence discussed above, and further below, in connection with attraction and retention discloses significant labour force deficiencies contributed to by the depressed rates in the current awards.

G.2 Attraction and Retention

840. In relation to the attraction and retention of RNs, ENs, and AINs / PCWs, the evidence reveals that it is necessary to increase the awards minimum rates in order to ensure that the fairness and relevance of the awards to the aged-care industry.

841. The evidence has been set out in Part E.13 above, and is not repeated here. It suffices to say that the evidence is all one way, in the Consensus Statement, from other employer bodies, from employer witnesses, from union officials, from workers, and in the Royal Commission reports—the wages paid in aged care are so low that it makes it difficult to find and keep staff.

842. That is not only to say that the wages are low in an absolute sense (though they are); it is further to say that they are low in comparison with other like work (acute health care; the disability sector), and other work which is not especially alike but which pays similar or higher wages despite not involving the same range of skills as are brought to bear in an aged-care setting (retail; hospitality).

843. From the perspective of the Modern Awards Objective, the foregoing reveals that award rates have not maintained their relevance for the aged-care sector.

G.3 Funding

844. In respect the relevance of funding to the Modern Award Objective, the ANMF makes five submissions:

845. *First*, ANMF adopts Background Document 1 [98], where reference is made to the concept of "*productivity*," as used in section 134(1)(f). The Commission is not constrained by reference to any suggested loss of productivity in its task of fixing appropriate rates. The impact of Government funding mechanisms and regulatory arrangements on productivity, in the relevant sense, are not material here.

846. *Second*, section 134(1)(f) references employment costs. The employer parties have advanced material as to their ability to fund any wage increase.[663] As to this evidence, the ANMF relies on decisions made in the context of the Four Yearly Review of the SCHCADS Award: [2019] FWCFB 6067 at [130]–[143], and [2021] FWCFB 2383 at [223]–[228]. In short the Full Bench concluded as follows:

(1) Constraints on employers imposed by funding arrangements should not be given determinative weight among the matters to be taken into account by the Commission (though funding is not irrelevant);

(2) The Commission's function is to ensure modern awards, together with the NES, provide a fair and relevant minimum safety net. The level of funding and any consequent impact on service delivery is a product of the political process, not the arbitral task in which the Commission is engaged; and

(3) If funding arrangements do not meet labour costs, that is for the funder to address and do not justify a distortion of the Commission's statutory function.

847. These observations are apposite to the applications now before the Commission and would be adopted and applied.

848. *Third*, the funded nature of the sector is not irrelevant. In circumstances where the statutory task is directed to maintaining a fair and relevant minimum safety net, it is appropriate to take into account the difficulties faced by the sector in attracting and retaining staff as a consequence of funding arrangements, particularly in respect of the not-for-profit sector and rural and remote facilities. If the usual tools available to employers to address labour shortfalls (such as over award payments or competitive collective bargaining agreements) are not available, then it becomes necessary for the Commission to maintain the relevance and fairness of the award minimum rates by appropriate adjustments.

849. *Fourth*, however, substantially the only material before the Commission in regard to funding are analyses conducted by StewartBrown, which are annexed to various witness statements. Nobody from that firm is called to prove that analysis. The analysis

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663 However, the position of the employer parties identified in opening submissions was that there is no capacity to pay argument relevant to the setting of the rates. Rather, "the affordability issue for [the employer parties] might very well concern operative date, phasing, those types of issues, but it's not a relevant consideration to the actual setting." Nigel Ward, Transcript 26 April 2022 PN464.

is plainly in the nature of opinion evidence, and yet the specialised knowledge of the authors of the report has not been proved. The link between that specialised knowledge and the conclusions expressed in the report is not apparent from the report, and will not be explained on oath. The report cannot, in that light, carry any significant weight.

850. A further reason why the analysis cannot carry significant weight is that none of the employer parties who rely on the StewartBrown reports have sought to demonstrate that the sample of aged care homes surveyed by StewartBrown is a representative sample. Page 24 shows a graph (self-reported, but let it be assumed it is accurate) showing that the proportion of home care packages represented in the survey varies wildly from jurisdiction to jurisdiction—63.5 per cent of South Australian packages, but only 7 per cent of Northern Territory providers or 13 per cent of Victorian packages. Similarly, with regard to aged care homes, 8.3 per cent of Northern Territory homes, 26.5 per cent of Victorian homes, and 88.5 per cent of ACT homes, are represented.

851. There is no basis for concluding that the figures appearing in the StewartBrown report are an accurate cross-section of the industry. If, for example, not-for-profit homes were overrepresented, or underrepresented—or homes in (say) Queensland were overrepresented, or underrepresented—there is no way of knowing whether that affects the reliability of the opinions expressed and the figures stated.

852. There is also no way of verifying the data provided to StewartBrown.

853. And, it is apparent from page 22 of the report that the data goes through a "*data cleansing process*," which involves (*inter alia*) a software program "*cleansing*" the data, and the exclusion of "*outliers*" and "*abnormal results*." What "*cleansing*" the software does, exactly, is not known. Who determines that a result is an outlier or abnormal, and on what basis, and how, is not known.

854. In any event, the Aged Care Financing Authority in the 2021 Annual Sector Report (annexed to CCIWA's submissions) provides the following information, which could theoretically be relevant with expert assessment.

(1) The average EBITDA per consumer per year for home care providers and for the period FY15–FY20 was positive in every year (page 60).

(2) Across all home care providers, profit for FY20 was $172M (page 61).

(3) The top three quartiles of home care providers have positive EBITDA per consumer per year for every year between FY15–FY20 (page 67), across for profit, not-for-profit, and government providers (page 68).

(4) The average EBITDA per consumer per year for residential aged care and for the period FY11–FY20 was positive in every year (page 97).

(5) While it is the case that, sector-wide, residential aged care was loss-making in FY20 (page 98), the top three quartiles of residential aged care providers have positive EBITDA per consumer per year for every year between FY17–FY20 (page 99), and across each of the for-profit, not-for-profit, and government sectors, there were overall surpluses of assets over liabilities (page 118).

855. The Commission would require considerably more assistance from a person with specialised knowledge to understand what is shown in the StewartBrown report and in the more-detailed Aged Care Financing Authority report. Certainly some results, in some sectors, for some kinds of providers, possibly in some quartiles, appear to be bad results. But other results do not appear to be bad results. And whether aged care results are worse than the results in other industries (so that capacity to pay is some unique problem in regard to aged care) is simply not knowable from the evidence adduced by the employers.

856. *Fifth*, and finally, as outlined in the ANMF's reply submissions dated 21 April 2022, it was an election promise of the (ultimately successful, in majority) Labor Party that it would fund an increase in aged-care modern award minimum rates. How that promise is actualised will (presumably) be revealed in submissions shortly to be made by the Commonwealth—but in any event, in the light of the election promise there is no reason to think that funding will present as a serious issue for the aged-care sector in the event that increases to minimum rates are ordered.

G.4 Bargaining

857. Various witnesses gave evidence of the difficulties associated with bargaining for improved wages in the aged-care sector.

858. Common themes were that employers claimed during bargaining to be constrained by an absence of funding,[664] difficulty organising aged-care workforces or in actually negotiating (*e.g.*, due to perceived power imbalance, reticence of workers from a CALD background to make waves),[665] and actual or perceived unwillingness of aged-care workers to take industrial action.[666]

859. Kevin Crank (Industrial Officer, ANMF) described his bargaining experience at some length from [11]–[21] of his statement, and he was not cross-examined.[667] He describes an absence of any real bargaining (in the sense that employers often just propose terms on a take-it-or-leave-it basis, or indicate preparedness to go to a vote, and then do go to a vote, on their proposed terms absent meaningful negotiation or agreement) (at [11(b)]–[11(d)]). He says, remarkably, that every single aged-care agreement in the bargaining for which he has been involved has failed the BOOT, so that section 190 undertakings were required ([11(g)]). He says that many employers have been unwilling to meet for bargaining at all in recent years (at [15]–[17]).

860. Paul Gilbert (Assistant Secretary, Victorian Branch, ANMF) gives evidence as to bargaining outcomes at [36]–[51] of his statement.[668] Saliently, he notes that bargaining in 2017/2018 (for the period 2018–2021) was difficult and headline annual wage increases were only around 2.5 per cent (at [40]), and that in the current round of bargaining, which is just beginning, it is unlikely that the ANMF will achieve even that (at [41]). This is in part because of concerns about future funding (at [41]).

861. Mr Gilbert's evidence is that Agreement wage rates bargained with private acute sector employers reflected the outcomes achieved in the public sector. However, the same did

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664 Statement of Christine Spangler dated 29 October 2021 at [42] (tab 257 page 13019), statement of Kevin Crank dated 29 October 2021 at [14] (tab 185 page 10758).

665 Statement of Jocelyn Hofman dated 29 October 2021 at [47]–[49] (tab 261 page 13158), see also Statement of Linda Hardman dated 20 October 2021 at [82] (tab 263 page 13275), statement of Wendy Knights dated 29 October 2021 at [98]–[99] (tab 272 page 13452); statement of Dianne Power dated 29 October 2021 at [100]–[103] (tab 258 page 13116), statement of Patricia McLean dated 29 October 2021 at [125] (tab 265 page 13321).

666 Statement of Linda Hardman dated 20 October 2021 at [82] (tab 263 page 13275), statement of Wendy Knights dated 29 October 2021 at [98]–[99] (tab 272 page 13452). See also the cross-examination of Christopher Friend (PN923–928), and the cross-examination of James Eddington (PN3513–3514).

667 Statement of Kevin Crank dated 29 October 2021 (tab 185 pages 10755–10759).

668 Statement of Paul Gilbert dated 29 October 2021 (tab 186 pages 10785–10786).

not occur in the aged care sector where the public provision of aged care was relatively modest in size.[669]

862. With respect to residential care, Mr Gilbert notes that the ANMF (Victorian Branch) only have a few residential aged care Agreements in Victoria that include home care workers in the private sector. As far as he is aware, numerous large residential providers don't have enterprise agreements relating to home care, despite providing those services. Mr Gilbert describes making claims in recent rounds of bargaining for home care workers to be included in the residential care agreement where the network provides home care services. However, that claim is invariably rejected and the NERR is issued in relation to residential facilities only.[670]

863. Robert Bonner (Director, Operations and Strategy, ANMF) gives evidence concerning the history of the divergence between the aged-care and acute-care sectors, at [36]–[38].[671] For a time after the introduction of enterprise bargaining in 1996, the two sectors maintained parity, but the ANMF has struggled to achieve the same kinds of outcomes for aged-care workers as for acute care workers (at [37]). The decline has, if anything, worsened in recent years (at [37]).

864. Mr Bonner attributes this to many of the same themes identified at [858]: employers claiming not to be adequately funded (at [38]), members' unwillingness to take industrial action (at [38]), members' unwillingness to exercise their industrial muscle due to perceived poor bargaining power and, more importantly, their relationships with residents (at [38]).

865. Christopher Friend, (industrial bargaining officer under the Aged Care division for the HSU New South Wales/Act branch), gave similar evidence under cross-examination, saying:[672]

> I'm yet to come across an employer in the sector who would say that they feel the employees they have are properly remunerated for the work. So the conversation with employers is usually them saying that they wish they could pay more, but then explaining that there are a number of constraints on them, and the primary one being lack of government funding and the uncertainty that brings.

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669 Amended Witness Statement of Paul Gilbert dated 3 May 2022 at [15].] (tab 186 pages 10778–10779).
670 Amended Witness Statement of Paul Gilbert dated 3 May 2022 at [35].] (tab 186 pages 10784 - 10785).
671 Statement of Robert Bonner dated 29 October 2021(tab 187 page 10803)
672 Cross-examination of Christopher Friend at [PN928].

866. Home care provider Alliance Community operates under an enterprise agreement reached in 2009. It directs employees to this document in relation to their terms and conditions of employment although the rates of pay contained in it are no longer applicable. Alliance Community has not entered into any negotiations with its staff to replace the agreement.[673]

867. There is evidence that difficulties bargaining would be lessened by an increase in the minimum award rates. So, Christopher Friend (at PN932–PN941) gave evidence to the effect that if the largest issue or sticking point—wages—were taken off the table or at least reduced in significance by an enforceable obligation to pay more than the current rate, then the parties could focus on bargaining on enterprise specific matters (which, after all, is substantially the rationale for enterprise bargaining in the first place).

868. That is the approach that the Commission would take to section 134(1)(b) of the *Fair Work Act 2009* (Cth). It is evident from the material summarised in [858]–[864] that bargaining in the aged-care sector is not presently working, so far as wages are concerned. Whether that is due to funding constraints or otherwise, there is no reason to think otherwise than that bargaining will continue to fail to achieve wage rises, and that the disparity between wages in the aged-care sector and other sectors (*e.g.*, acute care) will continue to grow. That is to say, the biggest impediment to bargaining is not really an enterprise-level issue at all; it is a sector-wide issue.

869. So, if that sector-wide issue were resolved, then one would expect the parties' focus to shift to matters that <u>are</u> specific to individual enterprises. That is to say, the objectives of collective bargaining would be furthered.

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673 Sue Cudmore cross-examination PN13559–PN13565.

H. PCW Classification Variation

870. At the highest level of generality, the rationale for the PCW Classification Variation is that the work performed by AINs/PCWs differs qualitatively from the work done by general and administrative services and food services workers, so their rates of pay should be treated separately.

871. The principles relevant to this amendment can be stated briefly. The PCW Classification Variation does not involve any variation to modern award minimum wages, so work value reasons are irrelevant, and so is the minimum wages objective.

872. Section 157(1) provides that the FWC may make a determination varying a modern award otherwise than one varying minimum wages if the FWC is satisfied that making the determination is necessary to achieve the modern awards objective. In this light, and in the light of submissions already made in relation to the nature of the work done by AINs / PCWs, this Part H can be brief, and really involves two propositions.

873. *First*, if the Commission is satisfied that there should be an increase in award rates for PCWs, but is not so satisfied in relation to the other workers with whom PCWs currently share a classification—general and administrative services workers, food services workers—then a separate classification structure for AINs/PCWs is nothing more than an obvious drafting technique or structure to give effect to those conclusions.

874. *Second*, if on the other hand the Commission is satisfied that there should be the same increase in award rates for PCWs and all other workers with whom PCWs currently share a classification, then in any event the ANMF still submits that a separate PCW classification structure is appropriate. The evidence from ANMF witnesses will establish that PCWs work as part of a "*nursing team*" with RNs and ENs. The work of PCWs is care work, and adjacent to nursing work, in a way that the work of (for example) gardener superintendents is not.

875. That is not, in any way, to diminish the work of gardener superintendents; it is merely to recognise that the existing classifications shoehorn together into a single classification varieties of worker who perform very different work. This carries with it the risk of stultification of development of particular terms and conditions (especially in relation to wages, but even otherwise) which take account of those qualitative differences between work.

876. All of the modern awards objective considerations are either irrelevant and hence neutral (*i.e.*, sections 134(1)(f), (h)) or support the ANMF's proposed variation. Of those that support the variation, they are in two categories: considerations that would immediately be furthered by variation; and, considerations that would be advanced in future by making the variation today.

877. To exemplify the first category, section 136(g) is immediately furthered by variation, because the award will be easier to understand if different work is treated differently. To exemplify the second category, section 134(d) and (da) would be advanced in future in the sense that dealing with AINs / PCWs differently would enable, in future, changes to remuneration to address (say) unsocial hours worked by AINs / PCWs (but not, say, gardening superintendents) more easily to be made. In the same way, dealing separately with AINs / PCWs would encourage the insertion of terms into the award (section 134(1)(d)), or in collective agreements (section 134(1)(b)), that address issues specific to AINs / PCWs.

878. The application also seeks modest changes to the content of the proposed separate personal care stream, retaining the substance of Levels 1 to 4. Classification titles would be amended to reflect the work of PCWs, and minor changes to the descriptors at Level 5 are proposed to reflect aspects of the work undertaken at this level.

I. Conclusion

879. For the reasons given above, as to the Award Minimum Wages Variation, the Commission would be satisfied that the nature of aged-care work has changed over about the last twenty years, including in that the work is now more complex and stressful than previously, it involves more skill and responsibility than previously, and is performed in conditions that are in many ways more demanding and worse than previously, but that award wages have not taken account of those changes.

880. The nature of these changes was summarised in [14] above. To further summarise that summary, the evidence demonstrates clearly that:

(1) residents have more acute care and complex treatment needs (which inheres a need for a variety of skills including, just to pick one, wound care);

(2) staffing levels are lower, and the staffing mix enhances the work demands and workloads of all classifications;

(3) person-centred, individualised, care is now required which is more complex and intense;

(4) regulatory changes have increased the work demands and responsibilities of workers;

(5) the need for complex dementia care and palliative care is now more pronounced;

(6) workers deal more frequently with death;

(7) the work is more mentally, physically, and emotionally demanding;

(8) workers face more violence and aggression;

(9) the nature of changes in supervision increase work and/or responsibility for supervisors, and supervisees;

(10) improvements in technology are not all one way and in any case have not been sufficient to offset the increased physical burden of the work;

(11) the direct care workforce is better trained and more qualified;

(12) difficulty in attraction and retention decreases efficiency;

(13) COVID-19 has increased the skill, complexity, and responsibility of the work on a way that is not short-term or transient.

881. These matters, which have not been matched in a wage increase, are all "*work value reasons*" within the meaning of section 157(2A) of the FW Act, and they justify an increase in the amount that aged-care employees should be paid for doing their work.

882. Further or alternatively, the wages of aged-care workers have historically been undervalued, in at least substantial part because of the fact of aged-care workers being overwhelmingly women. This undervaluation requires correction. That is, the wages that are in fact paid to aged-care employees do not, because of the gendered nature of the workforce, correctly reflect the nature of the work, the skill or responsibility involved in doing it, or the conditions in which it is done. These are work value reasons which, again, justify an increase in the amount that aged-care employees should be paid for doing their work.

883. Because work value reasons justify an increase in the amount that aged-care employees should be paid for doing their work, and because (for reasons given in Part G above) the modern awards and minimum wages objectives are met by the proposed amendments, the Commission would make the Award Minimum Wages Variation (in the form outlined in Annexure 2 to these submissions). And, because of the reasons given in Part H above, the Commission would make the PCW Classification Variation.

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22 July 2022

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ANNEXURE 1: HIDDEN SKILLS ANALYSIS

884. As outlined in Part F above, one of the two ways in which the ANMF supports the proposition that "*hidden skills*" are brought to bear by aged-care workers is a text-based analysis of some of the witnesses who gave evidence in this proceeding. That analysis appears in this annexure. The balance of this annexure is in two parts.

885. *First*, over the next three pages and for ease of reference only, there appear page extracts from Assoc Prof Junor's report, which show what the relevant skills are, for each of RNs, ENs, and AINs / PCWs.

886. *Second*, over the following 75 or so pages, there appear tables, separated by witness, in which extracts of witnesses' evidence are set out against the hidden skill elements.[674] For example, one of the skill elements is "*A2. Judging impacts*," one of the skills within which (for an RN) is "*L3 Make safe decisions in a context of uncertainty and information gaps*." In the first table, which relates to Irene McInerney (RN), the third substantive row relates to skill A3, and the right column extracts [52] of Ms McInerney's statement, which is as follows:

> "There is always the potential for violence from unpredictable residents who have mixed mental health diagnoses (including dementia). We need to know what triggers residents toward unexpected and potentially dangerous behaviours (and these triggers can vary between residents). All staff need to have good communication skills; we need to judge when to press and when to back off. Judging well comes of years of caring and nursing experience. The language from some residents is profane related to their high alcohol consumption. We have to have skills and time enough to divert and best manage any variation best we can. Residents can also pose a risk to other residents and this needs to be monitored and interventions implemented. Increasingly, the lack of time to deliver the care that residents should be getting, can see verbal and aggressive behaviours arise."

887. It is the same approach for every row, in every table. Evidence that demonstrates utilisation of a "*hidden skill*" appears in the right-most column, against (in the left-most column) the relevant skill element.

888. Not all witnesses refer to using all skill elements. The absence of a skill element in a table relating to a particular witness should not, of course, be taken to mean that the witness does not exercise that skill. None of the witness statements were prepared with

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[674] These tables identifying "*hidden skills*" do not form part of the evidence of Assoc Prof Junor but are prepared by an application of the taxonomy developed by Assoc Prof Junor as identified in Table MR-2, Table MR-4 and Table MR-5 as set out below.

Dr Junor's hidden skill elements in mind—if they had been, there is every likelihood that further hidden skills could have been identified.

889. Rather, what is relevantly to be drawn from the following analysis is that when witnesses are simply describing their work, it happens frequently that they ways in which they describe the work fall within Assoc Prof Junor's categorisation of hidden skills. This assists the Commission in finding that Assoc Prof Junor's categorisation of hidden skills does indeed draw out the kinds of skills that aged-care workers frequently utilise. It could not be denied that the skills outlined in Assoc Prof Junor's <u>are</u> skills, and <u>are</u> valuable.

890. Then, if Assoc Prof Junor's opinion is accepted that the skills she taxonomises are under-recognised, or "*hidden*," it is a simply step to find that the wages currently paid to aged-care workers do not compensate them for the "*hidden skills*" that they utilise. And, for reasons given in the body of these submissions, that opinion would be accepted.

Table MR-3 Selected activities illustrating use of Spotlight skills — Registered Nurses

Skill element	1. Orienting	2. Fluently performing	3. Solving new problems	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
A1. Sensing contexts or situations	5.5	7.5	12.5	9.0	3.5
L3 Piece together information from many sources to solve problems, sifting information for key details (UC)					
L4 Exchange rapid situational updates with colleagues, using codes or signals (UD)					
L4 Take stock and make contingency plans for impending critical palliative or pain management needs during weekends/after hours when no doctor available (UC)					
A2. Monitoring and guiding reactions	4.0	8.0	10.5	12.5	2.5
L3 Lead a daily reassessment of residents' preferences and wishes, prioritising them over routines (US, UC)					
L4 Be alert to co-workers' strengths and needs; including stress, emotional fatigue and burnout (US)					
L4 Anticipate family reactions and guide family decision-making. providing advance warning of end of life (US, UC)					
A3. Judging impacts	3.5	7.5	10.5	14.5	3.5
L3 Make safe decisions in a context of uncertainty and information gaps (H)					
L4 Constantly lead reflection on practice: How did we come to that decision? What do you think the impact will be?' 'What did we say to the doctor? (H, UC, UR)					
L5 Identify flow-on impacts of decisions on the organisation & beyond (UC)					
B1. Negotiating boundaries	3.5	4.0	8.0	12.5	4.0
L4 Consistently advocate for staff and residents in a way that retains goodwill (H, US)					
L4 Constructively provide upward and downward feedback in unequal power situations (H, US)					
L4 Gently manage unrealistic family expectations (US)					
B2. Communicating verbally and non-verbally	5.0	7.0	8.5	14.0	3.5
L4 Use a quietly authoritative and caring communication style that gains trust and cooperation (US)					
L4 Help staff reflect on language use, adapting to resident & family understanding & sensitivities (H, US)					
L5 Help build a consistent, respectful, aesthetic and ethical communication style for the organization ((UD)					
B3. Working with diverse people and communities	4.0	3.0	7.5	7.0	0.5
L3 Anticipate and act to minimise problems created by intercultural and disability barriers (H, US)					
L4 Appropriately incorporate elements of the cultures of staff, residents & families into work practices					
C1. Sequencing and combining activities	5.0	7.0	10.5	8.5	2.0
L3 Simultaneously manage acute-care & high-focus activities involving people, technology, ideas (UC)					
L4 Systematically follow up all non-routine events across the facility several times in a shift (UC)					
C2. Interweaving your activities smoothly with those of others	3.0	4.0	8.0	8.0	1.0
L4 Develop shared system for updating shift status and re-allocating tasks in the course of the shift (US)					
L4 Have in place and be able to activate unobtrusively the shared support networks needed to maintain workflow (US, UC)					
C3. Maintaining and/or restoring workflow	3.5	5.5	10.0	11.5	6.0
L4 Adeptly lead calm response to emergencies such as falls, escalations, fire alarms, infection (US, UC)					
L4 Restore work after an emergency, recognising the importance of emotional repair (UC, US)					
L5 Build & maintain backup systems to ensure against crises or to meet a critical service gap (UC)					

Table MR-4 Selected activities illustrating use of Spotlight skills – Enrolled Nurses

Incidence of reported activities reflecting Spotlight skills (R= Residential, C= Community)	1. Orienting	2. Fluently perform-ing	3. Solving new problems during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
A1. Sensing contexts or situations	4.0	7.0	9.3	8.0	1.3
L3 Monitor and manage home safety risks to clients and safety risks to self in travel, navigating sites (C) (UD) L4 Devise flip tab guide for carers to use in recognising incipient pressure injuries, preventing falls, etc (R) (UC) L5 In an EN friendship group, exchange information on training programs, new developments, techniques (R)					
A2. Monitoring and guiding reactions	4.0	7.3	9.7	10.0	2.0
L4 Respond to the grief and sadness of residents at loss of independence and possessions (R) (US) L4 Maintain concentration, manage safety, manage own stress in the midst of many interruptions (R) (UC) L4 Manage own and client's responses when managing 'horrendous' effects of neglected wounds (C) (H, US)					
A3. Judging impacts	4.0	5.7	11.0	9.0	1.3
L3 Understand the profound impact on a client of advising transition to residential care (C) (US) L3 In community settings, solve problematic safety risks for client and next service deliverer (C) (UC) L4 Manage adverse impacts on resident 's well being of inappropriate wishes of family who are in denial (R)					
B1. Negotiating boundaries	3.3	4.0	6.3	9.0	3.0
L3 Initiate service acceptance, navigating intense fear and shame, lest 'door slammed in face' (C) (H, US) L4 Prioritise advocacy for residents' rights, dignity and pain relief in interactions with doctors (R) (H) L4 Work with RN & doctor on approaches to resident's pain management, addressing regulatory issues (R) (H)					
B2. Communicating verbally and non-verbally	3.0	6.3	9.3	8.3	1.0
L2 "The power of touch is very important so I make sure that I touch everyone and I ask them how they're going [in the] so limited time to do my job" (R) (UD, UC) L3 Perceive resident's pain level using a scale based on facial expression (R)H L4 Combine professionalism, humour, empathy, projecting confident to establish trust and lighten mood (C) (US)					
B3. Working with diverse people and communities	3.0	4.3	9.7	4.0	1.7
L3 Use key phrases in resident's many mother tongues, establishing a phrase book for staff use (R) (US) L3 Devise effective communication with residents who remember only their mother tongue, e.g. pictorial (C, R) (UD)					
C1. Sequencing and combining activities	4.3	8.7	9.0	8.0	2.0
L3 'So I'm very time conscious. I do all the time sensitive medications first' (R) (UC) L3 Use time management within shift to incorporate extra demands, e.g. regular observations after a fall (R) (UC) L4 Frequently adapt daily schedule to client needs & travel times, multi-tasking during wound treatment to deliver holistic care (C) (UC)					
C2. Interweaving your activities smoothly with those of others	3.3	5.3	8.7	11.7	1.7
L4 Annotate handover sheet with key reminders for later accurate completion before handover (R) (UD) L4 Gauge your own and individual co-workers' strengths and weaknesses when scheduling each shift (R) (US, UC) L4 Compare notes with other client service providers to develop a common approach and avoid mix-ups (C) (UC)					
C3. Maintaining and/or restoring workflow	3.0	6.7	13.3	7.7	1.0
L3 Step in to help carers and RN in managing escalations and accidents, and in restoring order (R) (UC) L4 Finding a home visit emergency, reschedule the day's roster, negotiate with other clients & notify office (C) , UC)					

Table MR-5 Selected activities illustrating use of Spotlight skills – AINs/PCWs

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently perform-ing	3. Solving new problems as they arise	4. Sharing solutions, expertise	5. Expertly creating a system
A1. Sensing contexts or situations	3.3	8.7	8.3	4.3	1.3
L3 Piece together resident information – eg past trauma, to better understand present behaviour (H, US) L4/5 Participate in a Care Support Team to discuss ways of addressing challenges on the floor (H)					
A2. Monitoring and guiding reactions	3.7	8.7	11.0	5.0	0.3
L2 Through a fine-tuned knowledge of each resident's idiosyncrasies and preferences, support smooth patterns of hygiene, meals and sleeping (US, UC) L3 Use cues, redirection/distraction in order to overcome residents' fear and resistance eg in showering, lifting (H, UD) L4 Be alert to and help manage co-workers' emotional pressures, strengths and needs (US)					
A3. Judging impacts	3.7	7.3	8.0	8.0	0.7
L3 Quickly pick up early warning signs of an impending disturbance or an approach that's not working (UD) L3 Suspend judgment of a resident despite knowledge of unsavoury past history (H, US) L3 Observe, respond to and report even slight changes in residents, e.g. swallowing difficulties indicating need to change blend consistency (UD)					
B1. Negotiating boundaries	5.3	7.0	6.0	7.7	1.3
L2 'Use PR face' in politely but firmly refusing to be diverted from a safety-critical activity e.g. showering (US) L3 Advocate for residents to gain safe staff lifting ratios, or obtain comfort equipment, meal improvements etc (H)					
B2. Communicating verbally and non-verbally	4.0	6.7	8.7	3.3	0.7
L2 Adapt voice tone, body language to knowledge of how residents will best respond (UD, US) L3 Use singing, stories, residents' loved old TV comedies etc to provide enjoyable interactions and also distractions to gain compliance with showering (UD, US)					
B3. Working with diverse people and communities	3.7	3.0	7.3	5.0	1.7
L3 Use behaviour modelling and informal swap arrangements to protect co-workers from resident racism, while explaining dementia resident inhabit a past world (UD, US) L3 Ensure residents from the same language groups can interact; use multilingual cues (UD, US) L4 Facilitate initiatives in which linguistically diverse staff share their culture with residents (UC)					
C1. Sequencing and combining activities	5.7	5.3	7.3	5.7	0.3
L3 Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (UC) L3 Use and adapt routines in order to accommodate flexible resident-focused care (UC) L4 Clearly and briefly flag changes to work patterns (or the need for them) to team members as they arise (UC)					
C2. Interweaving your activities smoothly with those of others	4.3	5.3	5.0	5.3	0.3
L2 Smoothly switch back and forth between individual and paired or team work in managing resident lifts and mobility (UC) L3 Notice when a colleague needs support and step in to help avert an escalating conflict (UD)					
C3. Maintaining and/or restoring workflow	4.3	6.0	9.0	6.0	0.3
L3 Make time for caring listening and interactions amidst intense work pressures (US, UC) L4 Unobtrusively activate and participate in team support networks if a critical incident arises (UD, UC) L4 Provide support for a colleague in a major emergency or first experience managing a resident death (US)					

IRENE MARY MCINERNEY
RN Barrington Lodge Aged Care Centre, Hobart
Statement of 29 October 2021, tab 260, page 13139
Amended Statement 10 May 2022

	Para	Extract
A1. Sensing contexts or situations	54	I have had a lot of years of experience and can often see a need before an escalation occurs. Where possible, it is good to be preventative. This includes recognising triggers which can mean toileting a person so they don't fall, or taking time for a quick 1:1 chat so to divert the resident from absconding, or providing a shoulder to cry on because another resident died who was their friend. There is no end of emotional and psychological needs of our residents, and sometimes for their family members. These are situations where the Leisure and Lifestyle staff (if available) can be very helpful. A resident running out of cigarettes or beer can create huge problems and for them any waiting may not be an option.
A2. Monitoring and guiding reactions	23	If there are any incidents with residents such as falls, appointments, pathology requirements or acute ill health, then I have to prioritise workload. I have to decide on care needs and alone decide whether it is necessary to call family, doctor or an ambulance. We triage care needs, and at times, I feel like I am working in a mini hospital but without the resources and support available in other settings. Other settings have doctors and other support people on site at all times.
A3. Judging impacts	52	There is always the potential for violence from unpredictable residents who have mixed mental health diagnoses (including dementia). We need to know what triggers residents toward unexpected and potentially dangerous behaviours (and these triggers can vary between residents). All staff need to have good communication skills; we need to judge when to press and when to back off. Judging well comes of years of caring and nursing experience. The language from some residents is profane related to their high alcohol consumption. We have to have skills and time enough to divert and best manage any variation best we can. Residents can also pose a risk to other residents and this needs to be monitored and interventions implemented. Increasingly, the lack of time to deliver the care that residents should be getting, can see verbal and aggressive behaviours arise.
B2. Communicating verbally and non-verbally		[Same as A3, para 52]
C1. Sequencing and combining activities		[Same as A2, para 23]
C2. Interweaving your activities smoothly with those of others	36	As I have noted, the RN numbers have reduced, and more than ever we need to communicate well to get the work done. We often have to pass on requirements to other staff, so we do rely on team effort and support. With so many agency nurses providing different staff, we cannot guarantee continuity of good care for the residents. There is more fragmentation to the care now.
	37	I remain accountable for the care delivered while I am on duty. This means that I need to work with and rely on the nursing team and the carers. This includes identifying at

		handover and at the start of the shift those residents with particular issues or needs. The carers need to tell RNs anything that is out of the ordinary with any residents. The RNs then need to assess and address issues. Reporting, things as in bruising, an escalation in behavior, skin changes, changes in presentation or condition so the RN can monitor for health changes and make a plan of care.. As the RN I monitor resident condition, additionally watching for changes such as confusion or agitation, possible pain management issues, and swallowing issues at meal times. There is need for trust and support for the full team I work with.
C3. Maintaining and/or restoring workflow	44	[Same as C2 para 37] We have more on our job description than ever before, yet staffing has not kept up. Staffing numbers have eroded, and this in itself is affecting the mental health of many residents and staff. Staff are known to take mental health days off to get a recovery break and increase change coming back better for the next shift. I find myself supporting those who are under the pump. If we talk about our feelings together, we feel supported and not alone.

JOSEPHINE PEACOCK **Formerly personal care worker, recreational activities officer, at Hammondcare, Hammondville** **Statement of 30 March 2021, tab 223, page 12031**		
A1. Sensing contexts or situations	80	One of the greatest challenges in my work, and the work of RAOs and DTs, is to provide meaningful person-centred and relationship-based care through activities. It is sophisticated and complex work.
	81	I will use the game of Bingo as an example to highlight the complexity involved: a. Firstly, the RAO or OT will have already assessed each resident to establish whether bingo is an activity of interest, they will also have assessed what type of bingo (e.g., picture/music/number) they may be interested in. b. They will check/assess for any specific physical/psychological requirements (e.g., are they vision impaired, and do they require large print cards? What font? Do they need to be away from the window to avoid glare? Are they hearing impaired? Do they need to sit directly in front of the caller? Do they need their hearing aid switched over to the loop system? Do they have anxiety? Do they need a volunteer to sit with them for reassurance?). c. The game needs to be facilitated in a way that takes into account resident ability and acuity. If run for frailer residents it may need to be called more slowly and/or the numbers repeated, if run for higher functioning residents then it may be called faster or the games might more complex (e.g. racecourse, top line, four corners configurations) to challenge the player. d. In a dementia care home, consideration must be given to what is the best time to run the game? When are the residents most cognitively aware or alert? e. The length of the game will need to be adjusted as concentration levels vary. What suits the residents best on one day may not necessarily work the same the next day the game is run. Staff must always be in-tune with what is going on with each resident on a day-to-day, hour-to-hour basis. Bingo prizes need to be carefully considered - what is suitable for one resident may not be suitable for another (e.g., chocolate may not be suitable for a resident with diabetes, if the resident has dementia the staff member will need to be aware and alert so that that person gets a chocolate suitable for a diabetic). Staff have to be aware of all individual needs, likes, preferences and dietary requirements.
A2. Monitoring and guiding reactions	52	For example, with craft activities, you might buy special scissors so that residents could grip and hold them. You might buy different sized card so that those with good dexterity can do fine detailed work with small card, and those with diminished motor skills have bigger cards to work with.
	104	We also had an incubator and chick hatching program and I asked if she could keep a watch over the hatching chicks. would sit by the incubator and chick pen watching over them for hours, and once the chicks had grown up was still seen nursing the hens in the chook pen. She also put them in a basket on her wheelie walker and took them for walks.
	105	X developed a sense of responsibility and care for the hens, and it was possibly the first time in her life she had been given such an opportunity. She thrived knowing she was useful and needed, the hens needed her, and we needed her to look after them.
	106	She would very proudly show new staff and visitors the hens she was looking after, and staff in return would show her great appreciation for the good work and help she was providing. She felt valued and important and her behaviours of concern diminished markedly.
A3. Judging impacts		[Same as A1 para 80-81] [Same as A2 para 104-106]

	112	As an example of how well we get to know residents, while I was at Harbison, there was a resident there who, because of her religion, always wore a headscarf and pantyhose.
	113	She had dementia, and eventually was moved into the dementia unit, where she started to develop some challenging behaviours. I went to visit her, to see if I could help the staff, and saw that she had been dressed in tracksuit pants, when she probably had never worn pants in her life. She was beside herself, and no one could work out why her behaviours were so bad.
	114	I suggested dressing her in pantyhose, a skirt and with a scarf, given that was how she had always preferred to dress. When this happened, it was clear that she felt a lot more settled and her behaviour significantly improved.
	130	If the activity is too complex for their needs the risk is that they feel failure. If it is too simple for their needs they feel unchallenged.
	131	I always design lifestyle programs with the goal of residents to experiencing increased self-esteem, self-worth, achievement and/or fun.
B1. Negotiating boundaries	78	Every week since the COVID-19 outbreaks started I have also undertaken the concierge role and have had to manage very tricky situations where visitors, who didn't meet the criteria, had to be refused entry.
	79	They have then become emotional, angry and verbally aggressive and had to be managed sensitively, but firmly. This I have found to be emotionally challenging work.
B3. Working with diverse people and communities	47	When preparing the lifestyle program, it was important that I took into account the need for variety and balance in the program whilst at the same time meeting individual needs: physical, social, spiritual, cognitively stimulating activities as well as emotional support all had to be provided. [Same as A2 para 52] [Same as A1 para 80-81] [Same as A2 para 104-106]
C3. Maintaining and/or restoring workflow	124	Sometimes things do not go according to plan and you need to make changes on the spot, having the knowledge and skills and the ability to be flexible and adaptable are imperative. These skills are built up over time, with experience and training.

MAREA PHILLIPS **Former Community Support Worker, South East Community Care, Tasmania** **Statement 27 October 2021, tab 245, page 12638**		
A1. Sensing contexts or situations	24	When I assist with a shower it means the first question I usually ask when I arrive is 'have you had your medications' then I ask how they're feeling, how they slept, and if they're tired. I need to know how they are as I get ready. I set up the bathroom, towels, heater, clothes, and everything else I need to use so they are ready before I find out if they can shower themselves. This may be different for the same client on different days. If they can shower themselves, I leave the door to the bathroom open and make the bed, tidy up close by, checking that nothing in the house has changed since my last visit as this might indicate something bad happened. I check whether they've washed their hair, need help washing their back, that sort of thing, then help them to dry and dress. I always leave them with a drink at least, ensure they've had breakfast or get it if they need help, and if it's hot, make sure there's a jug of water in the fridge. I take out any rubbish and do a quick tidy generally.
A2. Monitoring and guiding reactions	47	I also cared for a sweet little lady in Sorell who was diabetic. The skin on legs was almost black when I first started caring for her. They were using a moisturiser that was full of alcohol and so her skin was breaking apart. Diabetics often suffer from poor circulation in their legs and feet and extra care needs to be taken. I suggested to her family that they a change to QV moisturiser and wash. This was reported in her notes and an incident report filed later.
B1. Negotiating boundaries	37	You have to be careful with how you approach a client with these types of issues. If you take issue with the way that a client's home is presented, then that can cause friction between the client and the worker. You must remember that this has been someone's home for decades, and you have to deal with this conflict in a considered way.

JOCELYN HOFMAN **RN Bodington Aged Care Facility Catholic Healthcare** **Statement of 29 October 2021, tab 261 page 13151**		
A2. Monitoring and guiding reactions	25	Interaction with General Practitioners requires advising of changes in resident condition requiring medical intervention, reporting on progress when necessary and also being an advocate for the resident. The GPs generally only visit residents once per week, but are contactable by phone. However, they don't always want to be contacted after hours and this leaves me as a Registered Nurse to make clinical decisions or make a judgment to send the resident to the hospital.
	30	Registered Nurses' scope of practice involve clinical assessments, plan, provide timely clinical intervention, evaluate and monitor care services. For example, when I administer medication during my medication rounds, I assess my resident's status. Is their swallowing compromised? Are they depressed? Are they in pain? As a Registered Nurse, it becomes second nature to observe changes when interacting with residents.
	39	As a consequence of the above there is an increased sophistication in the level of nursing skills required. As a registered nurse I utilise my clinical skills on a daily basis. The increases in the complexity of residents' health status and the care required can be illustrated in a routine example of when I administer medication. When doing so I simultaneously undertake a range of other functions such as: • Checking on side-effects of the medication, both immediate and longer term and assessing the benefit of the medication consistent with quality use of medicine guidelines; • Assessing changes in the communication and cognitive capacity of the resident; • Assessing the resident's overall well-being, oral and personal hygiene; • Falls risk strategies are in place; • Reviewing continence care; • Ensuring adequate hydration and nutrition; • Maintain our residents' skin integrity; • Safe behavioural management in dementia care; • Health emergency responses like identifying acute deterioration in residents related to infections compounded by co morbidities; • Infection prevention and control; • Palliative care including complex pain management; Oversee safe and effective care work carried out by the rest of my care team.
A3. Judging impacts		[Same as A2 para 25]
C1. Sequencing and combining activities		[Same as A2 para 39]
C2. Interweaving your activities smoothly with those of others	35	As a result of the staffing changes the delivery of care is always rushed. Daily work routines are pressured for the entire team of registered nurses, enrolled nurses and AINs/ PCWs/ CSEs. Accordingly, my work focus has shifted with a greater emphasis on exercising accountability for care. This means combining nursing assessments with other interventions, scanning residents at meal times to assess changes in such things as posture, mood, lack of appetite, as well as requiring and following up reports from care staff of changes in resident status.

		[Same as A2 para 39]
C3. Maintaining and/or restoring workflow	34	There had been a reduction in registered nurses and an increased number of AINs/ PCWs/ CSEs employed in the aged care sector. When I started work on a day shift at Sans Souci, now called Anita Villa, there were three registered nurses rostered with AINs. At Bodington, I work with two CSEs in 1 wing and with an EN or casual RN (for part of the shift only) in another wing with two CSEs and a short shift CSE. This has resulted in increased scope and extent of responsibility for me as the registered nurse who remains accountable for the care delivered. It has also required increased exercise of judgement in prioritising resident care demands. This may even involve deferring my medication round to attend to an emergency situation like a resident choking, a fall or if I am designated as in charge of the facility, I will be called to other serious incident elsewhere in the facility. When a doctor visits his residents in the afternoon, I also defer my medication round so I can update the doctor with our resident's current status, email the Pharmacy on medication changes, follow up the medical directives and update the family member on the doctor's visit and changes.

KERRIE ANN BOXSELL **Care Staff, Team Leader and Acting Assistant, Evergreen Life Care** **Statement of 31 March 2021, tab 236, page 12357**		
A2. Monitoring and guiding reactions	64	I think of myself as an advocate for residents when I am dealing with these professionals. I will try and identify residents' health issues and press for assessments and support for residents.
	18	As Team Leader, staff will often come to me because they cannot communicate with a resident, which has increased due to PPE and COVID restrictions. Less experienced staff struggle with interventions so as Team Leader, I will assist, guiding and mentoring the less experienced staff. This is a necessary requirement of my role but it means I'm pulled away from other work.
B2. Communicating verbally and non-verbally	56	I am always supported when I need it. If I have a resident that is behaving differently or there is a new issue that I do not know how to handle, they will always step in and help me. For example, we have recently had a new resident who is presenting with certain behaviours. As I do not know her well enough at the moment, I was unable to comprehend what she was saying at times. I spoke to the supervisors to try and get more information about the resident and her background. They provided me with information and also asked me to look at her paperwork to see if there was any information included there.
	61	As the residents are frailer, they can sometimes have difficulty communicating with care staff. We try our best to talk slowly so they understand. We also have cue cards where the resident can point to what they want. If a resident is unable to tell us how much pain they are in, we have a pain scale that the resident can point to.
	16 [**Reply 19 April 2022**, tab 236, page 12358]	PPE creates communication challenges. I have had to identify and implement more creative ways to communicate, which are often time consuming. For example, I will use my hands to gesture, use objects or draw and write out what we want the resident to understand. All of these approaches take longer for us to complete.
	17	We have not had an instance that I'm aware of where we could not get a resident to understand eventually. Ultimately, it is our job and a crucial requirement to proceeding with any care to ensure the resident understands, however sometimes we may be required to leave the resident and seek assistance from other staff. I've worked here for eleven years and with my experience, I find there is always a way to communicate with residents, it's simply far less straightforward or efficient under COVID PPE requirements.
	37	We will also spend more time reminiscing and exploring memories of their life to provide companionship, which residents could not get from their regular visitors.
B3. Working with diverse people and communities	48	Once a resident has died, we let the RN know who will come in and check on the resident. Some residents have an end of life plan and we try to follow every step of that plan. This could include putting the resident in their favourite clothes or pyjamas and/or making them look "kissable" (put on some makeup). We also make sure we follow any cultural or spiritual procedures that they have identified. [Same as B2 para 37]
C1. Sequencing and combining activities	43	To calm them down, I try to engage with them by talking or even singing to them. For example, one of our dementia residents was becoming very agitated when we were trying to assist him with personal care. I held his hand and talked to him while the other care staff wiped him down. We also try to give him something to hold to

		make him feel comfortable and supported. It is always a good idea to give him something to do or engage him by doing his buttons himself.
	67	No matter what their age or diagnosis is, we are always looking for changes and how to help residents. Our aim is to ensure they are pain-free, have always had enough to eat and drink and are comfortable. The staff are encouraged to engage with residents. The residents love one on one time with the staff which is why we always try our best to take time out of our shift to talk to the residents. For example, there is one resident who requires ice gel every day. I don't give her the ice gel during the morning medication rounds. I usually visit her later on in the day to apply the gel so that I can spend some one on one time with her. She really appreciates this.
	32	To make visits safe, it requires more work from staff. For example, staffing the tent at the front of the facility which I described above, families perform their RAT tests in this tent, staff oversee the process and ensure validity or results. This includes administering RAT tests, observing the process, documenting results, and ensuring validity of the tests, all while ensuring compliance with infection control measures.
	39	It is exhausting assisting in so many areas with so much unpredictability. I know the residents rely on us and need our help, so I just get the work done and find a way to make sure things happen. I get so exhausted because I'm going faster, not having breaks, sacrificing myself to meet the workload. If I slow down, the people that suffer are the residents
C2. Interweaving your activities smoothly with those of others	32	Helping the care staff includes making sure my team are okay and not overwhelmed with caring for all the residents. Our team is good in the sense we always fill in for each other and jump in to assist whenever someone needs help. We are always communicating and briefing each other during the shift. I have mentored them and performance managed any issues I have identified over the years. [Same as C1 para 43]
C3. Maintaining and/or restoring workflow	69	As a supervisor, you are responsible for assessing and supervising the work of your team and picking up the slack if the team is behind in their tasks. This means you often do not get to take your breaks. Your team will always come to you and notify you of what is going on. You are responsible for going out and assessing the situation if there is a problem with a resident. You are also responsible for liaising with the RN.

TERESA HETHERINGTON **Personal Care Assistant (home care) Australian Unity** **Statement 19 October 2021, tab 286, page 13557**		
A2. Monitoring and guiding reactions	Transcript 10 May 2022 PN10604	I take it that exception that be I might not be as talkative as normal or I might not be eating normally, is that the type of exception you might record?---Generally we tend to try to observe the clients, their environment, their mood swings, any decline like if someone has had a mini stroke we are - usually the higher levels are trained to notice any little fluctuations in the client's presentation, so we would document those, yes.
	Transcript 10 May 2022 PN10616	When you're there you're just, sort of - if you see a hazard you'll identify it and report it. You're not doing the specific hazard check when you're there?---Those are done annually, once a year, the checklists. But, yes, generally, like, the vacuum cleaner might break this week, but it didn't break three weeks ago, and the service coordinator wouldn't have seen that. Tripping hazards, like, if someone got a mat for Christmas from their grandchild, that's not going to be in the client notes, but the client just fell over it last week. So, we tend to try to monitor the environment and look for abnormalities.
B1. Negotiating boundaries	85	I am regularly called incompetent and generally talked down to. Body shaming is a regular experience.
	86	Bullying and harassment is also prevalent internally - the client directed nature of the work now leads to the sense from management that the "client is always right".
	87	On many days, where I know that I will be visiting certain clients, I put a protective layer on at the start of the day and mentally prepare myself to take steps to minimise my own risk. At the same time, I am aware that most clients need emotional support and I always reassure clients that we are there to help.
C1. Sequencing and combining activities	Transcript 10 May 2022 PN10583	You seem to be suggesting that it's work beyond that which a care worker would normally give?---Yes, that is true. We are not at medical grade, we don't perform hyperinvasive procedures, but we certainly are performing greater than what is generally expected of a care worker. Say for example hoist transfers, suction. A motor neurone client in particular secretes a fair amount of secretions through their mouth and that needs to be removed periodically so they don't choke to death. Some of us have been trained in that, others were trained watching another care worker perform that task. Those would generally be assistants. So we were essentially given that kind of training as we went. Putting on a uridome that is above the general needs of an average care worker, so we were specifically trained in that. The PEG feeds, applying and removing of PEG feed tubes, ensuring that the client has everything strapped down where it needs to be so he can be transferred to his care chair. Even essentially helping him to transfer himself into his shower chair that is slightly above the average needs of a care worker, or the requirement of a care worker.
C3. Maintaining and/or restoring workflow	67	There are occasions where clients may be scheduled for a 1 hour block, but the service can be completed within 15 minutes. Unfortunately, the lack of flexibility means that I cannot proceed to the next client but must wait until the next scheduled time.
	68	There is little certainty with the work. Client cancellations and scheduling can mean that work can appear and disappear "at will" digitally through the Procura app.
	69	Similarly, I must always remain on top of the Procura scheduling to ensure that clients are not missed.
	70	There is a sense that I must remain vigilant of my phone and emails at all hours, to ensure that my working day is properly planned.
	Transcript 10 May 2022 PN10612	I mean to - what happens with you?---Yes, I'm just let me finish my answer. What we generally would do to ensure that the client's incident has been properly recorded and looked at, we do all three at the same time. We will call the office staff at the time and report it, then we will put an incident in DoneSafe, and make a client note as well. Some workers will actually exceed that and call the client's family themselves just to make sure that they have been informed as well, because things are so

		chaotic at the moment, and the turnover is so great there have been repeated instances of clients falling between the cracks.

WENDY PAULINE KNIGHTS **EN Princes Court Homes** **Statement of 29 October 2021, tab 272, page 13438**		
A2. Monitoring and guiding reactions	73	In the dementia unit there seems to be more aggression now than there used to be. I often have to advise staff about how to deal with these situations –how to minimise triggers and to walk away and disengage when the resident becomes agitated. Several staff have been injured as a result of these interactions so OHS for staff and the other residents has become more of an issue**.**
	83	Finding the balance between privacy for families, explaining what is happening for families, providing care and separating our own emotions is all quite challenging. On top if that we often have to shepherd newer staff members through the process. Very rarely is a doctor present (except initially around medications or after death to sign the death certificate). An RN is always in the facility or contactable, but the comfort and care of the resident is usually in the hands of EN and/or carers.
B2. Communicating verbally and non-verbally	66	There are additional documentation requirements which require significant education and time to complete. For example, in the new Quality Standards they want us to document (preferably each shift, but certainly every day), how we have had contact or interactions with each resident. It might be talking to Mary about her trip to the dining room and her meal and documenting her descriptions of what she ate and whether she enjoyed it. On many days I have to do a minimum of 18 progress notes in the dementia unit that I didn't always have to do before. Previously it was only definitive changes that were documented. This daily interaction note often falls to me because the PCAs sometimes don't do them or aren't confident of their writing skills**.**
	77	Added to that is that many of our carers come from a CALD background themselves, so communication between residents and carers can also be a challenge. About 30 per cent of our nurses and carers come from overseas, mainly from India or the Philippines. While the English of the carers is okay in a normal situation, many residents have hearing issues or can't understand what is being said to them. Sometimes the carers can't pick up what residents are saying. As an Enrolled Nurse I am regularly having to go to a resident to ask them what they want or determine exactly what they said after a carer has reported something to me that I don't understand. Again, there are more carers from a CALD background than there were when I started at Princes Court.
	81	There has a been a lot more need for emotional support of residents who are lonely or don't understand (or forget) why their family can't come and visit (or they can't go out to visit them). You need to make time in the shift to try and give people attention because activities aren't being conducted as regularly because of COVID restrictions. We also used to have volunteers (from the adjoining retirement village especially) but because of COVID those volunteer visits have ceased, as have visits by male residents to the Men's Shed. Wearing masks has made that harder as residents can't even see you smile underneath the mask.
B3. Working with diverse people and communities	48	My feeling is that aged care is less institutional these days and we are often adapting to the resident's choices rather than them fitting them to a cookie cutter approach. That is great for the residents, and I support it, but it makes work harder and more complex for nurses and carers, especially in the context of fewer staff, higher acuity and more rigorous reporting requirements. [Same as B2 para 77]
C1. Sequencing and combining activities	42	Similarly, there is now a lot more consumer choice, especially under the new Aged Care Standards introduced in2018. For example, some residents want to sleep until 10am or 11am each day. This means their morning medication is actually given at lunchtime. Then their lunchtime medication is given at 5pm.

	43	That makes medications (as well as other care needs like toilets like personal care or meals) more complex. It used to be that you were able to structure your work or establish routines around the kinds of work that you would be doing at particular times. Now, you cannot do that —different work is required for different residents at different times, based on their preferences.
C2. Interweaving your activities smoothly with those of others		[Same as C1 para 42-43]

ANTOINETTE SCHMIDT **Specialised Dementia Care Worker, HammondCare** **Statement of 30 March 2021, tab 206, page 11708**		
A1. Sensing contexts or situations	75	As an SOC, residents rely on me to be their eyes and ears. I see residents all the time and I know when things are happening or if there is something unusual in their behaviour or appearance.
	102	Typically, we don't use medication to correct aggressive behaviour. We will often assess the situation and remove any triggers which may be causing resident distress.
	133	For example, we had one resident who became distressed when a family member of another resident would take the other resident out for coffee. When the resident was not getting attention or care, she became demanding and upset. I would try to include her in my everyday routine. For example, I would ask if she could help me prepare lunch. Sometimes she would ignore my request and go to her room. I would accompany her and get her a magazine or talk to her.
	134	People with dementia continue to need relationships and attention. However, they vary in their individual ways of giving and receiving affection, as the dementia affects their abilities differently. I can usually tell when a resident is enjoying my company because they will often smile and are more active and positive.
A2. Monitoring and guiding reactions	88	Unfortunately, a common phrase for a newly arrived resident is "I want to go home". We have one particular resident, who although she has been at the facility for one year will often state in a loud distressed voice "I am going home". Her behaviour triggers other residents to become confused, frightened or agitated. I will often try to redirect her attention to food or other activities. For example, I might ask her to assist me to unpack the dishwasher or peel potatoes.
	103	Many residents will endure abuse including hitting, kicking, bitting, scratching and spitting from other residents.
	104	To effectively handle incidents of resident on resident abuse we will try to distract the residents involved by directing them to a physical activity or tasks. I will use a calm, low soothing voice.
	14 **Reply** 20 April 2022 tab 207, page 11831	Other clients clients had a real fear of developing the disease, and would often say things like *"I'm worried about my health issue"* or *"I'm scared of this horrible disease, I don't want to get it".*
	15 **Reply**	To address their concerns, I re-enforced the fact that measures had been taken to prevent or avoid the spread of the disease and encouraged them to remain positive and proactive. For example, I often said *"You're vaccinated and if you practice good hygiene you're unlikely to catch it"* or *"we all get sick sometimes, it doesn't mean everyone dies"*
	28 **Reply**	Whilst I don't make decisions for clients, I can often be involved in decision making, when it comes to client care. Specifically, my role when it comes to client care is more participatory, supporting or guiding. Decision making usually involves the client and their family member, however I will often be asked questions regarding the client's care which can inform any subsequent decision making. For example, the types of questions I will get asked include things like: *"Has she had COVID-19?" "Has she been feeling sick?"*

		"Has she been taking her tablets at the times she is meant to?"
A3. Judging impacts	43	In my opinion many residents are incorrectly screened or assessed, which results in difficult social interactions amongst residents within particular cottages. Where I identify this, I raise it with the manager or nurse on shift to see if I can get a resident reassessed.
B1. Negotiating boundaries	7(a) **Reply**	In addition to issues with visibility due to the fog accumulating on my glasses and the difficulty wearing the mask, I have found verbal communication with clients whilst wearing the face mask difficult. My clients have difficulty hearing me. They have previously made comments such as "/ *don't know what you are saying. Take it off*'. I am not allowed to take my mask off if a client has difficulty understanding me so I have to gently explain why I have to keep it on and why it is necessary to reduce the risk of infection for them and for me. I have been advised by HammondCare to keep the mask on at all times. I don't think this will change any time soon as the pandemic continues on so I expect that I will have to continue to adapt my care to wearing a mask.
B2. Communicating verbally and non-verbally	76	It is my job to successfully communicate these concerns with the family or nurse, as most of the residents cannot communicate for themselves.
	89	I try to engage with residents throughout my shift. When I communicate with residents I always try to: (a) speak slowly and clearly, especially because I have an accent; (b) give them plenty of time to respond; (c) prompt them with visual cues; and (d) always provide clear step by step instructions.
		[Same as A1 para 134]
		[Same as B1 para 7(a)]
	12 **Reply**	The restrictions also left a lot of clients feeling isolated and lonely. Some of them would say *"my family haven't come to visit me"* or *"I'm bored"*. I would try and engage with them to reduce the impact of isolation.
C1. Sequencing and combining activities	49	SDC's are also expected to perform all cleaning work, including vacuuming, sweeping, dusting and general cleaning duties during the day. This means having to perform cleaning duties whilst also having to navigate other more variable elements, like interacting with residents and visitors.
	62	Safety controls and supervision of residents is a constant feature of my role. I have to keep in mind various distractions and re-direct the residents when they want to participate in dangerous activities, like cooking near a hot stove. [Same as A1 para 133]
C2. Interweaving your activities smoothly with those of others		[Same as A1 para 133]

LILLIAN LEANNE GROGAN **Care Worker Coach (home care) Australian Unity UWU** **Statement of 20 October 2021, tab 280, page 13514**		
A2. Monitoring and guiding reactions	21	You also need a lot of patience, and you can't be judgemental. A lot of the time you don't know what has happened to that person. You can't judge just by what you see. If you dig deeper there are reasons for different things. As an example, someone might be snappy or cranky but you don't know how much pain they might be in. Pain can make people really grumpy but they don't always say "I'm in pain", they snap your head off. You have to start talking to them to find the cause of the behaviour rather than rising to rude behaviour.
B1. Negotiating boundaries	14	We are also meant to identify issues such as elder abuse. On a personal care visit with a client who had dementia I noticed that the lady had quite bad bruising on her arm and her husband was cranky and verbally abusive on the day I was there. I had to report this because I didn't know how she got the bruises. I need to do this in such a way that can still preserve the working relationship, so I needed to be polite and clear that I was going to make a note about it.
B2. Communicating verbally and non-verbally	19	You have to have a high level of interpersonal skills. As care workers we need to have a different hat on for every house that we walk into. I might walk into a house and have to communicate about opera or poetry, but the next house might be about football or having a few drinks at the pub–we have to adjust our style to the client we are dealing with. You need to read the situation as soon as you get through the door. You also need highly developed interpersonal skills to deal with clients' families who may be overbearing, or negative family dynamics (for instance if the client does not believe that they need the care but their children disagree).
B3. Working with diverse people and communities		[Same as B2 para 19]

SANU GHIMIRE **Statement undated (late March 2021), tab 195, page 11592** **Care Service Employee and Recreational Activities Officer, Uniting Aged Care**		
A1. Sensing contexts or situations	46	As an RAO, I have to think about many things when planning activities. I consider their physical capability, their emotional needs and mental state and try and design activities around these things. Most of the residents have reduced mobility and a lot are in wheelchairs. Very few are able to walk. Every month I ask each of the residents what they would like to do before finalising the activities calendar. I design the program based on their suggestions however I do have to alter their requests sometimes. For example, the residents requested to do foot work activities because they wanted more leg exercise. However, it is very hard because of their reduced mobility and inability to go to a sports court. I figured out a chair football activity where you put all the residents in a circle and kick a ball around. I was able to meet their requests by doing this.
	5 **Reply** 20 April 2022, tab 196, page 11599	The lockdown meant that I was not able to conduct group activities anymore, given all the residents were required to be kept apart due to social distancing rules. This meant that often I needed to spend one on one time with each resident, when conducting recreational activities. During this time, I was very aware that because each resident would not be able to see their family or interact with other residents, the time I spent with them was the only time they would be engaging with other people throughout the entire week. It was my job to make sure they were emotionally ok. This increased the pressure I felt to make sure that each activity I designed and organised was as beneficial as it possibly could be.
	7 **Reply**	In addition, engaging with residents on a one on one basis, requires a different skill set, rather than hosting group activities. For example, I was required to tailor my interactions with residents to meet the needs, preferences, communication styles and abilities of each particular resident. Some residents are able to engage in activities, that others simply are not capable of.
A2. Monitoring and guiding reactions	37	Some residents have very specific bedtime routines. For example, there is one resident who likes to go to bed straight after dinner. As soon as he rings his buzzer for assistance, I have to make sure I attend to him straight away as he can become very frustrated and verbally abusive. Over time I have learnt to adapt to this to avoid him becoming agitated.
		[Same as A1 para 5 Reply Statement] [Same as A1 para 7 Reply Statement]
A3. Judging impacts		[Same as A2 para 37] [Same as A1 para 46] [Same as A1 para 5 Reply Statement] [Same as A1 para 7 Reply Statement]
	6 **Reply**	As a result, the schedule for activities that I had previously used, was no longer relevant, and I needed to re-design the entire recreational program. Some examples of the one on one activities that I designed for the residents to engagein on their own, included general exercises, balloon volley ball, and playing music videos to them using an iPad or iPhone. In designing these activities, I was required to assess how the residents might be able to engage in them on their own, as opposed to in a group

		setting, which varies greatly from resident to resident.
B1. Negotiating boundaries	56	I often encounter dementia residents murmuring to themselves and repeating sentences. I have learnt to respond to these types of behaviours during my time at Uniting. For example, in my **RAO** role, if I can see a resident becoming aggressive, I try and divert their attention with an activity or by talking to them in a calm way. I can also try and separate them from the group and give them more attention and time. I talk to them or take them to the garden and provide them with tea to try and calm them down. Although I try to calm them down, there are some instances where my methods don't work and I find it extremely challenging to deal with their behaviour.
B2. Communicating verbally and non-verbally	20	For residents who have difficulties communicating, I am required to engage in other forms of communication to determine what the resident requires. This includes observing their body language, nonverbal communication and observing physical changes in their body.
	10 **Reply**	I was also required to re-design some of the group activities that I had administered previously as a result of the social distancing rules. For example, we still tried to run bingo with the residents. But given they were not allowed to sit together, I would wheel each resident to the door of their room so that they were all facing the hallway. I would then call the bingo numbers from the hallway as I walked up and down, so the residents could hear what was being called. Conducting the activity in this way, required me to spend more one on one time with each resident, as I needed to transport them to the hallway. This took more time, and left less time for the activity itself.
	31	There are also some residents who cannot communicate. To ensure they are ready to eat, I have to read their body language as they usually respond by nodding.
	17 **Reply**	In addition, they did not recognise us, and didn't know who we were because they couldn't see our faces. This made care work even more difficult, because it hampered our ability to employ the skills we would normally use in communicating with residents suffering with dementia. For example, it was difficult to be calming and persuasive, when they were not able to see our faces at all.
B3. Working with diverse people and communities		[Same as B1 para 56]
	16	Further, during lockdown, I was allocated to the Dementia Ward. Wearing PPE made lots of the Dementia Ward patients very unsettled. They didn't know who we were, and did not understand why we were dressed in the way we were. They appeared frightened when I approached in PPE. However, it was very difficult to explain to them, what the PPE was for and why we were wearing it. As a result, residents would yell, hit and scream at us. They didn't know who we were, or that we were trying to help them. One resident thought we were aliens because we were all dressed up so differently. He was very upset by this. [Same as B2 para 17]
C1. Sequencing and combining activities	24	At around 3.00pm, I begin making rounds in my section to check on the wellbeing of each resident, to determine if their buzzer is within reach, to ask if they require water or food, or to assist with toileting and /or changing clotes. While I do this I make sure to chat with residents and find out how they are doing. [Same as B2 para 10]
	14 **Reply**	During this time, we had to wear PPE and were required to change it each time we interacted with a new resident. The PPE we were required to wear included a face shield, gloves, gowns and masks. I took the responsibility of wearing the appropriate PPE very seriously, and was very strict about changing it each time we saw a new resident. I observed that my colleagues conducted themselves this way as well. However, this meant that each task we were performing took more time than it otherwise would. Accordingly, we were required to adapt to the fact that we had less time to complete each task, by prioritising the tasks that needed to be completed.

C2. Interweaving your activities smoothly with those of others		[Same as B1 para 56]
C3. Maintaining and/or restoring workflow		[Same as B2 para 10]
	21	Accordingly, lots of staff would frequently call in sick and we had to manage these shortages by reprioritising tasks, and in some cases redesigning the recreational activities we had planned. We were luckier than most facilities because Uniting organised a group of people known as a ‘flying squad’, who would come in and help at centres where there was a staff shortage.

JUDITH CLARKE **PCW at Baptist Care** **Statement of 29 March 2021, tab 273 at page 13462**		
A3. Judging impacts	12	"Carers need to be able to discern residents' needs, especially when those needs cannot be communicated by the resident or their family. Carers have to be attentive not just to residents' physical needs but also their emotional needs. When a resident is distressed, you have to be able to work out what is causing them distress and know how to alleviate it."

LYN COWAN **Personal care worker with Bolton Clarke Residential Aged Care** **Statement 31 March 2021, tab 226, page 12114**		
A1. Sensing contexts or situations	112	What I have learned is that there is often a reason for behaviour. It may be their condition, their medication or a particular trigger. Sometimes a client needs rest and sometimes they want to be left alone. Regardless of the reason, I always try to avoid anything that can trigger a client into doing things that would make both my life and theirs difficult. I do this by getting to know my clients and their triggers and tailoring my communication and conduct to avoid triggers.
A3. Judging impacts	68	Being alert to even subtle changes to how a client is feeling, both mentally and physically, is an ongoing part of my role.
	69	I spend a great deal of time speaking to clients to ensure that their care plan is appropriate. I start with talking to them, and, most importantly listen for any changes in complaints that seem to be new or serious. For example, on one particular occasion I had a client who was complaining of fatigue. I had to assess the problem by speaking to him and listening to changes in his routine. As a PCW we have to be alert to even subtle changes in our clients, as the change may be a symptom of a bigger underlying health problem. This might trigger a change to a care plan.
	70	At times, clients are not as forthcoming or able to convey how they are feeling. In these circumstances I have to rely on careful observations to detect any changes in body language or behaviour that may indicate that they are in pain or discomfort.
	71	For example, some seniors can be observed having difficulty climbing stairs, which can be a sign of poor balance, grip strength or a deterioration in their condition. Other clients may present with bruises, which in most cases has been caused by an injury or fall.
	85	While I am bathing and dressing her, I am observing and assessing her mental and physical health. I do this by listening to her and observing her facial expressions. For example, I know if she is sad, disgusted or surprised when her lip, cheeks or eyebrows are raised.
B1. Negotiating boundaries	113	"… on one occasion, I entered a resident's home to find him naked on the couch. He was touching himself inappropriately and said something inappropriate. I did not react by replying to his comment, walking away or yelling. I remained calm and tried to distract from his action by changing the conversation.
B2. Communicating verbally and non-verbally	76	When I get to a client's residence, I will offer them a smile and a greeting. If I haven't met them before, I will introduce myself. I will then ask them a few a few basic questions, like whether they have slept well or if they have eaten. I try to always be respectful and maintain eye contact when speaking to a client. I am also careful to remain respectful of hearing challenges the resident might have and try to speak slowly and clearly, using short sentences.
	77-78	Some of the residents I visit are extremely lonely … Spending a few moments to have a conversation with these clients is often enough to put a smile on their face. Sometimes, I can sit down with residents while they recall people in photographs or play music that has a special meaning in their life. Spending time with residents is one important aspect of my role.
	30 **Reply 19 April 2022**, tab 227 page 12256	Re COVID-19: "It is hard enough having to communicate with clients who have difficulties communicating, but it becomes near to impossible with all the additional PPE. I have had to learn to use nonverbal cues or behaviours to communicate with clients, especially with those clients who lip read.

B3. Working with diverse people and communities	94	I will always consult the care plan, talk to them, engage with them and observe the client to identify any religious and cultural preferences they have, to assist me in providing culturally sensitive care. For example, I have a Filipino client who typically follows the tradition of removing shoes before entering the house.

ALISON LEE CURRY **AIN at Warrigal Mt Terry** **Statement of 30 March 2021, tab 204, page 11664**		
A1. Sensing contexts or situations	55(v)	Re dealing with a deceased resident immediately after death, with a view to family members visiting: "We try to be true to the person that the resident was. If they loved cats, we'll put some stuffed cats with them. If they loved a particular flower, I have run out to pick those particular flowers, if they wore make-up, we apply makeup.
	90 **Reply** 20 April 2022, tab 205, page 11701	New starters need to learn the residents' clinical needs, such as their dietary requirements, incontinence, mobility and the specific care they need at different times of the day, in addition to their personal preferences, personality traits and communication styles and past history (e.g. if they served in a war, the resident could be experiencing past trauma so the new starter needs to understand signs to look out for).
A2. Monitoring and guiding reactions	42	We check if their fluid diet is correct and is at the correct thickness for the resident as otherwise they may aspirate or choke. We also assist residents who can feed themselves by fully setting food up in front of them, applying a clothing protector and cutting up their food and positioning them in the correct position to for them to eat safely. I have come to know what each resident needs (and prefers) by observing them over the time they have been on the ward.
A3. Judging impacts	74	Following the death of a resident, we watch for changes in behaviour [of other residents]. If a resident is becoming isolated, depressed, has a change in mood, suicidal thoughts and self-harm, staff are quick to react, and appropriate support avenues will be sought for that person. For example, doctors may prescribe antidepressants, or the nurses and recreational activity officers may keep that person busy with various tasks to keep their mind off things. We have to watch out and advocate for this support.
B1. Negotiating boundaries	57	If the family are present at time of death we immediately offer our condolences . This means we are sometimes a witness to extreme emotional breakdowns and we then console to the best of our ability. We eventually are placed in a position of asking the family to kindly wait outside of the room so we can attend their beloved in a timely manner so they can then have some closure with them before they depart for the funeral home.
B3. Working with diverse people and communities	63-64	Individual residents will have religious or other requirements that need to be remembered and considered in the lead up to end of life and immediately afterwards … There may be particular rules about the gender of attendees. Usually that will be consistent with what they had arranged during their care, for washing and we will continue to respect that.
C1. Sequencing and combining activities	39	Extra incidents happen that take us away from our general work. This will include, for example, resident falls, aggression, a severe decline in health, assisting with a wound dressing, a transfer to hospital, family members that want your attention, a doctor visiting, finding a wandering exit-seeking resident and, sadly, the death of a resident.
	10 Reply Statement 20	When residents had COVID-19, they required more assistance than usual and would call us on their buzzers more frequently. This was an impossible task because we were frequently short staffed and there wasn't enough staff on to tend to everyone. We had to be more aware of any signs of a resident declining, as with COVID-19 older people can decline rapidly and we needed to be on top of this. We were run off our feet, very stressed and worried for our own safety and the residents' safety.

	April 2022, tab 205, page 11686	Even though we were short-staffed, we needed to make sure we were still doing our jobs properly. We had to try and figure out what was most urgent and most important just to keep people alive and cared for.
	71 **Reply**	The shift to person-centred care has had a major impact on the way we structure our shift. We have increased our quality of care to be more person-centred to accommodate the resident's choice. Whenever a resident wants to do something, we are expected to be there to provide assistance to them. We are to treat them as if they are effectively in their own home and making their own decisions about when they want to do something."
C3. Maintaining and/or restoring workflow	54	Re: end of life care: "The work involved is generally consistent to all carers. This is not an area of work that is provided for in formal training. It falls to more experienced carers like me to provide leadership, mentoring and guidance to junior carers.
	80 c **Reply**	When we are getting the resident ready for the day, we also communicate with the resident and have general conversations to get to know them better and find out their routine. We also ensure their environment is clean, their buzzer is working, they have fluid in reach, log any maintenance required, report or fix hazards and report any decline, pressure areas wounds, behaviours, mobility, incontinence and bowel information.

LINDA HARDMAN **AIN, Estia Health facility in Figtree.** **Statement of 29 October 2021, tab 263 at page 13265**		
A2. Monitoring and guiding reactions	52	Dementia and mental health issues also leads to wandering. Some residents wander into other residents' rooms, which can lead to conflict. Even if it does not, we spend time finding wandering residents and persuading them go back to their own room or in any event leave another resident's room. Sometimes we use strategies such as making a cup of tea, or finding an activity for the resident to undertake. At times I just have to make time to have a chat with the resident to reassure them or orientate them in time and place. This takes time, but it can prevent a resident becoming aggressive or intrusive into other residents' rooms.
A3. Judging impacts	22(a)	… AINs have and exercise the following skills in carrying out their work: … Observational skills. You have to know your residents very well, so that you know when they are off or something is up. I may not know all of the medical terminology, but by careful observation you can get a sense of when things are wrong and alert the ENs or RNs.
	22(b)	… AINs have and exercise the following skills in carrying out their work: … Recognising behaviours. Often, before a resident has problematic behaviours associated with mental illness or dementia, you can notice triggers or little changes in behaviour. It is important to recognise these sorts of things and report them to the RN.
	38	There is so much as an AIN that I need to be aware of when caring for a resident. For example, if I am showering someone I need see if there any change in their condition, they could be grimacing and therefore in pain. When residents are meant to eating, I need to see if they are eating. I need to make sure they're drinking water.
	51	With my experience, I am pretty good at recognising the kinds of triggers that will lead to behaviours, aggression, or abuse. But, despite all of my training and experience sometimes I do not see the warning signs. Sometimes, you just have to leave a resident's room because you can see that the resident is about to get aggressive. I always make sure the resident is safe before I leave. I then re-approach several times. I use strategies such as changing staff, to see if that makes a difference.
B3. Working with diverse people and communities	24	The diversity of residents has changed over time. There is an increase in residents from various cultural backgrounds. It can make it more difficult to communicate with the residents and rely on non-verbal cues and try to learn some of their language to understand their needs.
C1. Sequencing and combining activities	23	I also think that our ability to be adaptable and diplomatic has increased over the years I've worked in aged care. I think AINs have excellent time management and team skills because there are so many tasks that need to be finished in a shift.
C2. Interweaving your activities smoothly with those of others	36	Re documentation: There are a limited number of computer terminals. That means that you are competing with other workers for use of the terminal and you have to try to fit in when there is a chance to use it. If something happens when you're trying to complete your paperwork, which it often does (whether it is attending to a buzzer, assisting a resident with toileting, or something else), often someone else is using the terminal when you return, and even if not you have to log in again, and remember where you were up to.
C3. Maintaining and/or restoring workflow	74	For me to provide proper care means that I spend an extra five or ten minutes with residents. Sometimes they cry, and need a bit of TLC. That has to be done, but then it is harder to fit in all the other work.

SUZANNE CLAIRE HEWSON **EN** **Statement of 29 October 2021, tab 270, page 13417**		
A3. Judging impacts	29	I am constantly assessing the residents, looking at how much they are eating and drinking, and how they are interacting with other residents. I remain alert for any signs of deterioration or abnormal observations, and arrange for review by the RN or GP. I also rely on reports from the care staff as well.
B2. Communicating verbally and non-verbally	24(d)	The staff try to ensure that there is some levity in the day and that each resident feels valued. Even though we can only spend minimal time with them, we try to make it quality time.
C1. Sequencing and combining activities	21	I cannot recall the last time I completed a medication round without an interruption. There used to be a practice that nurses were not to be interrupted whilst undertaking a medication round to allow them to focus and avoid medication errors. Now, we are required to respond to multiple interruptions including call bells and phone calls.
C3. Maintaining and/or restoring workflow	23	Re dementia which presents significant aggression and violence in some residents: “Situations such as this are not unusual. They are very challenging to manage and the skills required to deal with them are often not taught. They are learned from experience and, if you are lucky, good mentoring from colleagues. I do my best to mentor my colleagues, but it is difficult in the limited time available.

CHRISTINE SPANGLER **AIN** **Statement of 29 October 2021, tab 257, page 13009**		
A2. Monitoring and guiding reactions	31	… if I am caring for a resident who I have known for a long time, I will be able to pick up if something is not right with them. I try to build rapport with the residents over time by learning what they like and learning their idiosyncrasies. We really get to know the residents, they become like extended family. We know what they want and what they need.
	32	For example, a certain resident I have likes a small blanket around her feet and another blanket on the top. She has three biscuits out so she can reach them in the night if she wants to, and she likes her call bell in the right spot so she can reach it. Another resident I have likes his dimmer light on, the curtains closed, his mobile phone not charging overnight and the door closed. He tells me the weather every day. He has a sound mind but cannot walk. Over time, you really get to know the person and what you need to do to meet their needs.
B2. Communicating verbally and non-verbally	24(i)	If a resident is really upset, one of us will sit with them and talk to them about their situation. Sometimes they are confused and this can be frightening for them.
C1. Sequencing and combining activities	27	Re person-centred care: “If we are assisting someone in the shower and another resident wants to get out of bed immediately, we simply cannot be in two places at the same time. But the other resident expects to be able to get out of bed when they want to. We just have to try to do our best.
C2. Interweaving your activities smoothly with those of others	22	It is very stressful when we are short staffed. It might be the other wing who is short staffed, so we have to help them do their round as well as our own. We are effectively trying to look after 60 people between us, including answering all the buzzers and making sure everyone gets the care they need.

VERONIQUE VINCENT **Home support worker with Regis Home Care in Mildura** **Statement of 28 October 2021, tab 255, page 12959**		
A1. Sensing contexts or situations	70	It takes time and patience to build trust and rapport with clients. It means talking to them and learning about their lives, finding things to connect over. Getting to know them properly is really important to be able to tell, from visit-to-visit, whether there has been any mental or cognitive decline.
A2. Monitoring and guiding reactions	66 (pp)–(qq)	Previously, I used to look after this client's wife for years, until she died. So, I have known him for many years too. He and his wife were pretty old fashioned. She would always set the table for meals with a tablecloth and so on. So, when I'm there, I set his table up in the same way with the tablecloth and cutlery. I also put some flowers on the table or, if his lemon tree is fruiting, collect some lemons in a bowl to put on the table … This is not something that is in his care plan or that I have to do, however I know he is more likely to actually eat if he is prompted with these visual cues.
A3. Judging impacts	53	With all our clients, we are required to always be on alert for any changes in health or behaviour. We have to be like detectives. We are always on the lookout for signs of dehydration and malnutrition, declines in health, cognitive declines, skin integrity issues, emotional fluctuations, and so on. If we don't pick up on these things, they could go unnoticed and lead to serious problems for our clients, particularly those who don't have much family support around or are socially isolated. This is a very important part of our job which requires us to really get to know our clients, and to build trust and rapport with them.
	71	For example, I attended a client once for a regular service. He had an ever so slight droop in his eye. This was very subtle, but because I knew him well and for a long time, it was something I could pick up straight away. I immediately knew something was not right and called an ambulance for him. This was fortunate, as it turned out he was in the early stages of having a stroke at that time.
B2. Communicating verbally and non-verbally	66 (ee)–(ff)	This client has breast cancer, which she's currently receiving treatment for. Because of her treatment, and because she is so isolated and distanced from her family, she has 'nasty days' where she can be quite crabby with me. I'll say to her 'you're not having a good day today love'. The other day I visited her, and she was in a very down mood. I generally try to lift her up as best I can while I'm there … She has come to trust me over time, which is good. She asks me to have a look at things on her body including in intimate areas like her bottom if she's worried about something.
B3. Working with diverse people and communities	66(p)	This client can be a little suspicious with some carers, however she connects with me because I know a bit of Italian and use that to speak to her.
C3. Maintaining and/or restoring workflow	66(d)	I then come in and try to have time for a little chat with the wife. She has the signs of early dementia–memory loss, and the like. Her family haven't yet formally put her through the diagnosis process because it is very upsetting for her. However, she is showing signs of decline. She thinks she knows me from years ago (which she doesn't), so I try and make sure I give her a little bit more attention.
	66 (w–x)	With this client, I always try to allow a few minutes to talk to his wife at this service, as it is clear to me, she has carer's burnout … So, it is not just the client we are looking after, it's their family members too. We become their emotional go-to person, the person they are going to seek out as someone to talk to or a shoulder to cry on … This client's wife appreciates a chat and often asks me for advice. She'll often tell me about problems she's having, and I try to give her advice on how to make

		things easier for her husband to be at home. For example, putting red dots on the doors so he knows to open them.
	66 (hh)	I usually stay longer with this client than my 30 minutes allows, particularly as I am concerned about meeting her emotional needs because she is on her own.
	66 (uu)	While I'm doing that, I have a chat to him–usually about what the neighbourhood cat has been up to–and use that to assess how he's going and whether he seems to be doing alright.

KRISTY LOUISE YOUD **Aged-care employee with Masonic Care Tasmania** **Statement of 24 March 2021, tab 216, page 11976**		
A2. Monitoring and guiding reactions	55	On the odd occasion, she might start getting a bit crabby with me. I deploy the tactic of leaving the room to allow her to calm down. One of the residents is very hard to understand at times. It gives you a bit more patience, because you need to sit there and really listen when he talks so that you understand his needs but also so that he feels that he is being heard and engaged with.
	78	"… usually I manage clients who are physically and verbally aggressive by adopting the following strategies: (a) Getting to know them and building a relationship of trust; (b) Understanding what will triggers them and trying to avoid those triggers; (c) Treating them with dignity and respect; (d) Speaking calmly when they get aggressive; (e) Understanding what each resident needs if their conduct is escalating (this could include removing ourselves from the room, let them calm down and then approach later); (f) Implementing a strategies tailored to each individual to de-escalate.
B3. Working with diverse people and communities	54	There is an [redacted] lady who has had a stroke and has only basic English. We use a little flip book to communicate with her- for example- it has pictures in it like a picture of a drink. We can figure out what she wants by using the book, on most occasions.
C2. Interweaving your activities smoothly with those of others	79	Some residents prefer to be attended by males and some by females so if that is an issue, we will approach someone in the team and ask them to go to that person. We have a new system where we put a pinky-red sticker if the resident prefers women, a blue sticker if they prefer male carers and no sticker if they don't mind. Most of the time we can only do our best in this regard because it is impossible to accommodate at all times.
C3. Maintaining and/or restoring workflow	50	A lot of the issues come back to loneliness, but we don't have the time to sit there and have a long chat with them. I wish we did. I always try and talk to them while I am performing my tasks but I have to prioritise getting all of the work done and I simply do not have time to spend with residents if I am not attending to their direct care needs.

PAUL REGINALD JONES **Care services employee United Protestant Association in Casino** **Statement of 1 April 2021, tab 232, page 12316**		
A3. Judging impacts	13	Accordingly, in order to get a sense of what their needs might be, often I am required to engage with them on a subtler level, including observing their body language, non-verbal signs such as grimacing and groaning, as well observing physical changes in their bodies
	16	Discussing dementia "The only way I am able to assess whether a care plan is up to date, or accurately reflects a resident's health care needs, is by carefully observing a resident's behaviour, what triggers their behaviour and any changes that may arise over time.
	41	Discussing the need for changes to a care plan - "This requires me to be aware of the subtle and often unnoticed signs of deterioration in somebody's health. I have learnt what to look out for, over time.
B1. Negotiating boundaries	24	Providing emotional support to residents is an important part of my job and I take this aspect of my role very seriously. I know that if I talk to every resident about their day, I won't get time to administer the medications within the timeframe, so I have learnt to engage and then politely end conversations relatively quickly during this time, with particular care not to agitate or upset the residents.
B2. Communicating verbally and non-verbally	43 - 47	(communication skills) including–at [46] "One of the techniques I have learnt in developing trust and good communication with the residents I look after in the dementia ward, is to use the resident's maiden name when talking to them. An effect of dementia is that while residents have trouble remembering recent events, their long-term memory is usually still intact. I have found that using maiden names makes residents in the dementia ward feel more at ease, and they are usually more responsive as a result. At my suggestion, female residents' maiden names are now included in their Care Plan.
	12 **Reply** of 20 April	Strategies engaged to overcome challenges of communicating with residents during COVID and wearing full PPE.

BRIDGET NICOLA PAYTON **Personal care assistant with SAI Home Care** **Statement of 26 October 2021, tab 253, page 12933**		
B1. Negotiating boundaries	80	Where she observed new symptom in a client "While it was outside the scope of the support I was meant to provide this client, I took it on myself to call her doctor and make an appointment, went to the appointment with her, accompanied her to specialists, made notes for her and chased up the hospital to try and get test results for her because if I didn't do it, I knew no one would. In the end, my client was diagnosed with an ulcer and needed special medication.
B2. Communicating verbally and non-verbally	83	I attended the home to find my client's wife and son there trying to get him to undress and have a shower. The client was refusing to move and lashing out at his wife and son, who had both become distraught. I had to go in and counsel the family and calm them down so that I could then sit with my client and gently talk to him and get him onside. After some time, he allowed me to undress him and get him into the shower and take a look at his feet.

TERESA EILEEN HEENAN **Home care employee with Warramunda Village** **Statement of 20 October 2021, tab 250, page 12875**		
A2. Monitoring and guiding reactions	72	He is the type of client that will let you do everything for him if he could. However, I am committed to the purpose of my work which is to enable the independence of elderly people in their homes as long as possible. So, I try to encourage him to do things for himself or to do things with me. He will say he can't do things, but I say to him 'come on, you know you can do this.
	79	It has taken a lot of patience and dedication to get this client to this point.
	80	When I arrive at this client, I prompt him to get up and moving. I get the things ready for his wash and encourage him to get his clean clothes ready. Once he is washed and dressed, I prompt him to have a shave and clean his teeth. Often, I use humour with him and say, 'come on, old bossy pants is here.
A3. Judging impacts	94	With respect to a faulty safety device "I was conscious that it was quite dangerous for him for the safety alert to not be working properly–if he needed to use it but couldn't hear or understand what was being said to him on the other line, that could be life and death. So, there was some urgency in getting it fixed. Us carers really become the advocates for our clients in these kinds of situations. If it wasn't for me taking it up for him, the device might never have been fixed or it might have taken even longer for that to occur.
	98	I have to know my clients well enough to be able to judge, for example, whether a client's low mood or energy is the result of just a bad day, or part of a pattern of behaviour that is more concerning. I have to develop strategies that are both sensitive to a client's mood (mental health) as well as adapted to looking after their wellbeing (physical health).

DONNA KELLY **Extended Care Assistant with Baptcare at the Baptcare Karingal Community Care (Karingal) in Devenport Tasmania.** **Statement of 31 March 2021, tab 210, page 11864**		
C3. Maintaining and/or restoring workflow	21 (tt)	Sometimes all of the work just cannot be done given the needs of residents, and management just has an unrealistic expectation of what we can achieve in a shift. I need to prioritise my work in order to provide the best possible care to as many residents as possible.
	35	We have to be careful not to invade a resident's space and always be on a cautious level of awareness. When I am dealing with someone with a behavioural issue, I put my arm in front so I can easily block an attack. Simultaneously I am trying to de-escalate the situation.”

CATHERINE ELIZABETH GOH **Home carer at Brightwater Care Group** **Statement of 13 October 2021,** **tab 278at page 13493**		
B1. Negotiating boundaries	24	Families don't always understand and there isn't always good communication. One family member wants things done one way and another wants it another way. It is difficult to negotiate those relationships.

KAREN ELIZABETH ROE **Home Support Team Member at The Benevolent Society** **Statement of 30 September 2021, tab 279 at page 13508**		
A1. Sensing contexts or situations	13	You also have to be aware of the surroundings, and how the client is on any particular day. You need to judge how much support is needed. When I come in, I have to ask lots of questions, like, how do you feel, do you have a cough, have you had any visitors and other COVID related questions. Is she feeling strong enough to stand on her legs and come out to the back to have her shower? If not, I have to judge whether to talk her into it or whether this is a time to let her be and do a sit shower in her chair.
A2. Monitoring and guiding reactions	24	You also need really developed social skills. It is not just care, it's also about being aware and exercising judgment. When I walk into someone's house, I can be anything they want me to be. I can be a listener, a talker, I can tell stories, be your sister, aunt, mother. I want them to be comfortable. I will laugh at their jokes although I heard them half an hour before because that's what makes them comfortable.
A3. Judging impacts	22	Clients with dementia pose particular complications. Everyone can be different in a day with dementia. You can visit someone you had a wonderful time with yesterday but the wind has turned or they have a urinary tract infection and they are angry at you or upset because their mother (who died years ago) is not home. It can all change very quickly. You think you've got a handle on it, but you have to be adept at judging the changing situations quickly.
B1. Negotiating boundaries	12	You always have to be observing your clients and their needs. I've been agitating on behalf of one client to get the door on her shower taken off. She refused to sit down in shower because couldn't get up. If she falls into the shower with a door, would have to break it to get her out. It has finally been done, after 6 months.

LISA BAYRAM **RN Grossard Court, Cowes** **Statement of 29 October 2021, tab 262, page 13226**		
A1. Sensing contexts or situations	66	… In aged care we need to deal with loss and grief more regularly and that is both a skill and a burden for staff. In aged care we also need to form relationships with residents because they are there for a relatively long time–to understand their interests, their families, their emotional needs…
A2. Monitoring and guiding reactions	80	One of the biggest issues we all face at Grossard Court is the advanced care planning and critical incident management and trying to get the balance right between the rights of the resident and doing the best by them clinically. For example, someone may have end stage dementia and have specified in their advanced care plan that they don't want to go to hospital. However, if they then have a fall and have a considerable injury, what do we do? These are difficult decisions but, unfortunately, the resources available to me at the time will often dictate the outcome rather than the resident's wishes. You have to try to manage the expectations of the family, the decisions of the resident, the risk assessment (clinically) as to whether to send them to hospital and what resources we have to manage them if they are kept in the facility. This can be a no-win situation. Whatever decision is made is never optimal. The skills of building trust with the family and good communication are essential. A key role is to try and help the family make good decisions at critical times, usually when there is a lot of stress present.
	82	Working out what information residents and their families want also requires significant skill. Some people want all the available information. Others want you to make the decisions. My role is often to work out what information people want and in how much detail. This is a balancing act because it is essential to be honest and acknowledge when things go wrong. Good communication involves building trust. This takes time, speaking with families, phone calls and meetings. Sometimes it means giving recommendations, asking questions. Sometimes it involves knowing to say nothing at all.
B1. Negotiating boundaries	68	In my role as an RN, team leader and AHC, I have to manage staff, including any reports in relation to medication errors or poor behaviour. I may need to deescalate conflict between staff and counsel them to get a return to a decent working relationship. I'm responsible for the whole facility on the PM shift.
	85	I try and advocate for better resources. For example, I tried to advocate around access to doctors. I have also been advocating for better palliative care management - trying to get a better palliative care tool that we have trailed but we are not currently allowed to use. I am also advocating for better staffing.
B2. Communicating verbally and non-verbally		[Same as A2 para 80–82]
C1. Sequencing and combining activities	38	[after describing action taken to deal with incidents in the facility] "As a result, my ordinary routine often gets put off while I deal with important issues.

VIRGINIA MASHFORD **Statement dated 6 May 2022, tab 271, page 13425**		
A1. Sensing contexts or situations	37 (a)	I understand how I fit into my working environment with regard to being part of a team of people who work both independently and together.
	37 (d)	I work to understand the needs of the residents who I work for and with. This is multi levelled. It requires me to be able to talk to a resident who is uncomfortable or unhappy and be able to articulate this for them. I need to identify their needs and help them with this. Sometimes it might just be a person feeling bad about something and they need someone to sit with them and listen.
A2. Monitoring and guiding reactions	36 (e)	discussing the provision of care to residents with dementia “There are also some behavioural issues and these residents can be difficult to manage. Being able to disengage in a kind and compassionate way can be difficult and requires particular skill.
A3. Judging impacts	37 (c)	I look at my own work performance and understand how these impacts on others. If I go into work and am not feeling bright, I have to leave that at the front door. I need to be positive in the workplace. I need to be engaged and present in the workplace.
C1. Sequencing and combining activities	26	What I do and how I do things changes from one shift to the next is dependent on lots of things, such as how many staff are on, how settled the residents are and what is happening in the nursing home on any given day/time. There is a basic routine, but it requires judgement, time management and good communication to work out the shift as well as the ability to readjust to changing staffing and work needs…

DIANNE POWER **Statement dated 29 October 2021, tab 258, page 13102**		
A1. Sensing contexts or situations	20	The percentage of residents who require assistance with mobility changes all the time. As their needs change, I need to adjust how I work and what I do.
A2. Monitoring and guiding reactions	46	Discussing dementia residents and sundowning "I need to be aware of what triggers their behaviour. Triggers can be anything, for example, trying to change clothes if they are soiled can lead to residents resisting, hitting out, screaming, and trying to flee.
B2. Communicating verbally and non-verbally	43	In relation to pain management generally, in order to do my job, and for resident safety and wellbeing, I need to observe residents' behaviour, their facial expressions, and note if they become resistive to movement, e.g., showering, and report this to RN, as all these things can indicate the resident is in pain.
B3. Working with diverse people and communities	63	Responding to diverse residents and their different cultural, emotional, and social needs is definitely a part of my job. We have Aboriginal residents, residents who are old diggers, residents who can't speak English. Lots of residents who have English as their second language go back to their first language if they have dementia. I need to be aware of different cultures and customs and ways of treating family.
C3. Maintaining and/or restoring workflow	67	… When buzzers go off, AINs must respond. If I am showering someone or toileting or transferring a resident and I cannot leave my current resident, it is very stressful, I have to leave my resident hurriedly to attend the buzzer. If there is an incident, the RN has to be found and help provided, all the while trying to attend to the cares of other residents needing toileting, changing, feeding etc. At times if there are numerous buzzers going off at once, the decision as to which resident is seen and who has to wait to have their needs met is again stressful. It is terrible to have residents wetting themselves or dirtying themselves because I took too long to get to them, it is undignified for the resident and is more work to clean up

PATRICIA MCLEAN **Statement dated 9 May 2022, tab 265, page 13303**		
A1. Sensing contexts or situations	40(i)	Where I noticed that a client's health and wellbeing was suffering because a family member or unpaid carer living with and supporting the client was not supported, I sometimes took steps to arrange more support for the family member or unpaid carers.
	42	Dementia care now involves looking at life from the perspective of the person with dementia to work out what makes them the individual that they are so that they can be treated with dignity and respect.
A2. Monitoring and guiding reactions	93	Working for Blue Care, I would engage in behaviour management of clients, particularly of those not wanting to interact with people, those who have little or no trust of others generally, and those who were verbally inappropriate by saying things to me like "buggar off" or swearing. The objective of my behaviour management was to reduce their stress levels, reassure them and practice other conflict resolution techniques so that they were able to receive the care they needed.
	PM2	Critical Job Demands Analysis. Overall Psychological Demand Level of the Role, p 5–identifies "frequent" occurrence of "High level of conflict resolution and negotiation required when working with clients who can display aggressive behaviours, maintaining a professional manner throughout.
A3. Judging impacts	117	In my work at Blue Care, some family members would ask me to discuss the client's medical status and interventions with them rather than with the client. I would need to make a judgement about whether I should discuss that request, depending on whether the relevant family member has a Power of Attorney for the client, whether the client has told me not to discuss their health or particulars with family members, and what I was aware of about the relationship between the client and the relevant family members and also the clients cognitive status.
B2. Communicating verbally and non-verbally	65	I have cared for aged care residents and community care clients from diverse cultural and linguistic backgrounds, including many Italian and Chinese clients, a few indigenous clients, gay men, transsexual and queer clients, men and women…
	66	Where a client did not speak English, sometimes a family member would assist in translation. If no one was present to translate, I would communicate with them in very simple English and worked to understand their broken English.
	67	I have had deaf clients and blind clients that I found ways to communicate with them.
	68	The need for me to respond to cultural, emotional, social, and psychological needs of residents and clients has always been part of my job, but it increased, especially in recent years.
B3. Working with diverse people and communities		[Same as B2 para 65–68]
C1. Sequencing and combining activities	76	Time management was a challenge when I began community nursing but I developed time management skills. I learnt how to focus on more than one activity simultaneously, such as listening to a client, often talking about matters unrelated to the treatment I was to administer in that visit, and talk to the client, while doing clinical work with them, like changing their wound dressing or their catheter…
C3. Maintaining and/or restoring workflow	63	I have much less time to do everyday nursing tasks that I did when I started at Blue Care. I have much less time to talk to clients, which is necessary to build rapport and trust. I used to have much more mentoring and training from RNs than I did when I finished at Blue Care. I would sometimes shorten my meal breaks to avoid

		clients missing out on necessary care. I worked outside my rostered paid time to complete clinical records and read / respond to work emails.

SHERREE GAI CLARKE **Statement dated 29 October 2021, tab 268, page 13365**		
A1. Sensing contexts or situations	32	I do a safety check of the residents, to see how they are, if they are in bed, or if they have got up and wandered from their rooms. Some residents have sexualised behaviour. I have observed one resident sexually assault a female resident so I make sure I know where the female residents are and that they are safe.
A2. Monitoring and guiding reactions	44	At Opal, all AINs at must have a certificate III. However, some new staff sometimes have very little experience in aged care. This requires them to step up very quickly to understand the needs of residents, as well as by developing technical skills. AINs are directly involved in recognising needs of residents. We are trusted by residents, and they rely on us for so much.
B3. Working with diverse people and communities	47	I work as part of a nursing team. This means that I am never solely responsible for specific residents. As a team, we are together responsible for all residents. In a nursing team it is essential that I know other AINs have my back. I make sure that I have the back of my co-workers. For example, some residents are sometimes abusive or racist towards my co-workers. When this happens, I feel that I have a responsibility to assist the resident but also support my co-worker.
	69	In addition to providing care to residents from diverse backgrounds (see [68]), Ms Clarks says "In my work at Morayfield Grove, I have organised cultural days. These included Philippines Independence Day, given the high portion of staff from the Philippines. I also helped organise a celebration for Diwali, celebrating my Indian, Nepalese and Fijian Indian co-workers.
C1. Sequencing and combining activities	34	The residents in the MSU generally do not have set routines. When working with other residents outside the MSU, timing is much more dependent upon resident preference. In the MSU I prioritise those that are up and about and deal with others later.
C3. Maintaining and/or restoring workflow	67	As an AIN I now analyse more information because there are less RNs on the floor. I receive information and feedback from residents. Based on that information I work out priorities, for example, what can be put off, when the RN needs to be called, how best to deal with families.

MAREE BERNOTH **Statement dated 29 October 2021, tab 264, page 13276**		
A3. Judging impacts	39	Discussing palliative care "… Palliative care involves managing symptoms, balancing competing care needs, interacting with families and challenging communication. In managing symptoms, first you have to identify the symptoms. This can be complex for someone with dementia for example. Then, you have to communicate that need and get it addressed. In acute care and in community care we have specialist palliative care teams with years of experience. This is a highly specialised area and very time-consuming work. In residential care facilities staff are required to deal with palliative care on a regular basis without the necessary specialised training and resources.
	54	We now have more residents in aged care facilities from culturally and linguistically diverse backgrounds. The use of aged care facilities by first nations people is increasing. This causes challenges in providing adequate care and takes extra time. With this diversity there is also requirement for the staff to be culturally aware and culturally safe. Things like food and respect for religious feasts present additional challenges. This is another requirement, another skills set staff have to develop.

STEVEN ANDREW VOOGT **Statement of 29 October 2021— tab 269 page 13391**		
A1. Sensing contexts or situations	41	Another issue I have noticed is the consequence of the difficulty getting some GPs to provide appropriate levels of care as discussed above. One result of this, is that facilities are left with the RNs and ENs trying to diagnose and manage behaviour. For example, RNs and ENs are required to figure out if behavioural issues have their genesis in an acute physical issue or pain. This occurs where the RNs may have three or four other residents in the same boat. This takes significant time and still the RN may have to manage the needs of another 60 or 70 residents as well as manage the staff around them.
	47	It is a real struggle for nurses and carers to provide psychological support for them and their families–often with absolutely no extra resources. The ACQSC has promoted advanced care planning (ACP) and most residents choose to stay in the facility for their final weeks–it falls back on the facility to do all of this. The nurses are the ones on PM and night shift who have to make a call on what to do. Many of the GPs simply aren't available to attend the facility or provide an adequate resource for out of hours care.
	52	I have also noticed increased expectations of PCAs around their observation of residents. PCAs are now expected to observe residents, recognise and report deterioration and be able to articulate it to the RN/EN. They are expected to be involved in giving out medications. They are no longer there just to do personal care "tasks". More and more they are expected to make judgements.
	48	The Advanced Care Plan may say that the resident is not for hospital transfer but at 2am when the resident takes a turn for the worse what does the RN do? If they keep them in the facility the family may complain because there aren't the staff or resources to manage the resident effectively. If they send them to hospital, it is a breach of the ACP and the family may complain. Where an ACP says that the resident is not for transfer to an acute hospital that this may be further complicated where family members are consulted about this and give a direction that is contrary to the ACP. It is not black and white and involves difficult choices between what is best clinically for the resident and what the resident says they wanted at the time they completed the advanced care plan.
	58	The time, resources and skills associated with managing residents with complex behaviours and to provide high level quality of life for residents in aged care has dramatically increased over recent years. Staff are expected to be highly skilled in management of behaviour complexities.
A2. Monitoring and guiding reactions		[Same as A1 para 52] [Same as A1 para 58]
	PN9362 **Oral evidence—9 May 2022**	If I was the resident, they're competent to observe that I'm less talkative today or more sleepy, but then - - -?---Yes, exactly, and they might feel hot.
	PN9363	Or they might feel hot?---Yes, and so it's within their scope. They might then decide–they might maybe point it directly to the RN or the EN, or they may decide to do some vital signs.
A3. Judging impacts		[Same as A1 para 47]

		[Same as A1 para 48] [Same as A1 para 58] [Same as A2 para PN9362] [Same as A2 para PN9363]
B1. Negotiating boundaries	60	I have also noticed that communication with cognitively impaired residents is a growing problem. Understanding what residents want and need is crucial to preventing behaviours that may be a risk to them or others or which simply make them distressed. That is added stress for staff in not being able to understand clearly what a resident wants or how much pain they are in. I've also witnessed a lot of racism from the residents towards staff which those staff members have to deal with without much support in many cases.
B2. Communicating verbally and non-verbally		[Same as B1 para 60]
B3. Working with diverse people and communities	46	… An example is the standard which requires the recognition and provision of culturally diverse services. For example, at Bentley Wood in Myrtleford there are a lot of people of Italian heritage, so they look to cater for their needs through Italian cuisine and language. At Monash Health where I'm working on a short-term contract there are over 10 nationalities, and the standard says there is a need to recognise each of them. It is extremely difficult to do that for staff, especially given the resource envelope they have.
		[Same as B1 para 60]
C2. Interweaving your activities smoothly with those of others	PN9325 **Oral evidence—9 May 2022** **PN9271**	So the RN is making a decision as to whether or not they need further assistance in the diagnosis of what's going on, and you would step in and play that role?---Yes, I think the RN would refer to me if they feel as though the issue needs to be escalated, if they feel the resident is in any danger or is becoming unwell.
	PN9326	Okay. And absent having you, I take it that the RN would escalate it to a GP?---Yes. Yes, if that's often they'll ring me. If that's between the hours of 9 to 5, as I was just saying to Mr McKenna, there's quite a few practices now not offering an on-call service at all, so, they would - out of hours they would be relying on a telephone service like My Emergency Care or sending the resident to an emergency department.

HAZEL BUCHER **Statement of 29 October 2021— tab 259, page 13117**		
A1. Sensing contexts or situations	28	The skills I use in my work day to day are predominantly highly developed communication skills, assessment skills, critical reasoning and mentoring skills. I provide informal education most of the time by encouraging clinical reasoning and critical thinking whilst mentoring.
	38	The care plans that are required to be written are lengthy, and whilst evidencing resident choice they are also directed to ACFI requirements. Resident care plans provide evidence to the ACQSC that we know our residents well however, day to day care staff rely on verbal reports and knowing the resident and needs are communicated through mentoring for new staff . Thus generally, care staff rely on verbal instructions and asking questions/mentoring
A2. Monitoring and guiding reactions	48	Palliative care takes time, experience and skill. It requires calm unhurried discussions with families and the residents to work through expectations, fears and desires, so death can be peaceful and grief uncomplicated. Both formal learnt and informal skills and experience are required. In my experience there is a significant increase in palliative care provided in RACFs compared to ten years ago, when more frequent transfer to hospital occurred for palliative care and pain relief.
A3. Judging impacts	31	The nature of work within RACFs has become more stressful over the approximately ten years in which I have been engaged in the sector. There are many competing priorities creating a home like environment but providing clinical grade service is challenging. Navigating the fine line between allowing the resident to steer the course of their day versus what is clinically better resulting in a healthier outcomes and improved quality of life is challenging. When the motivation to get up and have a shower is lost, and seeing the need for one less evident as dementia progresses, staying as engaged as possible to maintain strength and communication skills requires gentle persistence and energy from nursing and care staff. Supervising the staff and understanding the resident has become more important whilst attending to clinical tasks takes time with increased documentation to evidence the care being provided.
		[Same as A2 para 48]
B1. Negotiating boundaries		[Same as A1 para 28] [Same as A3 para 31]
	41	Family members with pre-existing mental health illnesses such as anxiety can be challenging to manage for the RNs as at times phone calls can be abusive and difficult to end. Over time interactions with families has become more frequent, with expectations and a need to provide feed back to and consultation with families increasing.
		[Same as A2 para 48]
B2. Communicating verbally and non-verbally		[Same as A1 para 38] [Same as A2 para 48]
B3. Working with diverse people and communities	23	… Many younger RN's from Non-English speaking backgrounds require further education both theory and practice for the aged care setting. …
	33	Supporting very new and clinically inexperienced RN's to develop and become empowered and productive isn't easy particularly with language barriers and cultural differences of overseas staff. This responsibility falls on a daily basis to more senior RNs.
	40	In the SCC Tas RACFs we have a mix of Australian, English and Culturally and Linguistically Diverse (CALD) residents mostly from European backgrounds, having moved to Australia after the Second World War–Hungarian, Greek; there are a few Asian residents who are younger with health issues. Equally there are substantial numbers of staff for

		whom English is a second language. Communication difficulties between residents and staff are not infrequently a source of frustration for both.
C1. Sequencing and combining activities	21	For example a RN may have concerns about a resident with a wound and the way it is tracking. I will review the resident's overall health status in collaboration with the RN looking at such matters as diet, oxygen levels, and options for dressings. In the event of an infection I will advise in relation to contacting the GP and advice to the resident's family. If I have a collaborative agreement in place I will manage the infection informing the GP, providing timely health outcomes for the resident.
C2. Interweaving your activities smoothly with those of others		[Same as C1 para 21] [Same as A1 para 38]

VIRGINIA ELLIS **Statement of 28 March 2021— tab 191, page 11528**		
A1. Sensing contexts or situations	34(d)	While bathing and dressing residents I look for skin integrity, excoriations, bruising and any spot where touching might hurt them (for example, they might flinch). You need to look for the physical signs of discomfort or underlying medical issues at all times as most dementia patients won't tell you there is any issue.
	35	One of the most important things I had to do in the Dementia Ward was to get to k now the patients and learn what triggers them. Somebody might be sitting quietly and someone else might come up into their personal space and you need to be aware that this might trigger distress or an angry or violent outburst. I needed to learn how to handle situations like this.
	36	Getting to know the residents and what triggered them allowed me to tailor all of my interactions to each person and adopt new approaches. Often, I would sit down and have a chat with them before I was going to do something (such as medication or personal care) and explain how I was going to help them in simple terms. This would help to prevent a violent outburst.
	37	We just come up with a new strategy for each person. We just can't agitate them or force them to do something that they don't want to do. As another example, we had this lady who didn't want to take her tablet, so I put some jam around it and told her it was something special from the kitchen and she took it straight away.
	42	As part of my role I was constantly trying to identify areas of opportunity to make residents' lives better. An example of this is that I had black toilet seats installed in the ward. I got nominated for an award for that. My thought process was that it would be less frightening and sterile for residents. It worked like a charm and it helped residents sit down easier because they were less anxious about going to the bathroom. This had flow on effects for the rest of the day as residents were less anxious and more calm. This helped them and also helped the day run smoothly.
	83	While I am attending to the personal care of residents I am constantly assessing their health, their skin integrity and any sensitivity or physical manifestation that might indicate that they have a medical issue.
	84	One example that happened recently was that we had a resident who couldn't really talk. She had blisters on her that the RN had looked at and prescribed treatment for. I was tracking her recovery and she wasn't improving despite the treatment so I called in the RN in and said to her words to the effect of "Are you sure this isn't shingles?". She agreed that it was. The lady would have been in a lot of pain.
	93	NoTea1ing or changed eating can also be an indication that there is a health issue so I will track any pattern of different eating and raise it with the RN if I think it is a problem.
	29	In relation to their physical health we had to observe their health closely, looking for any sign of deterioration that warranted different medical interventions. We did this four-hourly (including testing their temperature and oxygen). This was time consuming as was keeping all of the charts, notes and observations regarding their health. I had to prioritise what not to do with other residents as we were short staffed.
A2. Monitoring and guiding reactions	34(g)	While I was doing all of this I would try my best not to upset them. I would do this by talking in a way that suited each resident and by treating them in the way I knew would be least likely to upset them.
	34(h)	Some residents would get upset if they didn't have makeup on or their bed made before we left the room so I would do this for those residents. I would just assess their

		emotional needs and try and meet them and also attend to their physical needs
	34(j)	We would try and meet people's food preferences as this helps with their conduct. For example, some people liked finger food and nothing else, or some liked all their food in a bowl. Some people like to eat in their room because they dribble. One lady liked BBQ sauce on everything - whatever it was. But we gave it to them because that's what they wanted. We just tried to keep them happy.
		[Same as A1 para 35]
		[Same as A1 para 36]
		[Same as A1 para 37]
		[Same as A1 para 42]
	81	Generally, you need to adapt your approach to the resident. For example, some people are quite contracted in their knees and arms. This might mean that you need to contact families to get clothes that are cut down the middle so you can just put the resident's through them.
	59	We just needed to remain calm and be clear and direct. I had to listen and display empathy and compassion even in the face of great illness or great aggression. I developed better communication skills with the need to be supportive and listen.
		[Same as A1 para 85]
		[Same as A1 para 93]
	98	At Uniting, the food I prepare is tailored to individual residents. I make sure that I talk to them and get an understanding of what they can't eat because of allergies or intolerances but I also make sure I find out what they like to eat and how they like to eat it. For example has the skin off her tomatoes and eggs, the crust off her toast, a cup of tea which must have the Lipton Tea Bag left in and Sultana Bran with milk. will have fried eggs on toast.
	99	Since she's started getting frailer, gets Vanilla Sustagen in her porridge. I have observed that if it's hot and sweet she'll eat it. If I didn't tailor the food to her needs then I am concerned that her health would be compromised as she would stop eating. also likes a cup of tea but as she is getting frailer I have had to keep _____ find smaller and smaller cups as she can't lift a normal cup or mug. Sometimes other staff leave large cups in her room so I remind them of needs and health issues.
	28	These two residents were very stressed and upset while unwell with COVID. Care staff had to be very patient and use our listening and communication skills to offer personal care and also emotional support. Sometimes they wouldn't want treatment or recommended health measures and we had to use our best endeavours to persuade them. For example- the doctor had prescribed frequent fluids and the residents were resistant to drinking so we had to put a lot of effort into persuading them.
		[Same as A1 para 29]
A3. Judging impacts		[Same as A2 para 34(h)]
		[Same as A1 para 35]
		[Same as A1 para 36]
		[Same as A1 para 37]
		[Same as A2 para 59]

		[Same as A1 para 85]
B1. Negotiating boundaries	53	I had to learn how to build a good relationship with the resident's family members. received lots of calls and text messages from people asking lots of questions. Sometimes families need just as much reassurance as the residents.
		[Same as A2 para 59]
	78	I also act as an advocate for residents with doctors. In the past residents have told me different things about their life and how they were feeling emotionally. I tell the RN that they need some counselling. The doctors and RNs talk to you and listen to our opinion on the resident's physical and mental health because we know the residents.
	197	When one of my residents has passed away, I usually take a moment with them privately to say goodbye. Because someone is dead you still have to respect them. Sometimes I am incredibly sad, especially if it is one of my favourites and they have been with me a long time. It is an honour to get them ready for their final journey out of Lewin Lodge.
	203-205	After the family has been notified, and when they are ready, I will help the family pack up someone's belongings and help them dispose of anything they don't want. Sometimes it can be tricky dealing with the families. Sometimes people don't realise the reality of the situation and they can be really shocked when their loved one dies. You have to treat family members with respect too. You don't know what they're going through. I get on with most families pretty well. You have to be honest and direct and comforting.
		[Same as A2 para 28]
	39	We have a lot of contact with families of residents. This has significantly increased since I started in the job as the residents have become frailer and more unwell and less able to have their own meaningful contact with their families. Often the families seem needier for contact with us than the residents. I receive contact daily from resident's families who want to know what is happening that day for their parent and how they are doing physically and mentally. During COVID in my observation, families were more anxious and I spent a lot of time setting up Zooms with phone numbers that were wrong, facilitating calls in full PPE.
B2. Communicating verbally and non-verbally		[Same as A1 para 35]
		[Same as A1 para 36]
		[Same as A1 para 37]
		[Same as A2 para 59]
		[Same as B3 para 169]
	170	You also assess facial expressions to understand how much pain they are in if they are unable to verbally express anything. Examples of expressions include looking for moaning or groaning. There's always something we can do to ease the communication and help them.
	171	Sometimes where someone has hearing loss we need to talk in a deeper tone, or if someone is blind we need to approach them differently so we don't scare them. If they are deaf we also buy/make cue cards.
	172	You also learn gestures or use pain charts. There's always something that will help them to understand, communicate and feel less isolated.

		[Same as A2 para 28]
		Same as B1 para 39]
B3. Working with diverse people and communities	168	We have had a few Dutch and German residents come in. There are not a lot of non-English speaking residents in Springwood.
	169	If there's someone from a different nationality we have to adapt to people's language barriers. I go and buy or make cue cards so that we can communicate. I also use gestures to assist communication.
		[Same as B2 para 170] [Same as B2 para 171] [Same as B2 para 172]
	197	[Same as B1]
	203-205	[Same as B1]
	16	… Many of our agency staff don't have great English language skills and I have had to figure out howto train them while having communication issues. This makes it really hard so I slow down my explanations and try and do demonstrations. Sometimes it is easier to do it myself but l know I need to train them so I can get good support for the residents.
C1. Sequencing and combining activities	57	As we- had more high care residents this was more time consuming but we didn't get more staff. We were almost always working short staffed with just two of us on the floor for 20 residents with high care needs. This was very demanding and required high level prioritisation and organizational skills and great patience.
	142	I observe my care workers as they perform their jobs. If I think they can do something better or differently I will give them direction or demonstrate how to do things better.
	143	For example, the other night, I went in to say goodnight to a resident. She was sitting on a chair as the care worker was trying to pull off her pants to get her dressed for the night. The resident was getting a very agitated. So I said to the worker stop and get the stand-up lifter as it is easier on the resident. If this is what is on her manual handling chart we must follow it.
	144	If I see repeated performance issues that relate to physical handling of residents, I email or the RN and the physio. I have previously done this where I identified that we could all do with some additional manual handling training about using lifters - when to use them and how to use them properly. This resulted in the whole team doing manual handling training in January/February. Part of manual handling training is observing whether all staff can properly use the lifter.
	145	I have to manage any workers on compensation claims and keep track of their restrictions and what they can and cannot do, and support staff with mental illness. One of my team is on workers compensation at the moment. She just bursts into tears and walks out. She has mental health issues and finds that working in aged care is too hard at times. When she can't handle it she will sit in the RN's office with her support box. This leaves the team short and two of us left on the floor to pick up all of the duties.
	10 **Reply 20 April**	In order to deal with the short staffing, we have to focus on prioritising the more important tasks. I sometimes literally run from one task to another. I have to triage the order of urgency. We go to the neediest first, including people in pain or who are being aggressive or if they are a falls risk. Recently I had a situation where i was

	2022— tab 192, page 11564	showering a resident Someone else was calling me as they were in pain and then a visitor arrived at the front door and kept on buzzing. This was really stressful as I determined that I couldn't leave the resident that I was washing without jeopardising her safety and all other staff were attending to other residents in similar circumstances.
	12	When you are understaffed it is very hard to provide the full suite of person-centred care that Uniting requires us to provide. I find this hard to reconcile as we want to provide as much choice for residents as possible. By way of example, several weeks ago we were understaffed so I had to decide what was superfluous. I needed to prioritise so I deleted the scheduled group activity. I felt that I did not have a lot of choice- especially as the Recreations Officer was absent. I then printed out puzzles that residents could do on their own.
		[Same as A1 para 29]
	PN1538 **Oral Evidence—29 April 2022**	Okay, you ring her?---While I'm getting the food trolley from downstairs loaded up with stuff, I will be ringing her and saying, look, I'm here, is there anything I need to know; I'll meet you upstairs and we'll do the S8s.
	PN1539	When you ring her up and say is there anything I should know, I take it that's your handover?---Yes, she'll tell me if somebody's gone to hospital, somebody's come back from hospital, somebody's COVID-positive, somebody's had a fall, somebody's going out, you know. Maybe if I was on the day before she might say, you know, there's nil changes from yesterday, and so on.
C2. Interweaving your activities smoothly with those of others	38	As part of this role, I would have to liaise with the RN and doctors if I saw anything that disturbed me about a resident's mental or physical health.
	77	I have a good relationship and very close contact with the doctors at Springwood. They rely on me because I have a good relationship with residents too. They will call me in because I have a trusting relationship with residents so I'm often asked to come and keep residents calm when doctors come around. I sometimes feel like I need to interpret and explain what the doctor is saying so that the residents understand it.
		[Same as C1 para 10]
	11	I tried buzzing the Registered Nurses (RN) on duty but they must haw been busy as they didn't respond so 1 stayed with the lady 1 was washing and tried to speed up her shower process while maintaining the usual observations of her health and used my private phone to call the RN in Jacaranda House for assistance whilst still providing personal care. The RN then came and helped the resident who was in pain. I had to explain to the resident I was working with and the one who was calling out what I was doing and why. High level communication skills are key in managing these situations.
		[Same as C1 para 12]
	PN1537 **Oral Evidence—29 April 2022**	But you just said you go and find the RN; you go and do that, do you?---I normally ring her.

	PN1405	
		[Same as C1 para PN1538]
		[Same as C1 para PN1539]
C3. Maintaining and/or restoring workflow	197 203-205	

DONNA LOUISE KELLY **Statement of 31 March 2021— tab 210, page 11864**		
A1. Sensing contexts or situations	21 (ww)	The whole time that we are with residents we are observing their physical, emotional and mental health. I am looking for any deterioration in their mood that might demonstrate either a mental health or physical health deterioration. I am looking for marks or bruises or excoriations, checking their skin integrity. If I identify these I alert the EN so that she can identify and treat any health issues early and before they get out of hand.
	17	As a result of COVID we have had to offer residents (especially those in isolation) extra emotional support. I remember that one of our residents, Irene, found it really difficult to be in isolation. She did not have dementia and was acutely aware of the surrounding COVID-19 situation. She was very scared. She needed lots of reassurance She and other residents were very impacted in that they couldn't see each other. At one point the residents rebelled and refused to stay in their rooms. I had to negotiate with them to deescalate the situation. In the end it was decided to give them masks and allow them outside in small groups.
	24	I encourage other staff to problem solve too. We problem solve every day. I tell new staff to just treat residents like they are our grandparents. We have to make choices for them because they can't always make independent decisions themselves. The level of problem solving and assistance to make healthy decisions has dramatically increased since I started to work in Aged Care. Residents stay in their own homes longer and enter aged care facilities with more high care needs now. This has increased the need for care staff to adapt and come up with strategies to provide them with the best care possible.
A2. Monitoring and guiding reactions	21(f)	Some residents like to get up and have a shower early, others like to have a quick wash and sit up in bed. I know what residents' preferences are, having worked with them for so long, so I prioritise the list and my duties to account for those preferences.
		[Same as A1 para 21(ww)
		[Same as A1 para 17]
		[Same as A1 para 24]
	25	The increased dementia and behaviours in residents means that ECAs need to be more observant, and do more assessments of their health and conduct. We need to be warier as dementia residents are unpredictable. We need to prepare for the unknown and consider what type of behaviour we are going to meet when we walk into a residents room. We then need to manage residents by selecting and using careful communications, distraction and persuasive strategies. This has become an increasing issue in comparison to when I started at Karingal thirteen years ago.
A3. Judging impacts		
B1. Negotiating boundaries	37	The people who go into aged care think that it is all nice old ladies and cups of tea. 40 per cent are lovely old women and men. The other residents can be horrible. It is not their fault but it is hard to deal with mentally. But as a professional, it is my job to grin and bear it, not to take it personally and try to overcome any feelings of emotions I may be feeling at the time when I am being abused.
	22	The more frail and high needs a resident is the more family engagement that ECAs have with their families and the resident. The families need a lot of support. Their mum or dad is deteriorating and they are upset and scared. We provide end of life care for most residents (as few choose to go to hospital now). This requires ECAs to comfort the resident and their family. I am in tears frequently. After they pass, I tell families that their loved ones are finally at peace. This is one of the hardest things I

		do. I associate with them as I think about my mum. I really empathise.
		[Same as A2 para 25]
B2. Communicating verbally and non-verbally		[Same as A1 para 17] [Same as B1 para 22] [Sam as A2 para 25]
B3. Working with diverse people and communities		[Same as A1 para 17] [Same as B1 para 22]
C1. Sequencing and combining activities	21(p)	The time that I finish with triage depends on a couple of things. I could have some residents constantly ringing their bells. I could have an emergency (including a medical emergency). There are a lot of residents with behavioural issues, so I could be in with one resident for anywhere between 25 minutes and 50 minutes. I am usually finished with triage between 10am and 12pm
	26	Care has to be provided in an environment where there are not enough staff and too much time pressure. This means that we need to prioritise the care provided. The majority of residents are high care with high level behaviours (such as shouting, abuse or violent behaviour). Each has a call bell - they get more attention if they have increased behaviours. We also need to prioritise those residents who are a high falls risk. Lower needs residents still deserve (and get) our attention but we have to prioritise. To provide an example- there are 2 ECAs on shift after 1,30pm with 40 residents to care for. We are constantly running to the next resident.
C3. Maintaining and/or restoring workflow		[Same as C1 para 21(p)] [Same as B1 para 37]

MARION LEE JENNINGS **Statement of 26 March 2021— tab 178 page 9177**		
A1. Sensing contexts or situations	**PN2870** **Oral Evidence** **2 May 2022** **PN2776**	Right. Did your university qualification cover de-escalation?---No, but we did have a unit to talk about behaviours but a lot of de-escalation strategies were learned on the job from staff talking to other staff, telling them what would work with a specific resident, what they've done from experience that they've found to be useful.
A2. Monitoring and guiding reactions	94	Showering was one of the most challenging aspects of dementia care. Residents often refused, withdrew or fought during a shower. Specifically, residents would exhibit the following difficult behaviours during shower time: (a) physical resistance including kicking, scratching and biting; (b) verbal resistance including crying out or yelling; and (c) physical withdrawal
	97	If a resident consistently refused to shower, we would use alternative methods or come up with ways to encourage them to shower.
	103	On one particular occasion I detected a skin lesion on a resident which I suspected was cancerous and reported it to the team leader. This resulted in the timely detection, diagnosis and treatment of skin cancer. On another occasion, I detected a hernia in another resident.
	111	I remember having to get clever and sneaky with this resident. I planned a distraction ahead of time and then when she would get close to her room I would tell her “I need to show you something”. I used this as a distraction to get her into the room and quickly changed.
	178	Because many residents were unable to communicate when they needed to go to the toilet, we would need to watch for body language and behaviour that would indicate that they needed to use the toilet, for example, displays of restlessness or agitation.
		[Same as A1 para PN2870]
A3. Judging impacts	74	Only a speech pathologist or a medical practitioner could prescribe the thickening of fluids. However, CSEs needed to alert, and flag if a resident was having difficulty swallowing, so they could be referred to a speech pathologist or a medical practitioner. For example, early signs of dysphagia (difficulty swallowing) include coughing, gagging or choking while eating of drinking. If a resident displayed any of these symptoms, I would make a record of it in the resident’s progress notes with the view of having them referred to a speech pathologist.
	124	In my opinion, it was not safe for CSEs and other residents to remain in close proximity of that particular resident. However, we did not have any option.
	125	I recall on another occasion, I could see this particular resident pacing up and down the room, and suspected that he was on the verge of an explosive episode.
		[Same as A1 para PN2870]
B1. Negotiating boundaries		[Same as A2 para 94] [Same as A2 para 97]

B2. Communicating verbally and non-verbally	100	If I was bathing or showering a resident who had difficulty with verbal communication, I would tell them what was happening and look for any type of non-verbal communication, for example, facial expressions, body movements or postures, gestures or touch.
	130	As a CSE I was required to develop different communication strategies with residents depending on how advanced their condition was.
	131	For example, some residents would revert back to their first language. This is because dementia often impairs memory in the short term, however leaves remote memory relatively intact. This was frustrating for some residents who found it difficult to communicate with me.
	132	It was my job as a CSE to remain alert to gestures, movements and facial expressions. Body language and physical contact becomes significant when speech is difficult for a person with dementia.
	176(a)	Due to memory loss, cognitive changes and sensory deterioration associated with dementia, identifying food was difficult for residents. To help some residents, we would mimic the behaviour of eating, to enable a copy-cat behaviour. Once the resident had their first mouthful, their memory would start to return, and they would begin to eat.
B3. Working with diverse people and communities		[Same as B2 para 130] [Same as B2 para 131] [Same as B2 para 132] [Same as B2 para 176(a)
C2. Interweaving your activities smoothly with those of others	141	Handovers were both oral and written. At the beginning of the handover, a member of the oncoming team received a short verbal and a written summary of the residents. For example, the summary for Joanne might have read “Joanne opened her bowels”. It was not always possible to provide a written summary for each resident, especially if you had to prepare ACFI paperwork for a particular resident on shift.
	142	During the verbal handover, I would try to provide a clear message about significant concerns for the oncoming shift. For example, “Pat has been walking most of the day and is becoming unsteady, you will need to watch her and encourage her to sit.

HELEN PLATT **Statement of 29 October 2021 — tab 197, page 11604**		
A1. Sensing contexts or situations	37	We liaise with resident's families to learn things like this. I always try and talk to family members to find out about residents so I can give residents the best experience possible. One day I went in and a daughter was visiting and I was talking to her while I was feeding and she told me so I just remember that she liked it and I continue to do that. I encourage my team to talk to families and residents to find out their likes and dislikes. I also document matters such as this in progress notes so that other staff know about residents (including s) likes and dislikes
A2. Monitoring and guiding reactions	40	We need to check that the residents are eating everything. If they aren't it can be an indication that they need their food consistency changed or that their health is deteriorating. If I identify this I let the RN know so she can consider whether we need to notify a third party such as a speech pathologist or doctor.
A3. Judging impacts		[Same as A2 para 40]
	PN4813	And let's say that you notice that I had a large bruise I didn't have yesterday, you'd record that?---And report it.
B1. Negotiating boundaries	PN4805 **Oral Evidence 4 May 2022 PN4744**	Please do, please do? We had a resident that was non-ambulant. It was in the middle of COVID lockdown and he was quite distressed and upset that he hadn't seen his family. He didn't have a mobile phone so I rang, you know, FaceTime to his family and we put his family on and he was able to see their face and talk to them. So, you know, and it was a really, really love time to watch how happy that made him, and the family also. So, we do things if families - residents are short of clothing, we will ring families and just gently, you know, ask them could they bring in, you know, some more singlets or pants or whatever it might be. Mr Ward, we do liaise on the families quite regular.
B2. Communicating verbally and non-verbally		[Same as A1 para 37] [Same as B1 para PN4805]

JULIE KUPKE **Statement of 28 October 2021— Tab 252, page 12908**		
A1. Sensing contexts or situations	57	I am concerned that my client's teeth issues are causing him pain and contributing to his refusal to eat in the evenings. All I can do is report back to head office that I am concerned, and that I have recommended to my client's wife that she take him to the dentist.
A3. Judging impacts		[Same as A1 para 57]
	PN5509 **Oral Evidence** **4 May 2022** **PN5445**	So if I gave you an example of showering a client and you observe bruising on their arms, that would something that you would report back straight away?---That's correct.
B1. Negotiating boundaries	58	I am between a rock and a hard place sometimes–while I'm there for the client, if the family don't want something, it can be difficult. I have to remember I am in someone else's house–this is her husband, her house. So, I have to be careful what I say and how I say it.
	79	I have never felt unsafe with this client, however, sometimes with his anxiety and depression, he can get a bit narky and pushy. He feeds the magpies outside, and recently asked me to clean up the magpie poo on his porch. I have never said no to him before, but on this occasion, I told him I wasn't being paid to do that. I thought it was a bit over the line and didn't want to get wet and dirty cleaning up bird poo. He wasn't particularly happy with me for saying no and grumbled to me for the rest of the shift that I wasn't doing my job.
	98	I often become an advocate for my clients. While some clients can be quite demanding, I find with some elderly clients, they often don't want to be a hassle and are reluctant to ask for more. In addition, they often aren't informed as to what is available on their packages or what their funding can be used for.

PETER DOHERTY **Statement of 29 October 2021 — tab 239, page 12419**		
A2. Monitoring and guiding reactions	101	I've received another call from a carer who arrived to find a client passed away. This was someone the carer had visited for years and had come to know very well. My job is to ask the carer whether an ambulance has been called, whether the police have been informed, and so on. I then ascertain whether the carer is in a state to continue work for the rest of the day, or whether I need to fill their shifts so they can have the rest of the day off. I try to support them as best I can and talk them through it over the phone.
	104	I do my best to support the carer in these circumstances. While our carers are amazingly stoic people, I know this can be hard for people. Although it is difficult given our roster constraints, if I can tell a carer is very upset, I offer them the rest of the day off and work to reallocate their shifts. Otherwise, I remind them about the EAP and encourage them to use it if they need.
B2. Communicating verbally and non-verbally		[Same as A2 para 101]
		[Same as A2 para 104]
C1. Sequencing and combining activities	82	If a client calls with a complaint about a carer or service, I do the initial triaging if the complaint is of a more serious nature, or deal with it entirely if it is a less serious matter. Serious matters might include an allegation of theft–in these cases I take down the details and pass them on to my boss to investigate. For less serious matters, for example a complaint that a carer did not dust a surface while they were there, I reassure the client I will look into it. Then I usually call the carer and let them know and ask for their side of the story–and usually that will be enough to deal with it.
	142	There are only two of us managing a workforce of 50, juggling a constantly changing roster and at the same time balancing the demands of clients against the expectations of our superiors and the needs of our carers.
	144	We need to have excellent time management and efficiency skills to succeed in this work. We are constantly balancing completing priorities and interests.
C3. Maintaining and/or restoring workflow		[Same as A2 para 101]
		[Same as A2 para 104]

CATHERINE EVANS **Statement of 26 October 2021— tab 248, page 12842**		
A2. Monitoring and guiding reactions	39	A crucial part of my work with every client I see is assessing how my clients are. For some, we are the only regular contact with another human being they have. We might be the only ones who can assess whether their speech, mobility or mood has changed which may indicate a health or welfare issue. If I notice an issue or am concerned about a client, I report this back to my employer or their case manager.
	40	For some clients, I can tell if they are not feeling too good as soon as I walk in the door. For others, because of the generation we are working with, this can be harder to nut out.
	66	Some men prefer to shower in their underdacks because they are uncomfortable with a woman seeing them naked. I get creative and find another way to keep them covered, with a washcloth for example, to help them keep their dignity while allowing me to properly wash them. You're always having to juggle how you deal with people. And it all takes care, patience, understanding, and a lot of skill.
	18-19 **Reply 20 April 2022— tab 249 page 12870**	I had never seen this client before and wasn't aware before I arrived that she had dementia. I walked into her house not knowing anything about her. I had to ascertain the situation very quickly when I arrived. From talking to her I got the impression that she may have dementia, but I didn't know what type, or how severe it was. I was immediately hyper vigilant, asking questions and trying to gauge how to manage this client. It is stressful having to face these situations in home care. We are often thrown curveballs and have to do our best to service the client's care plan while thinking outside the box.
A3. Judging impacts	45	I had one elderly client who was an alcoholic. I helped him with some house cleaning, groceries and meal preparation. He was a tricky one to manage as his behaviour was very unpredictable. Sometimes I would arrive, and he would be ok, and sometimes he would be inebriated. If he was inebriated, he was a bit iffy. He could sometimes fly off the handle. There were occasions when it got a bit scary being alone in his house when he would become aggressive. We aren't really taught how to handle those situations, and it is not something you can really plan for or control. You just have to do your best to extract yourself from the situation calmly and carefully
	50	Although we reported his behaviour, the response was that there was not much that could be done, he needed his care. So, we just have to try to keep our head up and make sure he gets the care he needs despite the comments.
	51	All of this is just part of the job. We see a whole cross section of society going into peoples' homes. Everyone has their own histories, their own issues and triggers and sensitivities. It is my job to be prepared for anything with each front door I walk through, to remain calm and deal with issues as they arise and most importantly to treat each client as an individual and with sensitivity and compassion. However, it can knock you around a bit dealing with situations that can get a bit scary or uncomfortable.
	PN6160 **Oral Evidence 5 May 2022 PN6106**	In that instance you say that if you discovered a skin tear or a bruise while showering you would let the wife know and know that she knows what are the next steps to do in that respect but you would also as a step report it back to office as well, to the case manager?---That's right.

B1. Negotiating boundaries	53	Another common challenge in my job is dealing with expectations of family members that differ from or go beyond the care I am meant to be providing their loved one according to their care plan.
	59	I explained to this client's daughter that if she thought her mum needed extra care beyond what had been assessed in her care plan, that it really needed to go through her mum's case manager. That way sufficient time would be allocated to allow the tasks to be completed in a safe way without having to rush and upset her mum. When I explained this to the daughter, she responded by telling me I didn't know how to do my job. These kinds of interactions place a lot of pressure on workers. You want to do the best by your client, but then you have to deal with family pressures on top of already intense time pressures.
	61	I had another client, a 92-year-old woman. She was quite independent and used to cut her own wood. On one occasion, she had a fall outside. After this, her kids told her she wasn't to go to the woodpile anymore, nor cut her own wood. She was upset about this and spoke to me about it. While it is not my place to get in between family members, I am passionate about empowering my clients to maintain their independence so long as it is safe. I asked this client whether she had been cutting wood before she had a fall. She said that she wasn't cutting wood when she'd fallen. She'd only fallen because it was wet and slippery outside. I said she should be careful walking outside when it was wet, however, that if she wanted to, she should go ahead and continue chopping her own wood.
B2. Communicating verbally and non-verbally	38(j)	This client has quite diminished cognitive capacity. Some days are better than others. Usually, he requires a lot of prompting. This client does not look at people's faces, rather he will have his head turned to the side when standing in front of you. So often I have to use a mix of verbal and physical prompts.
	PN6172	Just making sure I'm staying with you on that. And then you refer to some skills in paragraph (j) where you recognised he had diminished cognitive capacity. You state he required prompting and you had to use a combination of verbal and physical prompts?---Mm-hm.
	PN6173	Were those skills–would that be drawing from your training you completed via the Certificate III?---No.
	PN6174	So where do you draw upon those skills from?---Looking after my Nan.
B3. Working with diverse people and communities	86	More and more we are dealing with elderly clients with complex needs dementia, Parkinson's, cancer, impaired vision, very limited mobility, even palliative clients.
		[Same as A2 18-19 Reply Statement}
	PN6214	Thank you for that clarification there. Now, later - a bit down in the same paragraph 41 you talk about when clients - you're referring to a client maybe having a bad day, and that's something that you might - you won't know until you walk through the door. Is that - if you see a - if you observe a client having a bad day, is that where you would draw upon and employ de-escalation strategies learnt in your Certificate III?---Yes, it would be.
	PN6215	Do you recall any specific - can you give me an example of a strategy that you might use?---I have one - had one client in Mildura who had early signs of dementia. I used to change my hairstyle before going in there because she didn't like who I was. Sometimes that would work and if her behaviour started to get out of control while I was in the home, I would tend to sit down because she was a lot shorter than me, so therefore making myself a lot smaller than her, and trying to calm her down. If that didn't work, I would generally just leave the home because I could tell that she was feeling uncomfortable with me being there.
	PN6216	So, you - in the Certificate III you learn that you may need to use an array of strategies when certain situations present themselves, and you also must - you have to be prepared to leave if it gets a bit - if you start to feel unsafe?---Not if I feel unsafe but if the client feels unsafe with someone being there. I would much rather leave and let the office know that I've left for this reason and email the relevant case manager. I don't see why we as carers should stay in a home when you know someone's

		being - is feeling very uncomfortable with you around.

CHARLENE GLASS **Statement of 29 March 2021— tab 198, page 11613**		
A3. Judging impacts	PN6737 **Oral Evidence** **5 May 2022** **PN6699**	Right. Can I ask you to go to paragraph 51(c)? You say in paragraph 51(c) - you talk about your responsibilities and technical responsibilities. You say: 'Actively observing any skin changes to track and assess residents' health'?---Yes.
	PN6738 **Oral Evidence** **5 May 2022**	Can you explain to me - is there anything you might have observed that made you go straight to the registered nurse?---If I find there was skin tears, bruising, any changes in the skin that can cause cuts, you know, things like that, we report straight away to the registered nurse.
	PN6745 **Oral Evidence** **5 May 2022**	If you observe the resident behaving differently - as in they were more - less active or less alert, you'd also write that in your progress notes too?---Yes, absolutely, and if the resident - if the behaviour is not - if it's out of sync we'd notify the RN straight away and she'd do a UTR assessment, yes.
	PN6751 **Oral Evidence** **5 May 2022**	Okay, and am I right that if you - let's say I was the resident and you were observing me to be quite withdrawn and unusual in my behaviour. I think you've said you might go and get the registered nurse straight away?---Yes.
B1. Negotiating boundaries	52	Being an advocate for the residents is one of the most important roles that we as carers play.
	53	Without us, they cannot do things on their own and they cannot speak up. In some cases, that can even include not being able to speak up with their own family members, so we take on a really important role for them as advocates.
	54	For example, I have one lady who I am caring for, who is one of our hardest residents with a lot of behavioural issues, but since coming on to the wing I have made it my goal to get to know her and to make friends with her. Just yesterday she told me that she has made a decision that she wants her ashes to be spread in the Newmarch garden, because this is her home and this is where she wants to carry on after she passes away.
	75	I am proud of the work I did to help residents during this time. One example of many that I look back on was, where I was able to make a positive impact on a resident by buying her a bird bath and plants for her outside window. She did not have anything to look at outside her window while she was confined to her room. I also bought her two miniature indoors plants that she could hold and tend to when she was sitting next to her window. Her spirits were lifted tremendously as she had something to look forward to in the day. I discussed the matter with the psychologist who was attending to her. Her family did not visit her very regularly and she was alone most of the time.
	PN6757 **Oral Evidence** **5 May 2022**	You talk there about advocating for residents?---Mm-hm.

	PN6758 **Oral Evidence 5 May 2022**	Could you just explain to me what you understand 'advocating' to mean? Okay, a resident can talk to us about a family member that's taking money from her.
	PN6759 **Oral Evidence 5 May 2022**	Right?---Initially not necessarily stealing the money, but, like, using her bankcard and then she would be informing the care staff, and then in turn we would notify the resident nurse who will notify the care manager.
	PN6760	I take it that's because you develop a relationship with the resident? ---Yes, yes.
B2. Communicating verbally and non-verbally	44	Another challenge is caring for residents with dementia who come from non-English speaking backgrounds, as many times they have lost their ability to communicate in English and they revert to their native language.
	45	I have cared for residents who are Chinese, Portuguese, Maltese and because of their dementia they have lost their English skills.
	46	When caring for those residents, I will use different techniques such as hand signals and changing the way I speak to them, in order to make them comfortable. Even just a gentle touch, such as holding their hand for a moment, gives them reassurance that you are there to care for them. It also helps them to build attachment with us, which assists us in our ability to care for them.
B3. Working with diverse people and communities		[Same as B2 para 44] [Same as B2 para 45] [Same as B2 para 46]
C2. Interweaving your activities smoothly with those of others		[Same as B1 para 75]

MICHAEL PURDON **Statement of 29 October 2021—tab 246, page 12712**		
A1. Sensing contexts or situations	67	I had another experience with a client, who I was providing palliative care. On one visit, I had just given him a shower, but couldn't get his temperature up again after. He was shivering and freezing cold.
A2. Monitoring and guiding reactions	30	I usually look after this client in his house when I see him. This client won't sit still and likes to be doing something at all times, however he doesn't like being told what to do and is very determined to do what he wants. Often the more you tell him to do something, the more determined he becomes not to do it. On one occasion, for example, the cleaners arrived while I was there and wanted to vacuum the floor. I tried to get my client to leave the room so the cleaners could do their work, but he refused. It took some time to convince him to leave the room. Rather than give him a directive, I had to think of something else he might like to do. On this occasion, for example, I said to him: 'Come on, let's go upstairs for a cup of coffee'. Eventually, on this occasion, this worked. However, sometimes it requires a bit of patience and creativity to bring him around to doing something.
	45	This client also had triggers with her brain injury and could present with challenging behaviours. For instance, she would be triggered if plans changed. Sometimes, for example, her husband would tell her he was going out for the whole afternoon. However, he would then come back in 30 minutes, and then come and go all afternoon. This would agitate her. She didn't like plans to change.
	46	As I had her confidence at this time, I was usually able to calm her down. With this client, she absolutely loved having her hair brushed. So, on these occasions I would calm her down by brushing her hair.
	62	One day, I had brought him home from the hospital and had just finished his shower, when he started complaining of chest pain. I assumed the worse–that he was having a heart attack.
	63	This client had an emergency buzzer which he wore around his neck which we tried to use to alert the ambulance. However, after a few minutes with no response it became clear to me the buzzer wasn't working. So, I called an ambulance and waited with him till it arrived.
		[Same as A1 para 67]
B1. Negotiating boundaries	44	I can understand how challenging it can be for families to come to terms with their loved ones getting a diagnosis like dementia and dealing with all the challenges that flow from that. However, it does make my work difficult when family members have different ideas about how their loved one should be cared for, and particularly when some family members do not accept or support the care their loved one needs. This is particularly challenging in a home care setting because you are in the private spaces of a client and their family. If you are in their space, they can sometimes expect you to do what they say. It takes a lot of patience and compassion to deal with both the client and their family and to balance their sometimes competing interests. I found I had to care differently for this client depending on whether her daughter or husband was around.
	57	I knew he needed and wanted more help. So, I tried to advocate for him by relaying that back to the care coordinators.
	73	Often older people don't want or know how to advocate for themselves–as they don't want to cause a fuss or rock the boat–so I have gone into bat for clients before.
B2. Communicating		[Same as A2 para 44]

verbally and non-verbally		[Same as A2 para 46]
B3. Working with diverse people and communities	39	I think the biggest challenges that come with the job involve handling abuse from clients and their families, dealing with client behavioral issues, particularly with dementia patients, the pressure to provide care beyond what I have time to do or am properly qualified to provide, and the emotional toll of becoming close to clients who inevitably become older and frailer and, eventually, pass away.
C3. Maintaining and/or restoring workflow	53	This whole experience left me very sad and shaken up. No one wants to see a client become upset and feel that they are the reason for it, despite trying your best to care for them.
	54	I didn't receive any support after this experience. There was no follow up from my employer. Home care workers are just expected to get over incidents like this themselves and get on with it. We are very much alone out in the field.
	55	As another example, I had a lovely old client who I had been providing care to who felt he needed to go into a facility. He was very tired, and really couldn't do anything for himself. Every time I left him; he would cry.
	56	I hated to leave him and felt guilty every time. I would spend a lot of time thinking about him and feeling so awful about him home alone and so upset.

TRACEY ROBERTS **Statement of 23 March 2021— tab 193, page 11575**		
A2. Monitoring and guiding reactions	108	If a resident who clearly needs a shower is still reluctant to take one, I will make a joke like "But I can smell you If the resident still refuses to take a shower we ask that they at least wash their hands and face and brush their teeth.
B2. Communicating verbally and non-verbally	97	With other residents I look for visual or verbal cues For example, a res1de'1t can yell out " I need to go to the toiler, or they may be fidgeting or trying to hurriedly get out of bed, a sign that they need to go to the toilet.
		[Same as A2 para 108]
	113	If a resident cannot communicate (approximately 6 out of 76 residents cannot) I focus on asking questions that only require a "yes" or " no" response The resident can respond by nodding shaking their head or saying " mmm" or in some way gesturing with their hand

SALLY FOX **Statement of 29 March 2021— tab 242 page 12524**		
A1. Sensing contexts or situations	57	When I help a client to shower and dress, I also discreetly look for any changes to their skin or body that need attention , such as: (a) skin tears, because older peoples ' skin is so fragile; (b) cracks between toes; (c) marks, bruises, bumps, or welts anywhere on the body, particularly on pressure areas; (d) skin on bottoms because the skin can break down when a person sits a lot; (e) sores, marks, welts, bruises or bumps in tummy folds and any other skin folds, including under breasts for women.
	66	You have to monitor changes to behaviour as well as physical changes, because behavioural changes might also indicate that something is wrong - for example, it might indicate that the client has a urinary tract infection ('UTI').
	164	Similarly, I have noticed that as dementia progresses, many residents have become very resistant to getting wet. This can make it very difficult to keep them clean, as they hate showering. This means I have to adopt high level persuasive skills when negotiating with them. I also have to be really patient and calm.
	165	Dementia patients in particular can become violent because they are upset, confused, angry or just don't understand what is happening. Residents have grabbed me by the hair, pulled me into their laps, refused to let go of me, bitten me, and tried to punch and kick me. It's not their fault, they have dementia. But it is very scary and upsetting.
	22 **Supplementary Statement of 28 October 2021— tab 243, page 12542**	Even when I am undertaking domestic duties, I will be taking account of the client and their house. Some clients can be quite rude and demanding, changes in their behaviour towards others can be an indication they are unwell or not managing, and they can be scared they won't be able to stay at home.
	29	I must be very vigilant when working with M because he is unable to verbalise when he is hungry or needs to use the bathroom. I must pick up on subtle physical cues and be aware of his emotional disposition to work out what he needs.
A2. Monitoring and guiding reactions	55	Everything that I do as a carer is client focussed. For example, one of my clients likes their curried sausage s made with milk, not water, so that is how I will cook them. I have to remember and apply all of these things.
		[Same as A1 para 66]
		[Same as A1 para 22]
		[Same as A1 para 29]
A3. Judging impacts		[Same as A1 para 57]
	81	When helping a resident toilet, I always look at their urine and/or bowel movements for any signs that the resident may be unwell. I look for colour, smell and density of the urine as well as for blood in the urine.

	(also 82–91 to the same effect)	
	163	I now understand that as dementia progresses, many individuals become less and less interested in eating savory foods, but love sweet foods, including dessert. Because of this, I pay close attention to what our dementia residents eat, and really encourage them to eat their main meals before eating dessert. It also means that providing a resident with dessert came be a very effective way to provide them with comfort.
		[Same as A1 para 164]
		[Same as A1 para 165]
B1. Negotiating boundaries	44 **Reply Statement of 14 April 2022—tab 244 page 12628**	We have to deploy additional skills due to the short-staffing. The key skill is to properly prioritise care management. We need to know the residents and their individual needs enough o know who is at high risk, to attend first to the person who needs it the most and to identify who is most at risk. Sometimes the residents have to wait, even for up to an hour after they call us. When we get to them (or when we are keeping them waiting) we need to clearly communicate what is going on and use our persuasive skills to try to calm them down and reassure them
B2. Communicating verbally and non-verbally	43	Working in reception involves a lot of people and relationship management skills.
		[Same as B1 para 44]
	44	I often have to deal with people who are angry, argumentative, drunk or confused. This has increased as a result of the restrictions imposed on visitors due to the Covid-19 pandemic.
B3. Working with diverse people and communities		[Same as A1 para 164]
		[Same as A1 para 165] [Same as A1 para 29]
		[Same as A1 para 29]
C1. Sequencing and combining activities		[Same as B1 para 44]

SUSANNE WAGNER **Statement of 28 October 2021— tab 247, page 12725**		
A1. Sensing contexts or situations	33	Knowing and building rapport with a client can be difficult when we are moved around a lot and don't have regular clients, as we do not have time to build rapport, nor have the benefit of knowing the client's circumstances over a period of time to be able to evaluate changes. Also it is more difficult for a client to trust and share sensitive or difficult issues if they constantly experience changes of support workers.
	36	I do this by engaging the client in conversation to determine any issues that might exist or have changed since my last visit. In particular I look for any signs of abuse, assess their current health and wellbeing, especially mental health, and ascertain what social support they are receiving from others, including family and friends, or if they are isolated and relying mainly or totally for social support on seeing their support workers.
A2. Monitoring and guiding reactions		[Same as A1 para 33]
		[Same as A1 para 36]
	71	I always ask clients about their preferences and invite them to participate in any activities I might be scheduled to perform, for example, housecleaning, some clients like to do what they can and I do the rest, or in shower assistance I always ask the client what they would like to do and what they need me to do and encourage the efforts they make.
	77	One client I cared for over a period of time I noticed started losing weight, her clothes were loser. I started weighing her weekly and because she couldn't think of any reason, I got her to keep a diary of any symptoms or changes during the week so she could discuss the diary with her doctor. She noted that she didn't always use her bottom dentures because they caused her pain. After getting new dentures, she put the weight back on.
A3. Judging impacts	61	If a client seems to be bruising more easily it might mean they are less steady on their feet and knocking up against things more often, or it might mean they have clotting problems.
	62	If they have oedema in their feet/ lower legs, they are retaining fluid and could be a symptom of heart or lung problems.
	63	If they have blue lips, they might be cold, or not getting enough oxygen.
	66	Part of my role is to provide information, educate and support clients on wellness or lifestyle choices. As I work with a client, I check their skin, report any changes eg: moles, sores, rashes, bruises etc. and assist client with skin care, discuss and explore exercise and diet options if necessary, with an allied health professional.
		[Same as A2 para 77]
	79	We need to be aware of and identify signs of abuse and neglect and reporting for follow up and possible action.
	PN10360 (see also 10358–10359) **Oral Evidence—10**	Just in your answer then, you said sometimes when you feel unsafe you can de-escalate. Do I take it from that answer that in other circumstances you have felt unsafe for the same or other reasons? ---Yes. Yes, you know, clients can get angry over–they want more from the service than they are getting, or they want you to do more than we're allowed to do in the scope of our role, and then they get frustrated and angry, and you need to be able to talk them through–and I mean, the way to de-escalate is first to affirm how they feel and understand where they're coming from, so that they feel you're not against them, and then to work a process of talking them through to understanding the situation. If that doesn't work then we would get the coordinator to come and talk to the client, which I had to do.

	May 2021	
B1. Negotiating boundaries	34	I have to be very aware of balancing my duty of care, with the client's right to the dignity of risk, making their own decisions even if there are risks involved, and uphold their rights, this can require discussion with the client to evaluate risk vs benefit and helping the client to modify the activity so they can still participate safely. I must ensure or assist clients to know their rights and assist in advocating for what they want or refer them to more appropriate people to support their own decision making.
	53	This became stressful for me. I felt responsible to ensure the client's primary carer was not upset or needing help which could compromise his care. The pharmacy said it could be dangerous depending on what medication she had accidently taken, but the coordinator did not support me helping. This put me, a part-time, low paid employee, into conflict with my work, and I felt stressed about addressing the problem.
	82(c)	Another client also refused showers and was always in bed, her husband and carer was also not trusting of carers which contributed to her unwillingness. He was Scottish and I developed rapport with him, having spent time in the UK, with my years of experience and self-motivated study, I managed to persuade her to shower. On drying her I discovered an extensive fungal infection in her groin area and folds of skin where she had not been dried properly by other workers due to her uncooperativeness. I reported by phone to the coordinator, who followed through with the clients, and told the husband he needed to take her to the doctor as it was very severe but with good treatment could be cleared up easily, this gave him confidence to take her.
	94	She used to ring me for assistance sometimes because she had no family or friend support close. If I couldn't understand fully over the phone what was wrong, which happened because she could only make 'aha' sounds and I could not see her gestures while listening to her, so I would drive around to ensure all was well. I was not permitted to continue doing this and there was no-one else I could hand over responsibility to.
	98	NDIS plans appear to me to have a lot of funding for clients but seem to provide very little change to before they were on NDIS. I still feel traumatized even though the client moved on nearly two years ago, and I feel that support workers are not given the recognition for their wisdom, experience with regular face to face contact, or empowerment to help make improvements for their clients. It is the support worker at the end of the day that sees if improvements have been implemented or not and then it is incumbent upon us to report or find ways that improvements and needs are met if the organization does not take on the responsibility.
	102	I must be able to assess the client and maintain appropriate distance and environmental considerations to be able to avoid such situations safely. I need the skills to de-escalate any tense situation and report to appropriate authorities of any challenging behaviours so they can be monitored, and plans put in place where necessary.
	103	I need to be able to balance my duty of care to the client with dignity of risk, the client's right to make their own decision to take [a] risk; or keep the client safe without taking away their right to choose. I must inform and discuss with the client the possible outcomes of risks they might want to take that could be harmful and help the client to participate in modifying activities so they can still participate in a safe way.
	142	As a support worker I am expected to advocate on behalf of my clients. Sometimes this means assisting them to complain about the service offered by our own employer, and others who have worked with them, helping them access advocacy services or government services for assistance to make a complaint. When a client has issues with my employer it tends to undermine my own trust and faith in my employer, which can impact on feedback to improve issues and services.
B2. Communicating	54	I have, and need, good communication strategies both verbal and non-verbal. I must observe as well as listen. A client's body language often gives clues to what makes

verbally and non-verbally		them uncomfortable or is bothering them.
	55	I had a client, when I arrived and asked how they were, responded saying they were ok, but their mannerism seemed to me as if they were feeling down, avoiding eye contact and shrugging their shoulders, and without enthusiasm. On engaging in conversation they said they used to love going out in the garden, but because of their declining mobility and stability and the terrain of the garden they couldn't do that anymore. I explained how other clients had been helped to strengthen their balance through the falls clinic and suggested they chat to their doctor, and that they talk to their coordinator to see if their package would allow for social outings to a garden or similar.
		[Same as B1 82(c)
	87	I initially found trying to understand the client's gestures very difficult, but over time we became more familiar with each other with gestures and techniques, but when something out of the ordinary was trying to be communicated or the client was distressed it could take up to an hour or more to decipher what the client was trying to communicate.
	88	We would make a grocery list together which would take a long time as it was difficult for me to understand her needs. I assisted her to download the Supermarket app which made things easier as she could show me a picture of what she wanted. Over time I compiled a comprehensive list of groceries and brand names that she preferred from my own trial and error. This assisted her and other support workers.
		[Same as B1 para 94]
		[Same as B1 para 102]
B3. Working with diverse people and communities		[Same as B1 para 102]
C1. Sequencing and combining activities	PN10292 **Oral Evidence—10 May 2021 PN10219**	I understand. Can I just explore that a little further while we're on it. Let's say that you were showering the client and you observed a skin tear who do you report that to, or do you not report it?---Well, yes, the first thing I have to respect the client's autonomy, so I tell the client and what they would like me to do. Depending on the nature of the skin tear I would recommend they see a doctor or a nurse. I would put it - I would note it in the progress notes and I would also inform the coordinator so they're well aware of what was happening so that they can also ensure that it's followed up and checked.
	PN10293	And I take it then if there's some different health practitioner required to call then they would follow that up?---Yes, and we also make sure, because - you know, sometimes coordinators are busy or things slip by so it's sort of we have to also ensure that it has been followed up, and that's through progress notes and through talking to the client and just ensuring that things are being looked after.
C2. Interweaving your activities smoothly with those of others	104	With people who have cognitive disabilities or communication difficulties this might entail collaboration with various parties and advocates/interpreters to ensure the client is understood and understands and is making their own informed choice. I have to be active in changing the social stigmas around disability by demonstrating respect and inclusion of people with disability.

		[Same as C1 para PN10292]
		[Same as C1 para PN10293]

NGARI INGLIS **Statement of 19 October 2021— tab 282, page 13524**		
A2. Monitoring and guiding reactions	24	In addition, you need to be really observant of the clients and know when to escalate when something is not right. I have done this quite a few times. Recently, I went to a very elderly client. I have been caring for her for just over 18 months. She did not look right. I asked if she was ok, and she said 'I don't feel well', she had a rash on her face and felt hot. The T-section on her face and forehead looked dry and scaly and it wasn't like her. You get to know your clients extremely well and how they communicate. I said, 'let's get your daughter here.' This client has a permanent catheter. I have learnt that having a catheter makes you susceptible to urinary tract infections. There are a lot of UTIs with catheters. If you didn't know that people were susceptible to UTIs when they have a catheter you might think it was something else. She ended up in hospital that afternoon.
A3. Judging impacts		[Same as A2 para 24]

SUSAN MARY MORTON **Statement of 27 October 2021— tab 284 at page 13539**		
A2. Monitoring and guiding reactions	**Oral Evidence—10 May 2022 PN10767** PN10805	Can I ask, though, where are the progress notes written? Are they written in a book in the client's house?---Generally, no. They keep it all on that–in that same (indistinct) and actually when you click and flick all this rubbish and it says, 'Write notes. Create a note.' And you actually go in there and you write what happened for the day, you know, if there was–you'll always have to write something. You know, whether you've just given them, you know, an assisted shower and, you know, do the care plan, you know, put their Sorbolene and stuff on. But if something you feel is not right, you know, with the customer, you would note it but also if it's bad enough, you know, then you would actually be doing it in a DoneSafe–which we call a hazard or an incident. But if I think it's bad enough I just ring the coordinator and say, 'Hey, you know, we better get something sorted.
A3. Judging impacts		[Same as A2 para 10805]
	PN10810	If you were showering me this morning and you saw a bruising or you saw a bedsore or you saw a tear in my skin, you would probably go straight to the coordinator?---Well, I would be telling her that we–you see, it also depends on, you know, the household. I mean, if your wife is there and she looks after you lovingly and she's the one that's going to, you know, do something, well, then you bring it to her attention but you would actually fill in an incident form to say that's there, you know, and you've told the wife. But, you know, like, if–and, I mean, as they get older too some of them are capable of doing things and some of them aren't.
C2. Interweaving your activities smoothly with those of others		[Same as A2 para 10805]

SANDRA KIM HAFNAGEL **Statement of 30 March 2021—tab 274 at page 13466**		
A3. Judging impacts	35	Examples of where I have called an ambulance for clients include: … • Where clients have displayed symptoms of strokes (such as slurred speech, face dropped on one side, eye twitching, loss of movement and pins and needles in the arm and slower response time to answer when asked a question); … • where clients appear 'off colour'; and • where clients display symptoms of urinary tract infections (such as confusion, disorientation and unsteadiness when standing as balance can be affected). (**A3**, see also [41]).

LYNDELLE ANNE PARKE **Statement of 31 March 2021— tab 275, page 13475**		
A3. Judging impacts	23	Caring for someone with dementia does not come naturally. It is not intuitive and sometimes the logical thing is the wrong thing. We must look for the emotion underneath the words, facial expressions and body language, create a safe environment and provide more specialised care. For example, if the client has developed swallowing difficulties, insisting that they eat may not be the solution and the client may in fact need serious medical attention.
	PN11738 **Oral Evidence—11 May 2022, PN11680**	If something was wrong, if something was out of the ordinary, I take it you would include it in those progress notes, but would you also then call the case manager?---Yes.
	PN11739	If a client was, say, less talkative than usual and you thought that might be - that concerned you, you would note it in the case notes so that the next carer would see, but you would also call the case manager and let them know that this is what you've observed?---Yes.
B2. Communicating verbally and non-verbally	14	Most people do not realise the interpersonal skills personal care workers need to have if they want a career in aged care because it is never included in the job advertisements. Interpersonal skills like empathy, strong communication with a variety of personalities and types of people, positive mental attitude, time management and the ability to handle criticism.
	22	Working with clients who have serious health or behavioural conditions is much more mentally challenging and requires a higher level of interpersonal skills and care. Dementia completely changes a persons' behaviour leading to reduced communication, hallucinations, aggression, depression and, as a result, a significant change in needs. Dementia and other similar conditions make our jobs much more difficult as the clients are harder to understand, more difficult to handle and require much more family engagement.
		[Same as A3 para 23]
B3. Working with diverse people and communities		[Same as B2 para 14]
		[Same as B2 para 22]
		[Same as A3 para 23]

ANNEXURE 2: AMENDED SCHEDULES

NURSES AWARD 2020 [MA000034] **New Schedule G** **(note Schedule F under the Nurses Award 2020 is now Part-day Public holidays)**	Minimum weekly rate (Full-time employee	Minimum hourly rate
G.1 General G1.1 The provisions of this schedule apply until [insert date 4 years after commencement]. G.1.2The provisions of this schedule are to be applied to employees in the classifications listed in Schedule B, engaged in the provision of: (a) Services for aged persons in a hostel, nursing home, aged care independent living units, aged care serviced apartments garden settlement, retirement village or any other residential accommodation facility; and/or (b) Services for an aged person in a private residence.		
G.2 Nursing assistant		
	Per week	
1st year	1104.30	29.06
2nd year	1121.50	29.51
3rd year and thereafter	1139.50	29.99
Experienced (the holder of a relevant certificate III qualification)	1176.10	30.95
G.3 Enrolled Nurses		
(a) Student enrolled nurse		
Less than 21 years of age	1025.90	27.00
21 years of age and over	1076.80	28.34
(b) Enrolled nurses		
Pay point 1	1197.90	31.52
Pay point 2	1213.80	31.94
Pay point 3	1229.90	32.36
Pay point 4	1247.60	32.83
Pay point 5	1260.10	33.16
G.4 Registered Nurses		
Minimum entry rate for a:		

4 year degree[1]	1338.10	35.21
Masters degree[1]	1384.30	36.43
[1] Progression from these entry rates will be to level 1—Registered nurse pay point 4 and 5 respectively		
Registered nurse—level 1		
Pay point 1	1281.50	33.72
Pay point 2	1307.80	34.41
Pay point 3	1339.90	35.26
Pay point 4	1375.50	36.20
Pay point 5	1417.80	37.31
Pay point 6	1458.80	38.39
Pay point 7	1501.00	39.50
Pay point 8 and thereafter	1540.00	40.53
Registered nurse—level 2		
Pay point 1	1580.90	41.60
Pay point 2	1606.00	42.26
Pay point 3	1633.90	43.00
Pay point 4 and thereafter	1660.60	43.70
Registered nurse—level 3		
Pay point 1	1714.10	45.11
Pay point 2	1745.60	45.94
Pay point 3	1775.80	46.73
Pay point 4 and thereafter	1807.60	47.57
Registered nurse—level 4		
Grade 1	1956.40	51.48
Grade 2	2096.60	55.17
Grade 3	2218.90	58.39
Registered nurse—level 5		
Grade 1	1974.30	51.95
Grade 2	2079.00	54.71
Grade 3	2218.90	58.39
Grade 4	2357.30	62.03
Grade 5	2599.90	68.42
Grade 6	2844.60	74.86
G.5 Nurse practitioner		
1st year	1972.50	51.91
2nd year	2031.10	53.45

B. Variation to MA000018: Aged Care Award 2010	
2. Amend clause 14 as Follows: **14. Minimum weekly wages** **14.1A Minimum wages - Personal care workers**	
Grade	
Grade 1	1119.40
Grade 2	1162.40
Grade 3	1176.10
Grade 4	1216.00
Grade 5	1304.50