FAIR WORK COMMISSION

Matter No.: AM2020/99; AM 2021/65; AM2021/63

S 158 – APPLICATION TO VARY OR REVOKE A MODERN AWARD (AGED CARE AWARD 2020);
S 158 – APPLICATION TO VARY OR REVOKE A MODERN AWARD (NURSES AWARD 2010)
s 158 APPLICATION TO VARY OR REVOKE A MODERN AWARD (SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010)

REPLY SUBMISSIONS OF THE UNITED WORKERS UNION

1. On 1 April 2021 UWU made submissions in support of the application filed by the Health Services Union (**HSU**) to vary the *Aged Care Award 2020* (**Aged Care Award**) on work value grounds (**the Aged care award application**) On 29 October 2021 UWU made submissions in support of the application filed by HSU to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* (**SCHADs Award**) on work value grounds (**the SCHADs award application**).

2. On 4 March 2022 employers and employer groups filed material in relation to the applications including substantive submissions and accompanying material filed by Aged and Community Services Australia (**ACSA**) and Leading Age Services Australia (**LASA**) and Australian Business Industrial (**ABI**) (**the ACSA/LASA submissions**).

3. Together with these submissions, UWU has filed the following witness statements:

    a. Statement of Donna Cappelutti, food services assistant, South Australia

    b. Statement of Jane Wahl, gardener South Australia

Similarity in submissions and supporting material

4. Many of the submissions made by UWU in support of the applications find a level of support in the material filed by the employers and employer organisations (together, "**the employers**").

5. There seems little doubt that the conditions under which the work is performed in residential aged care involve a higher proportion of residents presenting with more acute care needs than in the past.[1] At this stage of the proceedings, some employers' position with respect to home care is less clear, although there seems little doubt that in home care more people are choosing to stay living at home for longer.[2] UWU submits that it follows (and that the evidence will support the proposition) that clients for whom home care aged care employees provide care have

[1] ACSA/LASA Submission at [19.3]; Statement of Brown at [44]; Statement of Smith at [39] and [61] – [63]; Statement of Sadler at [58]; Statement of Bradshaw at [13] and [14]; Statement of Brockhaus at [32] – [34]; Statement of Matthew Bond at [13]; ; IRT Submission at [5], [6]; Uniting Care Australia Submission at 2.1; Uniting Care NSW.ACT Submission page 2; Aged Care Sector Stakeholder Consensus Statement at [1], [2], [3], [6]
[2] ACSA/LASA Submission at [3.18(d)]; Statement of Matthew Bond at [15]

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higher and more complex levels of need, including higher levels of physical, mental or neurological frailty, than in the past.[3]

6. Undoubtedly, the philosophical approach involved in the provision of care has also changed the nature of the work – particularly with respect to client "choice". In residential care this has changed the nature of the interaction between workers and resident and families - a change described by ACSA/LASA as both a pyscho-social interaction and a physical interaction[4] - requiring the exercise of new skills in this regard. In home care this results in a less structured stream of duties where additional or amended duties are negotiated with the client or client's family about which duties are performed within the funding framework,[5] requiring workers to be required to perform a broader range of duties and having to plan and adapt to highly different duties or routines from client to client.[6]

7. Further there seems little doubt that the has been impact on the nature of the work and the conditions under which it is performed stemming from matters including:

    a. fewer employees with "medical" expertise on site in residential care[7] resulting in the assistance with medications or the verification of medications;[8]

    b. the exercise of skill and responsibility associated with providing care and services to people with specialist care needs, such as dementia and palliative care;[9]

    c. changes in technology, including in relation to the provision of care and also facility systems and practices.[10]

    d. changes in the regulatory environment.[11]

Gender based undervaluation

8. In our submissions in relation to the Aged Care Award application, UWU submitted that a contributing factor to the undervaluation of work performed under these awards is a gender-based historical undervaluation of caring roles,[12] and made a similar submission in relation to the SCHADs Award application.[13] Employers (other than Uniting NSW.ACT) have largely ignored this submission.

9. The submission should not be ignored. The historical gender-based undervaluation of work performed in this sector is crucial part of the structural defect in the wage schemes in both Awards.

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[3] See pages 10-12 of Vol. 2 of the Report of the Royal Commission into Aged Care, Quality and Safety, 1 March 2021, https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-2_0.pdf;Uniting Care Australia Submission at 2.1; Uniting Care NSW.ACT Submission page 2; Aged Care Sector Stakeholder Consensus Statement at [19]
[4] ACSA/LASA submissions at [12.20]; see also ACSA/LASA submissions at [3.18(l)]; [19.8]; Statement of Matthew Bond at [17]-[18]; IRT Submission at [8]; Aged Care Sector Stakeholder Consensus Statement at [9], [12]
[5] Statement of Brockhaus at [152] – [154]; Aged Care Sector Stakeholder Consensus Statement at [17]
[6] ACSA/LASA submission at [10.25]; [10.33]; IRT Submission at [10]; Aged Care Sector Stakeholder Consensus Statement at [9], [12]
[7] See ACSA/LASA submissions at [3.18(c)]; Aged Care Sector Stakeholder Consensus Statement at [15] – [16]
[8] Statement of Emma Brown at [74] – [76]; Uniting Care NSW.ACT Submission page 2
[9] Statement of Emma Brown at [44], [49]; Uniting Care Australia Submission at 2.1; Uniting Care NSW.ACT Submission page 2; Aged Care Sector Stakeholder Consensus Statement at [2] – [3]
[10] Statement of Emma Brown at [51] – [52]; [81] – [82]; ACSA/LASA submissions at [21.4]; Uniting Care Australia Submission at 2.1; Uniting Care NSW.ACT Submission page 2
[11] See Statement of Brockhaus at [27] – [29]; Statement of Smith at [41] – [59]; IRT Submission at [7]; Uniting Care Australia Submission at 2.1; Uniting Care NSW.ACT Submission page 2
[12] UWU Submissions (Aged Care Award) at [31(b)]
[13] UWU Submissions (SCHADS Award) at [31(e)]

10. While the evidence is yet to be heard, there is substantial material before FWC that supports our proposition that gender-based undervaluation in these two Awards has contributed to the undervaluation of wage rates generally. This material includes:

    a. The residential aged care and home care frontline workforce is overwhelmingly female and the nature of work they perform is highly gendered, historically viewed as quintessentially 'women's work' and therefore of little economic value.[14]

    b. The gendered norms that underpin the devaluation of care work are premised on an 'ideology of domesticity' that positions the care that women do, both in home and as paid work, as natural and therefore unskilled.[15] The link assumed between unpaid care work in the family and paid care work that means aged care work has been significantly undervalued in government funding.[16]

    c. The gendered view of aged care work as similar to the unpaid care work women may perform means the nature and value of work undertaken by non-professional workers within residential care and home care is profoundly undervalued by the federal government and many providers.[17]

    d. Despite a shift to a discourse of 'relationship-based care', there is little recognition of the skills and time required to provide 'good' aged care in many contemporary residential aged care facilities and home care settings in Australia.[18]

    e. Skills required in care work include (but are not limited to): health or medical-related skills and knowledge of complex conditions; knowledge, understanding and ability to provide person-centred care and enablement; literacy, numeracy, language and communication competencies to be able to administer medicine, do the necessary documentation and communicate with service-users, carers, and medical professionals; technological and digital capabilities; 'employability' skills including the capacity to problem-solve, work in a team, management of stress and one's own health and wellbeing; and 'body work' skills, which require specialist knowledge and skill to enable care workers to care for the bodies of service-users, to protect skin integrity, uphold the dignity of the service user, and adhere to hygiene and infection control policies.[19]

    f. However, such skills tend to be viewed as somehow 'natural' attributes of the female workforce, requiring the 'right' attitude or personality rather than demonstrable skill.[20]

    g. Research has shown that jobs involving interacting with other people, which tend to be female dominated, are generally paid lower wages than comparable jobs, especially where caring or nurturing activities are

[14] Statement of Dr Sara Catherine Mary Charlesworth, dated 31 March 2021, at [43], Supplementary statement of Dr Sara Charlesworth, dated 22 October 2021, at [63].
[15] Statement of Charlesworth, at [43].
[16] Statement of Charlesworth, at [43].
[17] Statement of Charlesworth, at [46], Supplementary statement of Charlesworth, at [63].
[18] Statement of Charlesworth, at [46].
[19] Statement of Charlesworth at [52], Supplementary statement of Charlesworth at [71].
[20] Statement of Charlesworth at [54], Supplementary statement of Charlesworth at [71].

performed.[21] In other words, the gendered undervaluation of care work means that care occupations attract a wage penalty.

Workers other than personal care workers

11. If the material filed by both Unions and employers/employer organisations about the nature of the work, the conditions under which it is performed and the skills being exercised has a level of alignment or similarity in a number areas, the area of most divergence may be with respect to those roles performed in residential care (under the Aged Care Award) that do not relate to a direct caring function (such as food services, laundry, maintenance/gardening and administration). While the evidence is yet to be heard, UWU submits it is unlikely that significant changes in the work performed in aged care can arise in respect to one group of workers, and other groups of workers have been insulated from those changes in a residential care setting. In our submission, the significant changes in the nature and conditions associated with work in residential aged care impacts beyond those workers engaged in a role that involves a direct caring function, on to those who perform associated duties.[22]

12. In this regard, it is appropriate to consider whether people in roles other than direct care roles have face to face impact with residents and families. Plainly they do.[23] It therefore follows that the impact on the nature of the work that flows from a higher proportion of residents presenting with more diverse and acute care needs; the changed psycho-social and physical skill set flowing from a change in care philosophy; the relative absence of medical expertise on site; and the changes in regulation and technology all have a direct impact on the work performed by these workers.

13. In food preparation, the nature of the work, the conditions under which it is performed and the skills being exercised has changed, including:

    a. the preparation with respect to menu and meal preparation and the requirement to meet expectations for consumer choice with respect to meals and catering to individual needs (for example, dietary and physical limitations);[24]

    b. dealing with residents with more acute care needs, including dealing with dementia or aggressive behaviour;[25]

    c. dealing with the impact of client choice philosophy including with respect to communication with residents and families;[26]

    d. dealing with the impact of relatively fewer medical personnel on site;[27]

    e. with respect to new technologies, including kitchen equipment and technology used to create records associated with a greater level of regulation.[28]

[21] Statement of Dr Gabrielle Anne Meagher, dated 31 March 2021, Annexure GM1, pg.36
[22] Submissions of IRT at [12]; Uniting Care NSW.ACT Submission page 2
[23] Statement of Capelutti at [17]; Statement of Wahl at [16], [28] – [29]; Statement of Whyte at [47] - [68]; Statement of Hevan at [25] – [30]; Statement of Charlier at [44] – [50], [62] – [63]; Statement of O'Donnel at [84]; Statement of Sweeney at [20], [32], [36]; Statement of Gauci at [41]
[24] ACSA/LASA Submissions at [3.18(j)] 12.25; Statement of Capelutti at [12]; Statement of Matthew Bond at [19]
[25] Statement of Capelutti at [17] – [18]; Statement of Hevan at [35], [38]
[26] Statement of Capelutti at [42] – [44]
[27] Statement of Capelutti at [39]; Statement of Hevan at [31] – [32]
[28] Statement of Capelutti at [14] and [26]

14. The work associated with the performance of maintenance, laundry and gardening roles in residential aged care has also undergone transformation arising from the significant changes impacting on the sector. For example, a gardener or laundry hand in an aged care facility:

    a. must be cognisant of the particular caring requirements of residents, particularly when they are more diverse and there is a higher incidence of acute care needs; for example, the design of a garden for a resident with dementia will require a particular approach;[29]

    b. must deal generally with residents with more acute care needs including dealing with dementia, aggressive behaviour or incidents;[30]

    c. must deal with the impact of client choice philosophy including with respect to communication with residents and families;[31]

15. Similar changes have occurred in the nature of administration work associated with aged care facilities. In these roles:

    a. administration officers (and similar) must be cognisant of the particular caring requirements of residents, particularly when they are more diverse and there is a higher incidence of acute care needs;

    b. must deal generally with residents with more acute care needs including dealing with dementia, aggressive behaviour or incidents;[32]

    c. must deal with the impact of client choice philosophy including with respect to communication with residents and families;[33]

    d. new technologies – particularly stemming from the regulatory environment – have had a significant impact upon the nature of the work.[34]

The C-10 framework

16. The ACSA/LASA Submission address at length issues associated with the application of the "C10 framework" in relation to minimum wage setting in modern awards. UWU intends to address these matters after the evidence is heard in our closing submissions.

United Workers Union

21 April 2022

[29] Statement of Wahl at [12] – [13]; Statement of Charlier at [67]; Statement of O'Donnel at [96] – 102]
[30] Statement of Wahl at [36], [42]; Statement of Whyte at [61] – [67]; Statement of Charlier at [64], [67]; Statement of O'Donnel at [83] – [86], [101]
[31] Statement of Wahl at [19] – [20]; [40] – [41]; Statement of Whyte at [47] – [48], [51], [54] – [58]; Statement of Charlier at [43]
[32] Statement of Gauci at [68] – [70]
[33] Statement of Sweeney at [24] – [25], [31]; Statement of Gauci at [36] – [37], [50 – [53]; Statement of Matthew Bond at [20]
[34] Statement of Sweeney at [22]; Statement of Gauci at [57]

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STATEMENT OF DONNA CAPPELLUTI

I, Donna Lee Cappelluti, Food Services Assistant, care of 333 Marion Road, North Plympton, South Australia, say as follows:

1. I am currently [redacted] years old.

2. I am employed as a permanent part time Food Services Assistant (FSA) with Sothern Cross Care (SCC). I work at the Bucklands site at North Plympton.

3. This statement is made to the best of my own knowledge and belief unless stated otherwise.

Employment history and career progression

4. I have worked as a FSA for almost 7 years.

5. In about 2014, I started working as a FSA with SCC at Bucklands.

6. Bucklands is not a modern building. Some of it may be heritage listed. It is a 147-bed facility over 2 floors. 3 areas upstairs and 3 areas downstairs.

7. All the areas downstairs are high need. One wing is a lock up dementia ward. The rest of the areas on both floors are open.

8. Since I started, a cafeteria has been built and a larger gym was moved upstairs.

9. The café accommodates the families and friends of the residents to be able to spend more time with the residents. Previously there was only a café at the facility cross the road called The Pines.

10. The gym was made bigger because SCC is trying to make the residents more active. When I first started working there, the residents came in a more mobile condition, but now they are not. There were also more residents in princess chairs, but SCC avoids this option as much as they can to try to keep the residents mobile.

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11. In 2015, the entire kitchen was renovated because the floor was very slippery and now there is more foot traffic because more food is being prepared. More food is being prepared because now the diet requests of the residents have changed.

12. When I first started residents only needed vitamised foods or minced/moist food or soft or normal food. Now, we still have all of those foods plus lactose and gluten free foods, vegan, vegetarian and high protein diets. Essentially very specialised diets.

13. These changes occurred because the residents are arriving at an older age and living longer. They have more health conditions. Also, SCC provides more client centred care and try to cater for individual resident's and their family's needs and requests.

14. The other reason for the kitchen renovation was the equipment in the kitchen was old, such as the ovens, mixers, fryers, dishwashers. They needed to be replaced. Now, the dishwasher and one of the ovens are bigger. The rest was replaced at the same size.

Training history

15. In 2018, I completed a specialised certificate for first aid for residents with dementia through SCC.

16. In 2018, I commenced training for a WHS certificate through SCC. Training sessions are provided once per year over 4 years to be a WHS Officer. Unless I stop being an officer or sitting on the WHS Committee, I will be required to take refresher courses each year.

17. I have asked for extra training and raised it during WHS Committee meetings but, to date, it has not been provided. I mainly ask for dementia training because the behaviour of residents has continuously gotten worse over the years. The direct care staff receive the training but not the food services staff. I have raised with management that food services staff are required to deal with the residents also. We need to respond to their behaviours and interact with them, including responding to their aggressive behaviours. In recent years it has become much more common to serve meals to residents with behavioural problems. If you don't know how to speak to them correctly, they can get aggressive and act out. This could be directed at food services staff, other staff, residents, visitors or even themselves. We are not allowed to touch residents. So, if a situation escalates, we need to find a nurse or care worker to come assist us.

18. I have noticed over the years that when residents first come into the facility, they are more difficult to deal with and more often behave in an aggressive manner. In addition to these issues, over the last 12 to 18 months chemical and physical restraints are often not being used as they can now be considered elder abuse. This means that residents cannot be restrained when they enter the home with these issues. This has heightened the behaviours of many residents that were already an issue. Also, residents can be very regimented and there are often not enough care and nursing staff to prevent them from becoming upset and triggering this type of aggressive behaviour. This all means that non-care staff are now having to deal with the residents

who can be more aggressive. For example, residents can wander into the kitchen and servery areas. If we ask them to leave they can become quite aggressive and abusive. We have a lady in the dementia ward who will walk into the kitchen and stand right next to us in the servery. She wants to touch us and help us. We worry that she is going to hurt herself, such as slipping or cutting herself. We have knives there that they can injure themselves with or attack us with. They also love to throw drinks.

19. I am also required to have a current police clearance which SCC pays for. Although, SCC does not provide me with a copy because they paid for it.

20. I also do any Medi-guides I have to complete. A Medi-guide is online training. For example, manual handling and fire training. I read the scenarios and answer the questions. I need to get 100% to pass the training session. Originally, all training was attended in person at a training session. Now most training sessions are online. Some training such as manual handling training would be more useful if done in person. When I do manual handling training online, I am mainly looking at pictures of people handling items. It would be more useful if this was provided in person, so someone could watch me perform the action and provide feedback. When I first started working with SCC, I did training modules every three to four months, but now we are undertaking training on a monthly basis. If you do not complete the training within the timeframe provided, then you are not permitted to attend shifts.

Description of tasks and explanation of skills

21. My duties as a FSA include: -

    a) Serving meals;

    b) Serving morning and afternoon tea;

    c) Dishwashing;

    d) Cleaning of the serveries and kitchen;

    e) Paperwork related to food such as recording food temperatures;

    f) Setting tables; and

    g) Stocking areas.

22. Over the past two to three years my duties statement has become more involved with extra duties added. This includes more thorough cleaning duties such as cleaning fridges, dishwashers, cupboards and drawers after services or multiple times per day rather than just at the end of the shift. All the cleaning must be signed off on a record. Apart from Covid related concerns, this appears to be because there is a greater focus on hygiene and food quality. Recently, the record taking has become more extensive due to there being more duties on my statement to report on. The amount of time to perform the additional duties has not increased.

23. My general duties as a FSA depends on which area I am working in. Generally, 1 FSA looks after 2 serveries, 1 servery allocated in each area.

Overall, 3 FSAs look after 6 serveries and the remaining FSAs work in the kitchen preparing meals, dishwashing and performing other kitchen duties.

24. During a fortnight, 2 days out of 10 I work in a servery and the other 8 days I work in the kitchen.

25. I prefer to work in the kitchen because there is not such a strict timeline in the kitchen. When working in the servery we have a strict timeline. Sometimes, the carers do not get the residents out on time for breakfast. This puts us behind because we cannot serve breakfast until they are ready to be served. This is because we have to plate up hot meals and cannot do it before as it will get cold. This issue has gotten worse over the years because the carers find it harder to get the residents out of bed.

26. When carers bring the residents to the table, they need to put into the phone what the resident wants for breakfast before we serve it to them. This is so SCC can keep track of what the resident eats throughout the day. My understanding is that this phone system was brought in by SCC to help keep up with record keeping of things like nutrition and fluids as required by regulations.

27. Breakfast is supposed to start between 8.00am and 8.15am. But 2 serveries will always start at 8.00am and the rest will start between 8.30 am and 8.45am. We are told to stay there until the breakfast is served but that impacts on our break at 8.50am. SCC has said that if residents do not feel like getting out of bed and want, for example, breakfast at 10.30am they can. This makes our job difficult as we are preparing and serving morning tea at that time. But SCC does this because the care provided to residents these days is more client centred. When I first started, breakfast had an allocated serving time and it was done by then. I have noticed that this is more of an issue now because residents seem to stay in bed much more.

28. On a typical day, I arrive at 6.45 am. I check my bain marie, put the plate warmer on and check the stock in the fridge before I go to the kitchen.

29. At 7.00am, I'm in the main kitchen loading a trolley with all the items that are needed for breakfast such as juices and fruits.

30. Then I go to one of my allocated serving areas and do a part set up for breakfast and then go to my second allocated servery and set up breakfast there.

31. Then I go to the kitchen and get all the hot foods and stock both areas ready to serve by 8.00am.

32. Once I deliver the hot food, I wait for the carers to come out and tell me what to make for breakfast. I stay in the area until breakfast is finished. Then I take the dishes back to the kitchen and take a break at 8.50am. But if we are running behind time we have to go without a break.

33. From 9.00am to 11.15am, I do 2 lots of breakfast dishes, serve 2 lots of morning teas to the residents' rooms and then 2 lots of setting tables for lunch. Then general cleaning in each area as well.

34. At 11.15am we take our rubbish out, then go on our lunch break from 11.20am to 11.50am. That is if we are able to be on time. Otherwise, we have a shortened lunchbreak.

35. At 11.50am, I go back to the kitchen and stock a trolley with hot foods for lunch and stock an area and then do the same for my other area.

36. From 12.00pm, I start serving lunch and then I have to wait until lunch is finished. Then take dirty dishes back to the kitchen and help wash the dishes until 12.50pm.

37. Until 3.00pm I do the same as I did from 9.00am to 11.15am for afternoon tea and dinner. I stay in the area until afternoon tea is finished and then take my rubbish out again and leave for the day after a hand over in the kitchen.

Supervision

38. The Regional Manager is responsible for setting our rosters. However, while at work we answer to the Chef Manager. Currently, [redacted] is there Tuesday to Saturday. When the Chef Manager is not there, we answer to one of the Chefs.

39. There is supposed to be a nurse in each servery during all dining times. However, the nurses and carers are usually too busy to keep an eye on us. If an issue arises with a resident, we have to call a nurse or carer. We don't have a phone or pager, so we just hope that someone is around or we can get someone's attention.

40. We have 2 entrances to each servery and cannot keep an eye on both entrances at once. If a resident walks in, we are not able to remove them and need to call a nurse or carer. This means that I need to be more cautious, especially if working in the dementia area. There is a lot of responsibility on me to ensure that the residents are safe and do not harm themselves or someone else.

Changes over time

41. Since I first started, there have been a lot more duties added to my duties statement. Such as more vigorous cleaning due to infection control. I have to take more time with serving meals to deliver a dining experience. There a more dishes to deal with because there is more food being used.

42. People at head office seem to have a higher expectation of staff on the floor. It seems to me that the families of residents now have higher expectations of the facility as a whole, especially considering the amount of money that they pay to get into the facility.

43. Also, the residents are coming in with more issues. They seem to stay at home longer. There appears to be a stigma at the moment about going into aged care because of the quality of care. Residents are coming to the facility at an older age with more health and behaviour issues.

44. Now, SCC have quality of care standards that we must follow. There are 8 different standards relating to such things as interactions with residents. This means we have to give the residents more of our time. For example, when

serving meals asking them how they are, is everything okay. We have to interact with them more now. Some can be very chatty and it can be hard to walk away. This is on top of having to complete all our other food related tasks.

Pay

45. The entire time I have worked with SCC my work has been covered by an enterprise agreement. So, I have always been paid at least the base rates of pay under the Aged Care Award.

46. When I first started working with SCC, I was paid the casual rate of about $23.00 or $24.00. This was a base rate of about $19.00 without the casual loading. 2 years later I was transferred to permanent part time and paid the base rate.

47. Now I am paid a permanent part time base rate of $22.74.

Signed by Donna Cappelutti

On 21 April 2022

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Signature

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STATEMENT OF JANE WAHL

I, Jane Natasha Wahl, Gardener, care of [redacted], South Australia, say as follows:

1. I am currently [redacted] years old.

2. I am employed as a permanent part time Gardener with Gloucester Residential Care (**GRC**). I work at the Ingle Farm site.

3. This statement is made to the best of my own knowledge and belief unless stated otherwise.

Employment history and career progression

4. I have worked as a Gardener for almost 16 years.

5. In about 2006, I started working as a Gardener with GRC at Ingle Farm.

6. It is a modern looking Facility with a classical tilt. They try not to make it look sterile, but it still looks kind of sterile. They have always had an emphasis there that it is a home away from home. So, they encourage residents to bring in furniture and personal items, but there is a limit.

7. It has always been a high care facility. There are a high number of residents who have dementia who are spread out over the facility. There is a secure ward for dementia residents but when they become bed bound, they can be moved to other wards. They tend to leave the secure ward for those residents who are still mobile.

8. When I first started, the dementia ward was open and residents were able to move around the facility more freely. However, there were then some residents with dementia who sustained injuries and a decision was made to make the ward secure. So, about ten years ago the dementia ward was locked up. For example, a resident had hurt themself with boiling water when they wandered into our staff room. It seems that it was decided that they needed to be in a more secured and monitored environment. There were probably a few other incidents.

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9. When I first started, there were five wards and about 70 beds. About seven or eight years ago they added a ward. There was another site that was closed, and the residents were brought to GRC to fill the ward. Then about five years ago they added yet another ward. The two new wards have about 20 beds each. So, we now have seven wards and about 110 residents. I think it's because GRC is a profit organisation. So, more beds may make more commercial sense.

10. Despite the addition of two wards and around 40 additional residents there haven't been corresponding extensions to the kitchen, the laundry or the staff room. It is definitely an issue for kitchen staff, but the laundry is also very cramped.

11. There have been changes to my dedicated workspace on site and I have access to better tools. When I first started, they only had a hand trowel and a bin. I kept my petrol in a cupboard inside. Now I have a dedicated shed and I generally get whatever equipment that I ask for that is needed to complete my work such as a lawn mower.

12. As the facility has grown in capacity there have been changes to the existing grounds and new outdoor spaces. I have been asked to design the garden and implement those works. Whenever I have the opportunity to make changes in the grounds, I think about how that can be done to make improvements for the residents. When I am designing a garden or outdoor space, I always keep in mind the needs of the residents.

13. I've learnt more about the resident's needs and how that relates to their surroundings as I have worked in the aged care industry. Gardening is one thing but gardening in aged care is different, you need to be mindful of safety. This is especially the case if designing a garden or area that will be accessed by residents with conditions such as dementia as it will be different from the design of a usual resident garden area. For example, for a space used by residents with dementia you wouldn't include mirrors or very reflective surfaces as this can be a trigger for some residents. You would also implement straight line edging with a different colour. This is because the colour draws the eye and is a focus point and something that can be followed. Wherever possible I would try to edge in a circle, so the residents using the space will naturally be returned to where they entered the garden and so you minimise the possibility of a resident becoming lost, disoriented or distressed.

14. There are also considerations for the types of plants and flowers that are planted. Certain plants are stimulating due their size, shape and smell. While others are poisonous if ingested. As the residents will sometimes have conditions that will affect their cognition, I would always ensure nothing in the garden can be dangerous if ingested.

15. Prior to me commencing at the site there wasn't a gardener employed directly by GRC and instead periodically a contractor might be brought in. When I first arrived the garden spaces were just standard spaces that you might have in a commercial setting, all of the specific considerations that are particular to an aged care resident or residents weren't taken into account. I have made those changes over time and had the opportunity to design new spaces or re-design existing spaces to meet the specific needs of the facility and residents.

Training history

16. In 2006, I completed a Certificate 2 in Horticulture with TAFE, Torrens Valley.

17. Then in 2018, I completed a Certificate 3 in Laboratory Studies with TAFE, Gilles Plains.

18. I previously negotiated with GRC to increase my classification given my qualifications, I design gardens, I research dementia clients' needs and I am involved in garden clubs with residents.

19. There are lifestyle staff at the facility who provide different activities to the residents. However, some of the residents like gardening. So, I provide regular garden activities for the residents to participate in. I think GRC like that I am providing an activity or service that is client centred. Residents from the dementia ward are allowed to participate in the club but we need to monitor this because the program doesn't work if a resident is too demanding as it impacts on the quality of the session for the group. I plan what activities I will do with the residents. I work alongside them and engage with them. I can see what they enjoy or sometimes activities might be too physically challenging, so I make adjustments along the way. When I run these sessions the lifestyle staff will be in the vicinity, but I take the lead of what the residents are doing.

20. In addition to these activities I have quite a lot of interactions with the residents. My job is very active and I have to walk through the facility about 50 times per day. I am constantly bumping into the residents. GRC has a focus on making the facility a home to the residents, I will greet residents and speak with them. Even though I don't know all their names, I know their faces and they know my face. That's why I also have to do the training at work for hazard and incident reporting because I do have regular interactions with the residents. I need to be aware of how to report any incident where a resident might be at risk

21. I am required to have a current police clearance. Every four years that needs to be updated. I must pay for it. I don't need to have a current first aid certificate but only because the facility is full of nurses and care workers who do have a first aid certificate.

22. Fire training, manual handling, infection control (these days including Covid) and mandatory reporting are the compulsory training that I have to do. However, I have also sat in on other training session that are voluntary such as dementia training, schizophrenia training, thickening fluids, food safety and resident manual handling (including doing role play for training such as with lifters) and first aid. GRC is happy for me to sit in on these sessions even though it is not mandatory.

23. I find that learning more about the conditions that the residents have and the ways in which it affects them helps me in my interactions with them and it is also something I think about when I make changes or do design work for the outdoor spaces.

Description of tasks and explanation of skills

24. My general day to day duties as a Gardener include: -

    a) Watering.

    b) Weed control.

    c) Lawn control.

    d) Rubbish collection.

    e) Any garden related duties.

    f) Irrigation.

    g) Some forms of pest control.

    h) General reporting of damage and incidents with residents.

    i) Duties as needed.

25. On a typical day, I arrive at 6.30 am. The first thing I would do is open the gates on site and sheds and get my equipment ready.

26. My typical tasks depend upon the day. My days are separated into watering and non-watering days.

27. On non-watering days I am usually doing hedging or lawn care. On a watering day, I also clean the two courtyard areas.

28. I get a 10-minute break at 9.30am. Before 9.30am I try to get all my cleaning and watering duties done. At 9.40am, there is generally a meeting once a week with my special needs assistant, [redacted]. He's under the care of a disability group. He has a hearing issue, so they need to have a meeting with him once per week. This pushes the break out to 9.50am sometimes.

29. About five years ago [redacted] started as a volunteer, but he convinced GRC that there was a job in his duties, so now he is employed by GRC and is paid wages. Our [redacted] has a child with disabilities so is aware of the organisation which [redacted] comes from.

30. Usually then [redacted] and I will go to whichever garden is most in need of maintenance and do work in that area for around an hour. I will also complete any ordering I need to do, deal with any deliveries and if there is any research I need to complete.

31. I also look after birds in a metre-by-metre aviary that I look after twice per week. This was a lifestyle project for residents to come and look at the birds. I designed the garden that the birds are in.

32. This is probably another example of how gardening work in an aged care facility is different to commercial settings, the facility is supposed to be as

close to a home as possible and there are complexities that come with that. Taking care of animals isn't something you'd generally expect from gardening but in aged care you implement different things to try to enhance the resident's experiences.

33. If it's a non-watering day I also perform hedging, budding roses, pest control and pot management.

34. I don't have a lunch break because I finish at 11.30am. I work Tuesday to Friday across five-hour shifts.

Supervision

35. I am supposed to report to the Head Chef. However, her role is so different from mine that she has little involvement in the work I do. So, I work pretty independently and usually report to our Chief Executive Officer (who would normally be the Clinical Nurse in Charge in most aged care facilities). Most issues I have can be reported by paper if she is busy. Otherwise, I don't have much supervision. There are random audits to check the garden.

36. There have been incidents where a resident has been threatening or aggressive. About four years ago, a resident incorrectly thought he did not get his medicine. He was chasing the nurse in the area and I just happened to be there watering the small garden in the secure dementia ward. The nurse had her medication trolley between him and her. I asked her if she needed assistance and he directed his attention towards me. I put a table between him and I. He decided to continue chasing the nurse. We had to wait for assistance from other areas because the care workers in the area didn't know that this was happening, but the nurse had a DECT phone and called for assistance.

37. My assistant finds these kinds of incidents distressing but I have experience working with residents in an aged care facility and have learned how to deal with them. Also, I have done dementia training through GRC on a voluntary basis. When I observe a resident might be agitated, I understand the importance of giving them space, speaking calmly with them or distracting them. It can avoid a situation escalating or defuse an already escalated situation.

38. There is usually a nurse or a care worker nearby. We have emergency call bells in the rooms. I have also been given permission to have my mobile phone with me in case something happens when I am in the garden. It's only the last ten years that GRC has pushed for people to have phones on them, before then they had pagers.

Changes over time

39. Resident families have a higher expectation with everything now in residential care. They will come to us with issues, and we will try to fix it as much as we can within the parameters we have such as the budget. There has definitely been a change towards client centred care compared to when I first started working at GRC.

40. There is a more diverse range of residents now, we see people with higher needs but there has also been an increase in the cultural backgrounds people come from. Also, I have found the war era generation are easier to get on with. However, you do need to teach them more about reporting issues as they are very reluctant to make a fuss. Recently the Boomer generation residents have started arriving and they are more used to getting what they want and are more inclined to report issues.

41. When I first started, GRC did not have much of an expectation so far as my interactions with residents. Now they expect me to know how to deal with a resident if there is an issue. For example, if there is an incident, I need to know what to do and to know how to report it. There is a greater emphasis now on reporting and record keeping. I've witnessed a few incidents when residents have fallen and have needed to know how to react in those situations, such as not to move them, and to make sure that they are safe and comfortable and how to call for assistance. This means I need to know when and how to make contact such as where there are call bells. I also need to use judgement about whether the incident can wait on a call bell response or whether it is so urgent that I have to physically and quickly find someone for assistance. Sometimes there is no-one around in the immediate area, especially during a change of shift.

42. There does seem to be a general increase in incidents with residents and resident behaviours. In addition to residents initially arriving at the home with more health and behavioural issues, during the recent years I've noticed there has been a shift away from using medication to calm residents, there has also been a shift away from applying restraint unless absolutely necessary for their own safety or that of others. It seems that dealing with resident behaviours in this manner can now be considered elder abuse. Also, there is now an emphasis on resident choice. This means that redirection and de-escalation has to be done with a verbal approach, whilst this is mainly the care workers area, at times I do have to engage in this way with the residents.

Pay

43. During my employment with GRC I have been paid under an award. Now that is the Aged Care Award. This means I have always been paid at the award rates of pay.

44. When I first started working with GRC, I was paid a casual rate of about $21.83. This was a base rate of about $17.47 without the casual loading. Shortly after I was transferred to permanent part time and paid the base rate.

45. Now I am paid a base rate of $23.39.

Signed by Jane Wahl

On 21 April 2022

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Signature