From: Nick White <nwhite@gordonlegal.com.au>
Sent: Monday, 23 May 2022 6:11 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Amended Witness Statements

Dear Associate

Please find attached the amended statements of Ms Butler, Ms Bucher, Ms Wischer, Ms McLean, Ms Nasemena, Mr Voogt and Ms Knights including the attachments.

We note that the other amended statements filed by the ANMF do not have any attachments.

If you have any further queries, please let us know.

Kind regards

Nick White
Principal Lawyer
Accredited Specialist (Workplace Relations)

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IT'S PERSONAL

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From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Friday, 20 May 2022 12:20 PM
To: Nick White <nwhite@gordonlegal.com.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Amended Witness Statements

Dear Mr White,

I refer to the amended witness statements filed by the ANMF. I note that the amended statements were filed without attachments.

Would it be possible for the ANMF to refile these amended statement *including* the attachments? We only require the compiled versions in PDF.

Kind regards,

Madeleine Castles (she/her)

Associate to the Hon. Justice IJK Ross, President

Fair Work Commission

Australia's national workplace relations tribunal

T 03 8656 4645

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Level 4, 11 Exhibition Street, Melbourne, VIC, 3000
PO Box 1994, Melbourne, Vic, 3001

The Fair Work Commission acknowledges that our business is conducted on the traditional lands of Aboriginal and Torres Strait Islander people. We acknowledge their continuing connection to country and pay our respects to their Elders past, present and emerging.

This email was sent from Wurundjeri Woi Wurrung Country.

IN THE FAIR WORK COMMISSION

Matter No: **AM2020/99, AM2021/63 & AM2021/65**

Re Applications by: **Australian Nursing and Midwifery Federation and others**

AMENDED STATEMENT OF ANNIE BUTLER

I, Annie Butler, Federal Secretary of the Australian Nursing and Midwifery Federation, of Level 1, 365 Queen St, Melbourne in the State of Victoria say:

Employment

1. I am the Federal Secretary of the Australian Nursing and Midwifery Federation (ANMF). I was formally appointed to this role in June 2018, having previously served as the Assistant Federal Secretary since April 2014.

2. Prior to becoming an elected official of the ANMF I was employed as a professional officer, organiser and lead organiser at the NSW branch of the ANMF, the New South Wales Nurses and Midwives Association. I worked in these roles from 17/03/2003 to 31/03/2014.

3. I qualified as a registered nurse in 1985 and have maintained my registration for 36 years.

4. Details of my employment history are set out in my curriculum vitae at **Annexure AB 1**.

5. I hold the following qualifications:

    a. General Nursing Certificate, Concord General Hospital and Hawkesbury Agricultural College (1985)

    b. Bachelor of Health Science (Nursing), Charles Sturt University – *Graduated with distinction* (1997)

    c. Bachelor of Nursing (Honours First Class), University of Technology, Sydney – *Winner of student award – Best Honours Research Project* (2000)

    d. Certificate IV in Training and Assessment (2008)

    e. Craft of Organising Certificate, Lead Organiser Development Program (2011 – 2013).

6. I am, or have been, a member and/or director of the following:

    a. Australian Nursing and Midwifery Accreditation Council – Board Director - *Current*

    b. International Council of Nurses – Australian Technical Adviser, Council of National Nursing Association Representatives - *Current*

    c. Commonwealth Nurses and Midwives' Federation – Board Member - *Current*

    d. Global Nurses United – Member for Australia - *Current*

    e. Australian Council of Trade Unions (ACTU) – Executive member and ACTU Aged Care Working Party Member - *Current*

    f. National Nursing and Midwifery Strategic Reference Group – Member - *Current*

g. Nurse Practitioner 10 Year Plan Steering Committee – Member - *Current*

h. National Rural Nursing Generalist Steering Committee – Member - *Current*

i. Ministerial Advisory Committee on Skilled Migration – Member - *Current*

j. Australian Health Practitioner Regulation Agency Professions Reference Group – Member, *2014 – 2017*

k. National Nursing and Midwifery Education Advisory Network - Member – *2015 – 2017*

l. NSW Community Services and Health Industry Training Advisory Body – Board Director, *2003 – 2011*

m. NSW Nurses and Midwives Board Nurses Practice Committee – Member, *2005 – 2010*

n. Australian Nursing Federation Professional Advisory Committee – Member (NSW Representative), *2004 – 2010*

o. Australian Nursing Federation Vocational Education & Training Advisory Committee – Member (NSW Representative), *2004 – 2010*

p. NSW Nurses' Association Professional Issues Committee – Member, *2003 - 2010*

q. NSW Nurses' Association representative contributing to the development of the National Registration and Accreditation Scheme for Health Professionals in Australia, *2008 – 2010*.

7. As Federal Secretary, I am the principal officer of the ANMF, who, with the direction of the ANMF's Federal Council, is responsible for overseeing the activities of the ANMF's Federal Office to promote and protect the interests of ANMF members and to provide professional and industrial leadership for the nursing industry and the health and aged care sectors.

8. In pursuit of the aims outlined in paragraph 7 with regard to the aged care sector, my role requires significant engagement with members employed in the sector. Similarly, the role requires significant engagement with members who work in range of settings, including the acute public and private health sectors and primary and community care, and whose work intersects with recipients of aged care services in these settings, as well as with relevant Government Ministers, Health and Aged Care Department Officials, and Aged Care Industry Leaders. It has also required the development of substantial knowledge and understanding of how nursing and care services are delivered in the sector and examination and analysis of the factors required to realise improvements for ANMF members in the aged care sector.

9. This knowledge and analysis has been developed through the following:

a. Conducting regular surveys of the ANMF's membership employed in aged care and other sectors providing services to recipients of aged care;

b. Commissioning research investigating a range of areas relevant to ensuring the delivery of safe, quality care in the sector, including: care needs of the elderly and staffing and skills mix requirements; funding arrangements; financial and tax practices in the aged care sector.

c. Providing evidence, statements and submissions to key inquiries into aged care, including Parliamentary, Senate Select Committee and Standing Committee Inquiries and, most recently, the Royal Commission into Quality and Safety in Aged Care;

d. Participating in aged care committees and roundtable discussions on behalf of

members including: Commonwealth Department of Health and Aged Care Briefings; Ministerial Roundtables and Briefings; Commonwealth Department of Health and Aged Care and Key Stakeholder – COVID-19 Briefings and COVID-19 Vaccination Roll Out meetings; Aged Care Workforce Industry Council Briefings.

e. Leading political advocacy for improvements for aged members with all federal politicians and key industry, medical and health organisations and bodies.

f. Providing direction, leadership and oversight to ANMF Federal Office employees engaged in a variety of activities related to aged care.

g. Overseeing and authorising campaigns to improve both the industrial and professional conditions of employees working in the aged care sector and the safety and quality of care delivered to recipients of care.

10. While I have not been employed in the aged care workforce, I have had more than 10 years of experience as a clinical nurse working in a range of settings. In my role as an employee of NSWNMA, I engaged with members working in the aged care sector through professional representation of their interests and legislative and professional policy review and development, and education. I supported members in managing workplace issues and in developing and organising campaigns for improvements in their working conditions and to the care provided to recipients of aged care services.

11. In my role as an elected official of the ANMF Federal Office, I have engaged extensively with matters related to the aged care sector, as outlined in paragraphs 7-10 above.

Introduction

The ANMF

12. The ANMF is Australia's largest national union and professional nursing and midwifery organisation. The ANMF is an employee organisation registered under the *Fair Work (Registered Organisations) Act 2009* (Cth). The ANMF was first registered as an employee organisation under the *Conciliation and Arbitration Act 1904* (Cth) as "The Trained Nurses' Guild" on 24 February 1922.

13. At 30 June 2021 the ANMF had more than 300,000 members. ANMF members work in the public and private health, aged care, disability and higher education sectors across a wide variety of urban, rural and remote locations.

14. Based on membership data recorded at Branch level, it is estimated approximately 45,000 members of the ANMF work in the aged care sector. Branches collate this information based on information provided in membership forms, which includes members advising their clinical area of practice and the name of their employer. Members identified as working in the aged care sector work across the classifications of:

- Assistants in Nursing (**AINs**);
- Personal Care Workers (**PCWs**);
- Enrolled Nurses (**ENs**);
- Registered Nurses (**RNs**);
- Nurse Practitioners **(NPs**)

15. The classifications of AIN and PCW may both be known by other titles, such as nursing assistant, extended care assistant or personal care attendant. For the purposes of my statement I will refer to AINs and PCWs.

16. The ANMF has eight branches with one in each state and territory of Australia. The branches operate autonomously to a large extent. Each branch is named after the state or territory it operates in except for the branch with coverage of Queensland, which is known as the QNMU Branch.[1]

The Rules of the ANMF

17. The Rules of the Australian Nursing and Midwifery Federation (**ANMF Rules**) (**ANMF 1**) specify the purposes for which the organisation is formed and provide for the conditions of eligibility for membership, the powers and duties of committees branches, and office holders. The ANMF Rules were last altered on 4 June 2021. In accordance with the ANMF Rules the affairs of each branch are managed by a Branch Council which, subject to the rules, is the highest policy and decision making body of the branch.[2] Each branch has autonomy in matters affecting members of the branch only.[3]

18. Eligibility to join the ANMF is defined by Rule 5 of the ANMF Rules. Sub-rule 5.1 applies to all branches of the ANMF. It states:

> *5.1 Membership shall be open to the following classes of employees engaged in the nursing industry or midwifery industry:*
>
> *5.1.1 Who hold a certificate of three years training as a nurse in a recognised general hospital or an undergraduate or post graduate diploma or degree as a nurse or midwife from a higher education institution*
>
> *5.1.2 who can produce evidence of training to the satisfaction of the Council*
>
> *5.1.3 or who are registered in Australia by the Commonwealth or any State or Territory.*
>
> *5.1.4 Together with such other persons, whether employees in the industry or not as have been appointed officers of the Federation and admitted as members thereof.*

19. Registered nurses, midwives and enrolled nurses are eligible to join the ANMF in accordance with sub-rule 5.1.3. This is because all nurses and midwives must be registered with the Nursing and Midwifery Board of Australia (NMBA), and meet the NMBA's registration standards, in order to practise in Australia. The NMBA is a creation of a series of state and territory Acts of Parliament which create the nationally consistent Health Practitioners Regulation National Law **(ANMF 2)**.[4]

[1] ANMF Rules r 59.
[2] Ibid sub-r 65.1.
[3] Ibid sub-r 4.3.
[4] *Health Practitioner Regulation National Law Act 2009* (Qld) sch Health Practitioner Regulation National Law.

20. Sub-rule 5.1.2 allows employees (with evidence of training) who work in the nursing industry to join the ANMF. For example, many personal care workers working in the nursing industry in aged care have the qualification of a Certificate III in Individual Support (CHC33015), which is recognised by the Federal Council as constituting satisfactory evidence of training.

21. Sub-rule 5.2 provides additional eligibility criteria, separate to sub-rule 5.1. With respect to sub-rules 5.2.1, 5.2.2 and 5.2.3 and 5.2.5 these sub-rules largely mirror the eligibility rules of the corresponding state union being respectively:

    a. Queensland Nurses and Midwives' Union of Employees;

    b. The Australian Nursing Federation, Industrial Union of Workers Perth;

    c. Australian Nursing and Midwifery Federation (SA Branch); and

    d. New South Wales Nurses and Midwives' Association.

22. Sub-rules 5.2.4, 5.2.6 and 5.2.7 are concerned with eligibility of certain classes of employees working in residential aged care.

23. Sub-rules 5.2.4 and 5.2.6 are only concerned with the states of Victoria and South Australia respectively. These rules allow the ANMF to enrol as members anyone who provides or assists in the provision of nursing care or nursing services, or both in residential aged care, however described or titled.

24. Sub-rule 5.2.7 is concerned with the state of Tasmania. With respect to this sub-rule the ANMF is eligible to enrol into membership employees primarily engaged in providing nursing care under the direct or indirect supervision or at the direction of a nurse, midwife or medical practitioner and who are engaged (however titled) as an assistant in nursing, personal care assistant or extended care assistant in a residential aged care facility.

25. Members of the ANMF who work in residential aged care facilities are either:

    a. A nurse practitioner;

    b. A registered nurse;

    c. An enrolled nurse;

    d. An assistant in nursing (also known as a nursing assistant); or

    e. A personal carer (also known as a personal care worker, personal care assistant or extended care assistant).

The ANMF application and the aged care sector

26. The ANMF has made application to vary the *Aged Care Award* (**ANMF 3)** as it applies to personal care workers and to Lifestyle and Activity officers, and the *Nurses Award* (**ANMF 4**) as it applies to registered nurses, enrolled nurses and assistants in nursing working in both residential and home care aged care settings.

The Aged Care Award

27. The *Aged Care Award* covers employers throughout Australia in the aged care industry and their employees in the classifications listed in the Award. The classification structure set out in Schedule B of the *Aged Care Award* includes aged care employees described under three streams- being general and administrative services, food services and personal care.

28. I refer to paragraphs 17-25 of my statement above in relation to the ANMF rules concerning eligibility for membership of the ANMF. Based on the ANMF's eligibility for membership, the ANMF does not have industrial coverage of people employed in either the general administrative or food services stream of the *Aged Care Award*.

29. By virtue of Rule 5.1.2, the ANMF has coverage of and capacity to represent the industrial interests of employees working in the personal care stream. The ANMF application to vary the *Aged Care Award* is confined to the personal care stream.

The Nurses Award

30. The *Nurses Award* covers employers throughout Australia in the health industry and their employees in the classifications listed in Schedule B- Classifications and Definitions.

31. Schedule B of the *Nurses Award* includes the following classifications:

- Nursing assistant (referred to in my statement as AIN);
- Student enrolled nurse;
- Enrolled nurses;
- Registered nurses;
- Occupational health nurses; and
- Nurse practitioner.

32. The ANMF has coverage of and is entitled to represent the industrial interests of all of the classifications as defined in the *Nurses Award*.

33. The application before the Commission is confined to those employees who work in the aged care industry. Save for the classification 'Occupational health nurses', each of the classifications set out in the above paragraph can and do work in all areas of the aged care sector.

THE AGED CARE SECTOR DEFINED

The aged care sector[5]

34. Three main types of service make up the aged care sector:

- **Home support** (Commonwealth Home Support Program), which provides entry-level services focused on supporting individuals to undertake tasks of daily living to enable them to be more independent at home and in the community.

[5] Unless otherwise noted, information provided in this section (paragraphs 36-59) is from the Commonwealth, Department of Health, *2019–20 Report on the Operation of the Aged Care Act 1997* (Report, 2020). **(ANMF 5)**

- **Home care (Home Care Packages Program),** which is a more structured, more comprehensive package of home-based support, provided over four levels.
- **Residential aged care**, which provides support and accommodation for people who have been assessed as needing higher levels of care than can be provided in the home, and the option for 24-hour nursing care. Residential care is provided on either a permanent, or a temporary (respite) basis.

35. There are also five types of **Flexible care** provided as an alternative to mainstream residential and home care services:

- Transition Care;
- Short-Term Restorative Care;
- Multi-Purpose Services;
- National Aboriginal and Torres Strait Islander Flexible Aged Care; and
- Innovative Care.

Residential aged care

36. Organisations providing Australian Government-subsidised residential aged care must be approved under the *Aged Care Act 1997* before providing care. As at 30 June 2020 there were 2,722 residential aged care services, operated by 845 approved residential aged care providers.

37. The number of operational residential aged care places as at 30 June 2020 was 217,145. The occupancy rate over the 2019-2020 period was 88.3%. Table 1 provides a breakdown of the ownership of residential aged care places over the period 2011 to 2020.[6]

Table 1: Ownership of operational residential aged care places

Proportion of total places	Unit	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Private for-profit	%	35.3	35.9	36.2	37.4	37.3	38.4	39.0	40.6	41.0	41.2
Religious	%	27.1	27.2	27.2	26.4	25.1	24.4	24.3	23.9	23.4	23.2
Community-based (d)	%	13.7	13.4	13.5	13.6	13.6	13.8	13.7	13.5	13.3	13.1
Charitable (e)	%	17.7	17.5	17.6	17.4	17.6	17.3	17.1	17.8	18.3	18.7
State or Territory Government	%	4.9	4.8	4.5	4.3	5.5	5.4	5.2	3.6	3.4	3.3
Local Government	%	1.3	1.0	1.0	0.9	0.8	0.7	0.7	0.6	0.6	0.5
Total number of places		**182,302**	**184,570**	**186,278**	**189,283**	**195,949**	**199,449**	**204,335**	**207,142**	**213,397**	**217,145**

(a)	Data from June 2015 to June 2017 (inclusive) include flexible residential places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Innovative Pool program and Multi-Purpose Service Program.
(b)	For more information on data quality, including collection methodologies and data limitations, see the AIHW website (www.aihw.gov.au/national-aged-care-data-clearinghouse/about/).
(c)	In 2014-15, in the NT, there was a large transition of places from particular provider types to other provider types.
(d)	Services to an identifiable community based on location or ethnicity, not for financial gain.
(e)	Services to the general community or an appreciable section of the public, not for financial gain.

Source: Department of Health Ageing and Aged Care Data Warehouse; Department of Health (unpublished).

[6] Based on Section 14 Aged Care Services of Productivity Commission, *Report on Government Services 2021* (Released 20 January 2021) Table 14A.10 ('*GS Report*'). **(ANMF 6)**

38. Between 2011 and 2020 the share of places owned by private for profit providers increased from 35% to just over 41% in 2020. Charitable providers were the only other provider type to show an increase in the share of total places, increasing 1% from 17.7% in 2011 to 18.7% in 2020. Religious, Community based, State/territory or Local government providers' share of places decreased over the same period.

39. The size and distribution of residential aged care services, measured by the number of operational places is set out in Table 2 below. As at 30 June 2020, 80% of facilities contained 61 or more places.[7]

Table 2: Operational places by service size - 30 June 2011-2020

	2011 %	2012 %	2013 %	2014 %	2015 %	2016 %	2017 %	2018 %	2019 %	2020 %
1-20 places	1.4	1.3	1.2	1.1	1.1	1.1	1.0	0.9	0.9	0.8
21-40 places	10.1	9.4	9.2	8.5	8.1	7.6	7.2	6.8	6.5	6.1
41-60 places	21.9	20.4	19.6	18.1	17.4	16.4	15.4	14.2	13.1	13.3
61 + places	66.6	68.90	69.9	72.2	73.3	74.9	76.4	78.0	79.6	79.8

Source: Department of Health (unpublished)

A more detailed breakdown of the size of facilities by the type of provider is provided in Table 3 below. This includes additional data on the size of facilities at 30 June 2020 showing over 50% of facilities provide 101 plus aged care places. **Annexure AB 2** to this statement is a customised data report requested by the ANMF from the AIHW National Aged Care Clearinghouse for the purposes of preparing this statement.

Table 3: Places in residential aged care, by organisation type and size, at 30 June 2020

	Organisation type		
Size of the facility	**Government**	**Not-for-profit**	**Private**
1–20	1,052	619	14
21–40	2,876	8,082	1,450
41–60	1,876	16,229	6,210
61–80	805	18,652	12,154
81–100	635	20,031	14,934
101+	1,186	55,586	54,677
Total [(a)]	**8,430**	**119,199**	**89,439**

40. In 2019–20:

- 244,363 people received permanent residential aged care at some time during the year;
- the average age (on entry) was 82.5 years for men, 84.8 years for women;
- the average completed length of stay was 35.3 months; and
- On 30 June 2020, there were 183,989 people receiving permanent residential care.

[7] Ibid Table 14A.13

Commonwealth Home Support Program (CHSP)

41. The CHSP supports older people living in the community to maximise their independence through entry-level support services taking into account each person's goals. CHSP support is underpinned by a wellness approach building on each person's strengths, capacity and goals to help them remain independent and to live safely at home. Services may be provided on an on-going or periodic basis depending on need.

42. In 2019–20, a total of 1,452 aged care organisations were funded to deliver CHSP home support services to clients. CHSP providers include government, non-government and not-for-profit organisations.

43. In 2019-20 the CHSP provided services to 839,373 clients with an average age of 80.1 years.

Home care- Home Care Packages Program (HCPP)

44. The HCPP assists people to remain living at home by providing services to meet care needs as directed by the client. The package is coordinated by an approved home care provider chosen by the client, with funding provided by the Australian Government (and some contributions from the consumer). A range of personal care, support services, clinical services and other services are tailored to meet the assessed needs of the client. Packages range from level 1 to 4 depending on the individual care needs of the client.

45. Table 4 below shows the total number of people in a home care package on 30 June each year from 2017 to 2020. The average age of those who accessed a package was 81 years.

Table 4: Number of people in a home care package on 30 June each year from 2017 to 2020

2017	2018	2019	2020
71,423	**91,847**	**106,707**	**142,436**

46. Table 5 below shows the number of people in home care packages by provider type at 30 June 2020. Together, not for profit providers (religious, charitable and community based) are the main providers of home care services.

Table 5: Number of people in a home care package, by provider type at 30 June 2020

State/territory	Religious	Charitable	Community based	For profit	State/territory and local govt	Total
Australia	30,687	38,341	27,157	37,043	9,208	142,436
% of Total	**21.5**	**26.9**	**19.1**	**26.0**	**6.5**	**100.0**

47. The four levels of Home care packages are:

- Level 1 – to support people with basic care needs;
- Level 2 – to support people with low level care needs;
- Level 3 – to support people with intermediate care needs; and
- Level 4 – to support people with high care needs.

48. Table 6 below shows the distribution of people across the four levels of home care package.

The number of people in a level 3 or 4 package grew from 50,457 at 30 June 2019 to 67,176 in 2020, an increase of 33.1 percent.

Table 6 : Number of people in a home care package, by current care level at 30 June 2020					
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Total**
	16,418	58,842	29,336	37,840	142,436
% of Total	**11.5**	**41.3**	**20.6**	**26.6**	**100.0**

49. The Australian Government has announced an additional 80,000 home care packages to be provided over the 2021-22 and 2022-23 financial years as part of their response to the Final Report of the Royal Commission into Aged Care Quality and Safety.[8] (**AMNF 7)**

Home care packages program data

50. As stated in paragraph 48 home care is provided at four different levels depending on assessed care needs ranging from basic (levels 1 and 2) to high (levels 3 and 4) needs.

51. At 30 June 2020, 142,436 people were receiving home care packages. Of these, 47.2% were at levels 3 and 4 with 41.3% at level 2 and 11.5% at level 1.[9] Over the 12 month period 30 June 2019 to 20 a total of 174,992 people received a home care package; 88,745 people received a level 1 or 2 package and 86,247 received a level 3 or 4 package.[10]

52. Updated quarterly data published by the Department of Health reports there are 167,124 people receiving a home care packages at 31 March 2021. A further 16,252 packages assigned to people were also under consideration.[11]

53. Of the 167,124 people receiving home care packages, 81,990 were a high care level (level 3 and 4) package. This is 28.5% more than the number of people (63,809) with a high care level package at 31 March 2020.[12]

Flexible care services

54. At 30 June 2020, there were 10,389 operational flexible care places across the five types of service. Just short of half the flexible care places (4180) are Transition care places managed by State and Territory governments who are the approved providers.

55. There were 94 operational Short Term Restorative Care (**STRC**) services delivered by 58 approved providers. This program provides a multidisciplinary approach focussing on early intervention care to optimise functioning and independence and reverse and/or slow functional decline in older people. STRC can be delivered in either a community setting, such as the client's own home, a residential care setting, or a combination of both.

56. The Multi-Purpose services program provides residential and home care services to older people in rural and remote communities. Nationally there were 3,668 operational places as at 30 June 2020.

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[8] Commonwealth, Department of Health, *Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety* (Report, May 2021).
[9] *GS Report* (n 6) Table 14A.9.
[10] Ibid Table 14A.2.
[11] Department of Health (Cth), *Home Care Packages Program: Data Report 3rd Quarter 2020-21* (Report, June 2021). **(ANMF 8)**

[12] Ibid.

57. The National Aboriginal and Torres Strait Islander Flexible Aged Care Program provides culturally safe care to enable people to remain close to home and community. At 30 June 2020 there were 1,264 residential and home care places delivered by 42 aged care services.

58. Innovative care services support people with aged care needs who live in state or territory supported accommodation homes who were at risk of needing residential care. At 30 June 2020 were 36 operational places.

THE AGED CARE WORKFORCE

59. The residential aged care workforce data and the home care and home support workforce data to follow is provided in four parts. The first part is data covering the period 2003 to 2016 based on the National Aged Care Workforce Census and Survey (**NACWCS**) commissioned by the Department of Health and published periodically since 2003 in relation to residential care. The NACWCS has until 2020, been conducted every 4 years by the National Institute of Labour Studies **(NILS)** at Flinders University. The NACWCS census and survey data is reported in a report commonly referred to as the NILS Report. In the paragraphs below I refer to the NILS Reports produced in 2003, 2007, 2012 and 2016**.(ANMF 9, 10, 11 and 12**)[13]

60. Part two is workforce data drawn from the 2020 Aged Care Workforce Census (**2020 Census**) filed in the Fair Work Commission by the Australian Government Solicitor on 31 August 2021. The data in this section also draws on the report of the same name published on 2 September 2021 (**2020 Census Report**) (**ANMF 13**).[14]

61. Part three and four cover data in relation to home care and home support, derived in part three from the 2007-2016 NACWCS data, and in part four from the 2020 Census and 2020 Census Report.

62. I note the comments by the Australian Government Solicitor in their submission of the 31 August 2021 on the conduct of the 2020 Census and the limitation to the data.

63. I also note the 2020 Census Report indicates a number of limitations to the data collection including as follows: *"Where possible, the 2020 Census results were compared to 2016 results…….While every effort has been made to ensure comparisons are valid, there are differences between the methodologies and questions asked which may influence the results".*

64. The 2016 data shows a significant change in the skill mix of direct care staff over the previous decade in both residential and community aged care. The 2020 Census data indicates that there has been little change in the composition of the direct care workforce since 2016.

[13] Sue Richardson and Bill Martin, National Institute of Labour Studies ('NILS'), *The Care of Older Australians: A Picture of The Residential Aged Care Workforce* (Report, Released February 2004); Bill Martin and Debra King, Department of Health and Ageing (Cth) and NILS, *Who Cares For Older Australians?: A Picture of the Residential And Community Based Aged Care Workforce 2007* (Report, October 2008) ('*2007 NILS Report*'); Debra King et al, Department of Health and Ageing (Cth) and NILS, *The Aged Care Workforce 2012* (Final Report, Released February 2013); Kostas Mavromaras et al, Department of Health (Cth) and NILS**,** *The Aged Care Workforce 2016* (Report, Released March 2017) ('*2016 NILS Report*').

[14] Department of Health (Cth), *2020 Aged Care Workforce Census Report* (Report, Released September 2021) ('*2020 Census Report*').

Part One: Composition of the Residential Aged Care workforce 2003 to 2016

65. Overall, total PAYG employment in residential aged care in 2016 was estimated at 235,764, an increase of approximately 50 percent since 2003. Of the total, 153,854 are employed in direct care roles. Specifically, Nurse Practitioner, Registered Nurse, Enrolled Nurse, Personal Care Attendant, Allied Health Professional and Allied Health Assistant roles.

66. While the overall number of people employed in residential aged care has grown by 50 percent since 2003, the estimated proportion of employees working in direct care roles has declined falling from 74 percent in 2003 to 65 percent in 2016.[15] The table below shows the respective number of employees over this period:

Table 7: Size of the residential aged care workforce, all PAYG employees and direct care workers: 2003, 2007, 2012 and 2016 (estimated headcount)

Occupation	2003	2007	2012	2016
All PAYG employees	156,823	174,866	202,344	235,764
Direct care employees	115,660	133,314	147,086	153,854

Source: Census of residential aged care facilities (weighted estimates)

67. The occupational composition of the residential aged care direct care workforce has changed dramatically over this period. Registered nurses made up 21% of the direct care workforce in 2003 but only 14.6% in 2016. Similarly, enrolled nurses have gone from comprising 13.1% of the direct care workforce in 2003 to 10.2% in 2016. In contrast, the number of care-workers, (AINs, PCWs however titled), have increased from 67,143 in 2003 to 108,126 in 2016 comprising 71.5% (almost three quarters) of the direct care workforce. In 2003 carers made up 56.5% of the direct care workforce.[16]

68. Tables 8 and 9 and Figure 1 below show the changing size and composition of the direct care workforce in terms of headcount and full time equivalent employees:

Table 8: Direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2003	2007	2012	2016
Nurse Practitioner (NP)	n/a	n/a	294 (0.2)	386 (0.3)
Registered Nurse (RN)	24,019 (21.0)	22,399 (16.8)	21,916 (14.9)	22,455 (14.6)
Enrolled Nurse (EN)	15,604 (13.1)	16,293 (12.2)	16,915 (11.5)	15,697 (10.2)
Personal Care Attendant (PCA)	67,143 (58.5)	84,746 (63.6)	100,312 (68.2)	108,126 (70.3)
Allied Health Professional (AHP)*	8,895* (7.4)	9,875* (7.4)	2,648 (1.8)	2,210 (1.4)
Allied Health Assistant (AHA)*			5,001 (3.4)	4,979 (3.2)
Total number of employees (headcount) (%)	**115,660 (100)**	**133,314 (100)**	**147,086 (100)**	**153,854 (100)**

Source: Census of residential aged care facilities (weighted estimates).
*In 2003 and 2007 both of these categories were combined under 'Allied Health'.

[15] *2016 NILS Report* (n 13) 12.
[16] Ibid 13.

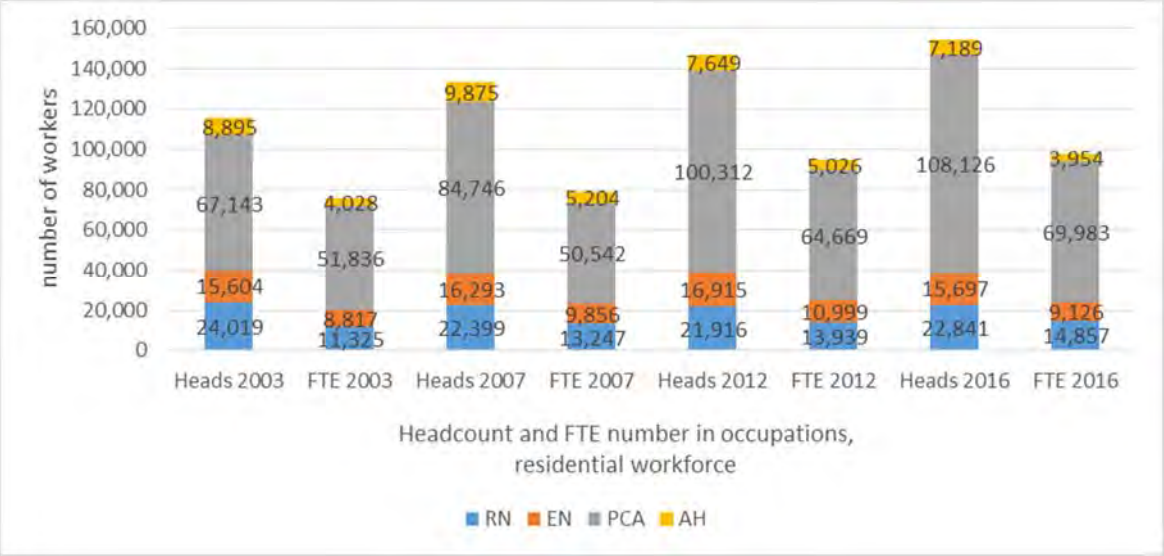
Table 9: Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated FTE and per cent)

Occupation	2003	2007	2012	2016
Nurse Practitioner	n/a	n/a	190 (0.2)	293 (0.3)
Registered Nurse	16,265 (21.4)	13,247 (16.8)	13,939 (14.7)	14,564 (14.9)
Enrolled Nurse	10,945 (14.4)	9,856 (12.5)	10,999 (11.6)	9,126 (9.3)
Personal Care Attendant	42,943 (56.5)	50,542 (64.1)	64,669 (68.2)	69,983 (71.5)
Allied Health Professional*	5,776* (7.6)	5,204* (6.6)	1,612 (1.7)	1,092 (1.1)
Allied Health Assistant*			3,414 (3.6)	2,862 (2.9)
Total number of employees (FTE)	**76,006**	**78,849**	**94,823**	**97,920**
(%)	**(100)**	**(100)**	**(100)**	**(100)**

Source: Census of residential aged care facilities.

*In 2003 and 2007 these categories were combined under 'Allied Health'.

Figure 1: Number of the occupations for the residential direct care employees (headcount and FTE)



Note: Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in 2003, 2007, 2012 and 2016 in Figure 1.

69. The shift in the composition of residential aged care workforce over this period saw the number of all direct care employees increase by 33%, while the number of registered nurses actually decreased by 6.5% in terms of headcount and 10.5% on a full time equivalent basis.

70. The 2007 NILS Report highlighted the shift noting a significant restructuring of nursing staff in nursing homes with an overall increase in nursing care delivered by staff other than registered and enrolled nurses. The Report states:

> *"Overall, these figures suggest a significant reorganisation of care in residential aged care homes so that more care is provided by PCs and less by nurses. Moreover, a greater proportion of new hires continue to be PCs suggesting that the trend towards increased use of PCs will continue"*[17].

71. This trend was confirmed in the 2012 NILS Report and noted again in 2016:

> *"…residential facilities continue to rely increasingly on PCAs to provide direct care to residents. There has been some increase in the number of RNs, but there has been a corresponding and larger fall in the number of ENs. PCAs are the only residential direct care occupational category to substantively raise its share of employment since 2012…"*[18]

Characteristics of employment in residential aged care

72. In 2016, 87 percent of the direct care workforce were female. By occupational group, 87.6% of RNs are female; 91.4% of ENs; 86.2% of PCAs and 88% of allied health workers are female.

73. The latest report notes the age of the direct care workforce is slightly younger than in previous years with the proportion of the workforce under the age of 35 increasing from 19 percent in 2012 to 25 percent in 2016.

74. The median age for all direct care occupations is 46 years, down from 48 in 2012. This is attributed to the impact of the recent recruitment of a greater number of younger people.[19]

75. Table 10 below details the median age of recently hired employees in each occupational group demonstrating the change in the age structure in 2016 compared to 2012.[20]

Table 10: Median age of the residential direct care workforce (number of years), by occupation, all direct care employees and recent hires: 2012 and 2016

	All direct care employees (Column 1)	Recent hires* (Column 2)	Difference in years in median age recent hires relative to all direct care employees (Column 3)
2016			
Registered Nurse	47	42	-5
Enrolled Nurse	50	37	-13
Personal Care Attendant	46	35	-11
Allied Health	50	33	-17
All occupations	46	36	-10
2012			
Registered Nurse	51	47	-4

[17] *2007 NILS Report* (n 13) 10.
[18] *2016 NILS Report* (n 13) 12.
[19] Ibid 15.
[20] Ibid 17.

Enrolled Nurse	49	44	-5
Personal Care Attendant	47	38	-9
Allied Health	50	41	-9
All occupations	48	40	-8
Source: Survey of residential care workers. *Recent hires have been employed for 12 months or less			

.

Type of employment and hours worked

76. Overwhelmingly, the direct care workforce in residential aged care is employed on a part time or casual basis (88.2%). Table 11 below shows the breakdown in employment type by occupation with 67.7% of RNs, 78.9% of ENs and 80.3% of PCAs employed on a part-time basis.[21]

Table 11: Form of employment of the residential direct care workforce, by occupation: 2012 and 2016 (per cent)

	Permanent full-time	Permanent part-time	Casual or contract	Total
2016				
Registered Nurse	22.4	67.7	9.8	**100**
Enrolled Nurse	13.4	78.9	7.8	**100**
Personal Care Attendant	8.9	80.3	10.8	**100**
Allied Health	19.9	75.3	4.8	**100**
All occupations	11.9	78.1	10.1	**100**
2012				
Registered Nurse	19.3	61.3	19.4	**100**
Enrolled Nurse	10.5	74.7	14.8	**100**
Personal Care Attendant	6.9	73.6	19.5	**100**
Allied Health	12.0	72.9	15.1	**100**
All occupations	9.5	71.8	18.7	**100**
Source: Census of residential aged care facilities. Row percentage shown.				

77. Data presented in the NILS report in relation to the hours of work shows that overall, 44% of the direct care workforce is working 35 hours per week or more. By occupation, hours of work vary. For RNs, 41.8 % work 35 to 40 hours per week, as opposed to 38.2% of ENs and 31.8% of PCAs. PCAs (57.2%) and ENs (47.6%) are the most likely to be working less hours in the range of 16 to 34 hours per week.[22]

[21] Ibid 25.
[22] Ibid 26.

78. The report notes that a high proportion of the direct care workforce (44%) want a change in their hours of work with 30% indicating they want to work more hours. This indicates there is a significant degree of under employment and potential to increase hours of care within the existing workforce.

Part Two: Composition of the Residential Aged Care workforce – 2020 Census

79. The information provided below is drawn from the 2020 Aged Care Workforce Census report. The Census was sent to 2,716 residential aged care facilities. Responses were received from 1,329 facilities (49%). Providers completed the Census in relation to their workforce for the month of November 2020.

80. 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. [23]

81. The report also notes 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".*[24]

82. According to the Report, the total number of staff in Residential Aged Care (**RAC**) in November 2020 was 277,671 including permanent, casual/contractor and agency/subcontractor jobs across administration, direct care and ancillary/pastoral roles.

83. There are 208,903 direct care staff in total. Of these 201,543 are in permanent or casual/contractor positions. In addition to the direct care roles, there were 52,801 working in ancillary roles such as cleaners, cooks and laundry assistants, 14,021 in management and administrative roles and 1,946 in pastoral care and educational roles.

84. Table 12 below shows a breakdown of the direct care workforce by occupation and number by headcount and full time equivalent (FTE). On a FTE basis, PCWs make up 71.2%, (72.15% including trainees), of the direct care workforce, RNs 15.6% and ENs 7.7%.

Table 12: Direct care workforce by occupation and number by headcount and full time equivalent (FTE)

Occupation	Headcount	Percent of direct care workforce Headcount	FTE	Percent of direct care workforce FTE (2)
Nurse Practitioner (NP)	203	0.10%	163	0.13%
Registered Nurse (RN)	32,726	15.7%	20,154	15.6%
Enrolled Nurse (EN)	16,000	7.7%	9,919	7.7%
Personal Care Worker (PCW)	144,291	69.1%	91,893	71.2%
Personal Care Worker Traineeship	2087	1.0%	1221	0.95%
Allied Health (AH)	13,596	6.5%	5,801	4.5%
Total Direct care workforce	208,903	100% (3)	129,151	100% (3)

Notes:
1. Of the total number of direct care workers 208,903, 201,542 are employed on a permanent or casual contactor basis.
2. FTE is only for permanent and casual/contractor roles
3. Figures do not add up to 100 percent due to rounding

[23] *2020 Census Report* (n 14) 51.
[24] Ibid 12.

85. Table 13 below shows the type of employment by occupation of the direct care workforce, (excluding Allied Health roles). Of the total direct care workforce in permanent positions, (full-time and part-time positions) 93% are employed part time. By occupation, 84% of RNs are employed part time; 93% of ENs and 96% of PCWs.

86. Of the 201,542 direct care workers employed in permanent and casual/contractor positions on payroll, overall 20.2% were employed as casual/contractor on payroll. By occupation, 22% of RNs, 17.6% of ENs and 20.5% of PCWs were casual/contractors engaged on the provider payroll.

Table 13: Direct care workforce (excluding AH) by employment type

	Permanent Full-Time	Permanent Part-Time	Total permanent	Casual/contractor on payroll
Nurse Practitioner (NP)	**104**	60	164	4
Registered Nurse RN)	4,093 (16%)	**21,210 (84%)**	25,303	7,147 (22%)
Enrolled Nurse (EN)	927 (7%)	**12,175 (93%)**	13,102	2,802 (17.6%)
Personal Care worker (PCW)	4,887 (4%)	**109,132 (96%)**	114,019	29,372 (20.5%)

87. Eighty-six percent of the aged care workforce in direct care roles identify as female. This figure includes workers in agency/subcontractor roles in addition to those in permanent and casual/contractor employees.

88. Table 14 below shows the aged distribution of RNs, ENs and PCWs working in residential aged care. Overall, 70% of the direct care workforce is under the age of 50. Just over half (51%) are under 40 years of age. By occupational breakdown, 78% of RNs are under the age of 50 and 61% under 40; 61% of ENs are under 50 while 42% are under 40 years old and 70% of PCWs are under 50 with half under 40 years old.

Table 14: RAC – Age of RNs, ENs and PCWs

Age groups	Registered Nurse	Enrolled Nurse	Personal Care Worker
60+	10%	15%	10%
50-59	12%	**23%**	18%
40-49	17%	19%	20%
30-39	**41%**	**23%**	**26%**
20-29	20%	19%	24%
<20	0%	0%	2%

89. 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% as without a response and are assumed not to hold or be studying for Certificate III. The remaining 7% were reported by the employer as unknown.

90. The 2020 Census report also identifies the number of facilities and providers that report having direct care workers with formally obtained specialist skills in 22 different areas. Figures A.4.1, A.4.3 and A.4.5 from the 2020 Census report are **Annexures AB 3**, **AB 4** and **AB 5** to this statement.

91. Facilities reported that as at November 2020 29% percent of all workers in direct care roles had left their employment between November 2019 and November 2020. By occupation, 37% of RNs and 28% of both ENs and PCWs had left within that twelve month period.[25]

Part 3: Composition of the home care and home support aged care workforce 2007-2016

92. The Aged Care Workforce, 2016 report by the National Institute of Labour Studies, (**2016 NILS report**) also provides data on the size and composition of the direct care workforce in the home care and home support aged care areas.

93. The 2016 NILS report states the '2016 census estimates that total employment in home care and home support aged care is 130,263 workers, of which 86,463 are in direct care roles.' [26] Tables 15 and 16 below show firstly the headcount by occupation for the years 2007, 2012 and 2016 and secondly by Full Time Equivalent (FTE).

Table 15: Direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2007	2012	2016
Nurse Practitioner	n/a	201 (0.2)	53 (0.1)
Registered Nurse	7,555 (10.2)	7,631 (8.2)	6,969 (8.1)
Enrolled Nurse	2,000 (2.7)	3,641 (3.9)	1,888 (2.2)
Community Care Worker	60,587 (81.8)	76,046 (81.4)	72,495 (83.8)
Allied Health Professional*		3,921 (4.2)	4,062 (4.7)
	3,925 (5.3)		
Allied Health Assistant*		1,919 (2.1)	995 (1.2)
Total number of employees (headcount) (%)	**74,067 (100)**	**93,359 (100)**	**86,463 (100)**

Source: Census of home care and home support aged care outlets.
* Note: in 2007, these categories were combined under Allied Health.

[25] Ibid 23.
[26] *2016 NILS Report* (n 13) 69–70.

Table 16: Full-time equivalent direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated FTE and percent)

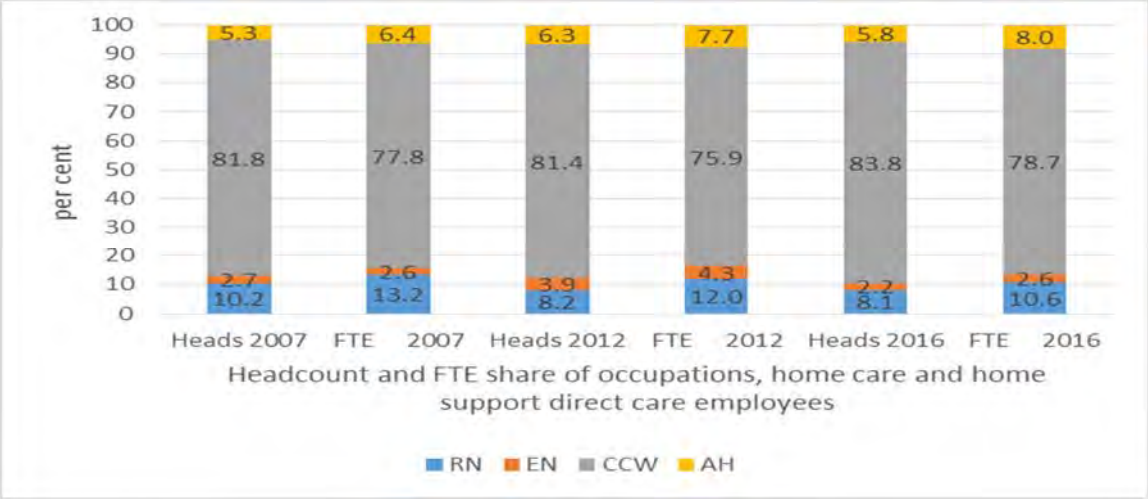
Occupation	2007	2012	2016
Nurse Practitioner	n/a	55 (0.1)	41 (0.1)
Registered Nurse	6,079 (13.2)	6,544 (12.0)	4,651 (10.5)
Enrolled Nurse	1,197 (2.6)	2,345 (4.3)	1,143 (2.6)
Community Care Worker	35,832 (77.8)	41,394 (75.9)	34,712 (78.7)
Allied Health Professional*	2,948 (6.4)	2,618 (4.8)	2,785 (6.3)
Allied Health Assistant*		1,581 (2.9)	755 (1.7)
Total number (FTE)	**46,056**	**54,537**	**44,087**
(%)	**(100)**	**(100)**	**(100)**

Source: Census of home care and home support aged care outlets.
* Note: In 2007, these categories were combined under Allied Health.

94. The tables show there has been a decrease in numbers in the direct care workforce between 2012 and 2016, both as measured by 'headcount' and ' full-time equivalent'.

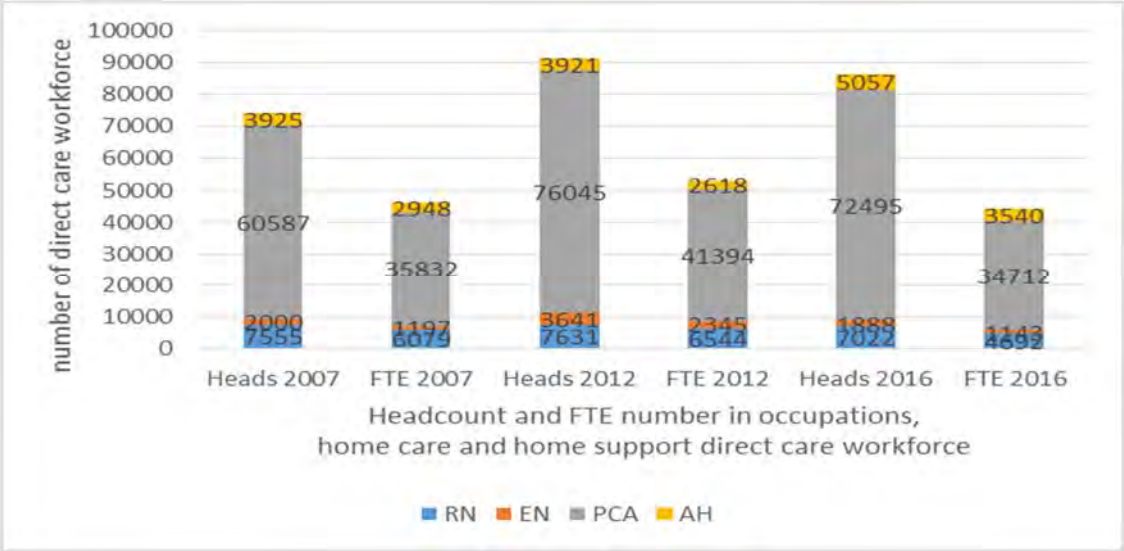
95. Figure 2 from the 2016 NILS report[27] shows the share of occupations for the home care and home support direct care employees as both headcount and full time equivalent (FTE) in per cent of total workforce and Figure 3 shows the number of occupations in headcount and FTE[28].

Figure 2 Share of the occupations for the home care and home support direct care employees (headcount and FTE, per cent)



[27] Ibid 71.
[28] Ibid.

Figure 3 Number of the occupations for the home care and home support direct care employees (headcount and FTE)



Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2016 in Figure 2 and Figure 3. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in both 2007, 2012 and 2016 in Figure 2 and Figure 3

96. The 2016 NILS report data shows that the total workforce reduced in headcount size by 13% and the total headcount size in direct care by 7% between 2012 and 2016. The NILS report estimates the reduction in FTE to be 19% and also suggests the discrepancy between the reduction in headcount and FTE means there was an increase in the proportion of workers employed for fewer hours.[29]

97. The above tables show that not only has there been a reduction in the total size of the workforce, there has also been a reduction in the proportion of registered and enrolled nurses relative to the whole workforce between 2007 and 2016 and again between 2012 and 2016.

Table 17: Employees not providing direct care in the home care and home support aged care workforce, by occupation: 2016 (per cent)

Occupation	2012	2016
Care Manager/co-ordinator	33.2	29.8
Management	22.3	25.6
Administration	35.3	37.0
Spiritual/pastoral care	1.6	0.5
Ancillary care (home maintenance, modification, etc.)	7.7	7.1
Total	**100**	**100**

Source: Census of home care and home support aged care outlets.

[29] Ibid 70.

Employment arrangements for home care workers

98. The 2016 NILS report shows the number of workers employed under permanent part-time arrangements has increased from 62% in 2012 to 75% in 2016.[30]

99. The percentage of community care workers in part time employment increased from 63% to 79% from 2012 -16.[31]

100. In 2016, across all occupations, including allied health - when casual is added - nearly 90% of workers are part time or casual.[32]

101. A significant number, 40 percent of community care workers indicated they would prefer to work more hours.[33]

Employment in residential and home care/home support aged care compared with the nursing workforce and Australian workforce-2016

102. Table 18 below compares characteristics of the employment between the residential aged care, community care, nursing workforce in general and the Australian workforce as a whole based on 2016 data.

103. The residential and community care workforces are overwhelmingly female dominated across all classifications. In 2016, 87% of the residential direct care workforce was female[34] and in home and community care 89% of the direct care workforce was female.[35]

104. Across the three occupations, RN, EN, AIN/PCW/CCW, the community care workforce is slightly older than the residential care workforce. Nurses employed in both residential and community care are older than the average age of nurses in general. For RNs, the median age is 47 and 48 in residential and community care respectively compared to an average age of 43.9 for RNs generally. Similarly, for ENs, median age is 50 and 51 in residential and community care, compared to an average of 46.1 for ENs in general. For the AIN/PCW/CCW group, the community care workforce is older than the residential care workforce – 52 years old compared with a median age of 46 in residential care.

105. Overwhelmingly, the residential and community care workforce is employed on a part time basis. (A significant number of employees in both the residential and community care workforce, (30% and 40% respectively), indicated they want to work more hours suggesting a significant level of underemployment in the sector). The percentage of part time employment for all nursing and carer occupations is well above the rate of the Australian workforce in general. In residential care, 78.1% of the direct care workforce is employed part time compared to 32.7% in the general community. In community care, the figure is 75.3% compared to 32.7% in the Australian workforce.

106. Additionally, full time employment is extremely low in both the residential and community care sectors. Just 11.9% and 11.2% of the direct care workforce are employed full time in residential and community care respectively. Compared to 62% in the Australian workforce.

[30] Ibid 84.
[31] ibid.
[32] ibid.
[33] Ibid 86.
[34] Ibid 17.
[35] Ibid 74.

107. The percentage of direct care employees in both residential and community care engaged on a casual or contract basis is below the general workforce figure of 25%. 10.1% in residential and 13.5% in community care.

Table 18: Gender, Age and Employment comparison

	Residential aged care (1)			**Community care (1)**			**Nursing Workforce (NHWDS) (2)**			**All Occupations (4)**
	RN	EN	AIN/PCW	RN	EN	AIN/CCW	RN	EN	AIN/PCW/ CCW	
Female	87.6%	91.4%	86.2%	93.7%	94.3%	88.8%	88.3%	89.8%	Not included in NHWDS	47.5%
Male	12.6%	8.6%	13.8%	6.3%	5.7%	11.2%	11.7%	10.2%		52.5%
Age	47 median	50 median	46 median	48 median	51 median	52 median	43.4 average	45.3 average		40-45 median
FT	22.4%	13.4%	8.9%	34.9%	23.8%	5.7%				62%
PT	67.7%	78.9%	80.3%	59.4%	71.5%	79%				32.7%
Casual	9.8%	7.8%	10.8%	5.7%	4.7%	15.3%	13% **(3)**	NA		25% **(5)**

Notes:

1. The Aged Care Workforce, 2016 *Mavromaras K, Knight G, Isherwood L, et al. 2017*
2. National Health Workforce Dataset (NHWDS) 2019 – https://hwd.health.gov.au/resources/publications/factsheet-nrmw-2019.html
3. ABS 2019, customised report. Labour Force, Australia, Quarterly May 2019 for employees by paid leave entitlement status by select occupations
4. Department of Jobs and Small Business – Occupational Profiles Summary – Australia. Based on ABS data – Census of Population and Housing 2016, Place of Usual Residence
5. ABS 6333.0 Characteristics of Employment, Australia. August 2016

Part Four: Composition of the Home Care Packages Program (HCPP) and the Commonwealth Home Support Program (CHSP)- 2020

108. The information below is drawn from the 2020 Census Aged Care Workforce Census Report.[36] Data in the report is based on response from 616 HCPP providers (47%)[37] and 505 CHSP providers (38%)[38]. Providers operating across both programs were asked to provide a separate response for each service care type. Therefore it is noted that an individual staff member working for one provider may have their hours split between the two programs.[39] I note also the Report states that comparison with previous years is not possible as the 2016 Census treated the services as one care type.[40]

Home Care Packages Program

109. The 2020 Census report identifies there are 80,340 workers in the HCPP, including permanent, casual contractor and agency sub-contractor roles across administration, direct care and ancillary/pastoral care roles. Of these, 64,019 (80%) are in direct care workers, that

[36] *2020 Census Report* (n 14).
[37] Ibid 25.
[38] Ibid 37.
[39] Ibid 7–8.
[40] Ibid 25, 37.

is, nurses, PCWs and allied health staff.[41]

110. Table 19[42] provides a breakdown of the numbers by headcount and FTE of direct care roles in HCPP services. PCWs make up 88% of the FTE direct care workforce.

Table 19: Home care packages program – Direct care workforce

Occupation	Headcount	Percent of direct care workforce Headcount	FTE (1)	Percent of direct care workforce FTE
Nurse Practitioner	60	0.09%	28	0.11%
Registered Nurse	3,022	4.7%	1,241	4.9%
Enrolled Nurse	887	1.4%	357	1.4%
Personal Care Worker	54,837	86%	22,224	87.8%
Personal Care Worker Traineeship	1,405	2.2%	546	2.16%
Allied Health	3,808	5.9%	913	3.6%
Total HCPP Direct care workforce	64,019	100%	25,308	100%

Notes: 1. FTE is only for permanent and casual/contractor roles

111. More than half (55%) of direct care workers were employed either permanent full time or part time with 91% employed on a part time basis.[43] In the 12 months to November 2020, 34% of all direct care workers in these roles as at November 2019 had left their employment. The turnover of RNs and PCWs was higher than that of other roles, with 30% and 35% leaving their employment.[44]

Commonwealth Home Support Program

112. The Census reports the total number of staff in the CHSP service was 76,096 based on permanent, casual/contractor and agency/sub-contractor workers across all roles. Of this total, 59,029 (78%) were in direct care roles.[45]

113. Table 20[46] below shows the number and FTE of direct care staff. The Report notes that FTE numbers are likely to be higher than the number shown because FTE could not be calculated for approximately 4 percent of workers. On the data supplied, PCWs make up 75% of the FTE direct care workforce, RNs 11% and ENs 3.8%.

[41] Ibid 27.
[42] Data extracted from ibid 26 Table 3.1.
[43] Ibid 28.
[44] Ibid 35.
[45] Ibid 39.
[46] Data extracted from ibid 38 Table 4.1.

Table 20: Commonwealth Home Support program- Direct care workforce				
Occupation	**Headcount**	**Percent of direct care workforce Headcount**	**FTE** (1)	**Percent of direct care workforce FTE**
Nurse Practitioner	184	0.31%	131	0.6%
Registered Nurse	5,008	8.5%	2,298	10.9%
Enrolled Nurse	1,699	2.9%	813	3.8%
Personal Care Worker	45,861	77.7%	15,501	73.3%
Personal Care Worker Traineeship	1,267	2.1%	317	1.5%
Allied Health	5,011	8.5%	2,083	9.9%
Total CHSP Direct care workforce	59,029	100%	21,141	100%
Notes: 1. FTE is only for permanent and casual/contractor roles				

114. More than 90% of the direct care permanent CHSP workforce work on a part time basis. By occupation, 79% of RNs, 87% of ENs and 97% of PCWs are employed part time.[47]

Gender, age and employment in Residential and Home care/Home support aged care – 2020 Census compared with the nursing workforce and Australian workforce

115. Table 21 below compares characteristics of employment between residential aged care, home care, home support, the general nursing workforce and the Australian workforce based primarily on 2020 data.

116. The workforce across all areas of aged care is overwhelmingly female, similar to the general nursing workforce.

117. The median age of the direct care workforce in residential care is not specifically stated however the Census report notes around half direct care workers were aged under 40 years, continuing a trend identified in 2016 of a younger workforce compared to previous census data.[48] Not dissimilar to the general nursing workforce with the average age sitting at 43 and 45 for RNs and ENs respectively. The median age of direct care workers in Home care and Home support (estimated between 40 and 49 years of age) is slightly higher than the median age of 39 in the general workforce.

118. The 2020 Census data indicates a predominance of part time and casual employment across all areas of aged care. The figures below, (based on the direct care workforce excluding Allied health workers), show in residential care, two thirds of RNs and over three quarters of ENs and PCWs work part time. Full time work is more common for RNs (22%) than for ENs (5.8%) and PCWs (3.5%).

119. According to the 2020 census Home care data, just over half the direct care workforce (RNs, ENs and PCWs) work part time hours. Again, full time employment is more likely for the occupation of RN (18%) and EN (17.3%) than PCW (3%). High levels of casual employment exist across all classifications in Home care with 29.5% of RNs, 26.6% of ENs and 44.8% of PCWs identified as casual compared to 22% of the general workforce.

[47] Ibid 40.
[48] Ibid 16.

120. Employment in the Home support area is also predominantly part time. Two thirds of RNs and almost three-quarters of the EN and PCW workforce are working part time. In line with residential and home care, RNs in Home support are more likely to work full time (17.6%) than ENs(10.6%) and PCWs (2.4%). PCWs are more likely to be in casual employment (25.5%) compared to RNs (16.8%) and ENs (19%).

Table 21: Gender, Age and Employment comparison -2020

	Residential aged care (1)			Home care (1)			Home support (1)			Nursing Workforce (NHWDS) (3)			All Occupations (5)
	RN	EN	AIN/PCW	RN	EN	AIN/PCW	RN	EN	AIN/PCW	RN	EN	AIN/PCW	
Female	2020 Census reports 86% of direct care roles in RAC identify as female			93%	See note **(2)**	89%	93%	See note (2)	89%	88.3%	89.8%	Occupation not included in NHWDS	47.4%
Male	14%	See note **(2)**	14%	7%		11%	7%		11%	11.7%	10.2%	NA	52.6%
Age	NA	NA	NA	Estimate 48 median	Estimate 40-49	Estimate 40-49	48 median	Estimate 40-49	Estimate 40-49	43.4 average	45.3 average	NA	39 median
FT	22%	5.8%%	3.5%	18%	17.3%	3%	17.6%	10.6%	2.4%	NA	NA	NA	68.5%
PT	65.4%	76.6%	76%	52.6%	56.1%	52.2%	65.7%	70.3%	72.2%	NA	NA	NA	31.5%
Casual	12.6%	17.6%	20.5%	29.5%	26.6%	44.8%	16.8%	19%	25.5%	11% **(4)**	11%**(4)**	NA	22% **(6)**

Notes:

1. 2020 Aged Care Workforce Census Report Australian Government Department of Health; https://www.health.gov.au/resources/publications/2020-aged-care-workforce-census
2. Data for ENs not available
3. National Health Workforce Dataset (NHWDS) 2019 – https://hwd.health.gov.au/resources/publications/factsheet-nrmw-2019.html
4. ABS (2021), customised report. Labour Force, Australia, Quarterly August 2020 to November 2020 for employees by paid leave entitlement status by select occupations
5. Australian Bureau of Statistics (2021), Labour Force, Australia, July 2021, cat. no. 6202.0, Table 1. Labour force status by Sex, Australia - Trend, Seasonally adjusted and Original viewed 8 September .2021, https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/latest-release#data-downloads
6. ABS 6333.0 Characteristics of Employment, Australia. August 2020 viewed 8 September 2021 https://www.abs.gov.au/statistics/labour/earnings-and-work-hours/characteristics-employment-australia/aug-2020#key-statistics

Direct care workforce turnover

121. The 2020 Census report[49] provides data on workforce turnover across the three areas of aged care for the period November 2019 to November 2020. For direct care roles in residential aged care, 29 percent of all workers left their employment within that period. The survey design did not question whether staff leaving employment were remaining in residential aged care or were leaving the sector altogether.[50]

[49] Ibid.
[50] Ibid 22, 23.

122. Table 22[51] below shows the percentage of employees who left their employment by occupation over the twelve month period. The turnover of NPs and RNs was 37 percent with 28 percent of ENs and PCW leaving over the same period.

123. Tables 22-24[52] indicate similar rates of turnover across direct care workers in the home care and home support services over the November 2019 to November 2020 period. 35 percent of PCWs and 30 percent of RNs working in home care left their employment.

Table 22: RAC - Direct care workforce attrition Nov 2019 to Nov 2020

Job role	Employees who left between Nov 2019 and Nov 2020	Proportion of Nov 2019 employees
Nurse Practitioner	185	37%
Registered Nurse	10,206	37%
Enrolled Nurse	4,200	28%
Personal Care Worker	36,039	28%
Allied health professional	1,097	25%
Allied health assistant	862	28%
Total	52,588	29%

Table 23: HCPP - Direct care workforce attrition Nov 2019 to Nov 2020

Job role	Employees who left between Nov 2019 and Nov 2020	Proportion of Nov 2019 employees
Nurse Practitioner	14	13%
Registered Nurse	712	30%
Enrolled Nurse	222	24%
Personal Care Worker	17,770	35%
Allied health professional	389	26%
Allied health assistant	71	23%
Total	19,177	34%

Table 24: CHSP - Direct care workforce attrition Nov 2019 to Nov 2020

Job role	Employees who left between Nov 2019 and Nov 2020	Proportion of Nov 2019 employees
Nurse Practitioner	53	27%
Registered Nurse	718	17%
Enrolled Nurse	284	15%
Personal Care Worker	12,833	27%

[51] Ibid 23.
[52] Ibid 35.

Allied health professional	907	26%
Allied health assistant	184	30%
Total	14,980	26%

124. The turnover rates presented in the 2020 Census report indicate that staff turnover across the aged care sector is almost four times higher than the workforce in general. The latest ABS release on job mobility for all employed people reports an overall rate of 7.5% in the 12 months to February 2021, lower than the previous figure for the year ending February 2020 of 8.1%.[53]

125. The 2016 Aged Care Workforce Report presents information on the proportion of the residential direct care workforce actively seeking work. It reports that overall, across all direct care occupations, 10.2% were actively seeking work (similar to 9 percent in 2012).[54] Table 25 below shows the proportion of the residential direct care workforce actively seeking work, by occupation and tenure in current job in 2016.

Table 25: Proportion of the residential direct care workforce actively seeking work, by occupation and tenure in current job: 2016

Tenure in current job	RN	EN	PCA	AH	All occupations
12 months or less	17.1%	20.3%	15.7%	12.9%	16.1%
More than 1 yr-4yrs	14%	11.4%	11.9%	9.9%	12.1%
More than 4 yr-9yrs	9.9%	9.6%	9.8%	5.4%	9.6%
More than 9 yrs	5.6%	5.4%	5.2%	8.7%	5.5%
All years	11.5%	9.1%	10.2%	9.0%	10.2%

Direct Care workforce position vacancies

Residential aged care

126. The 2020 Census Report[55] presents data on vacancies in direct care roles at the time of the Census. Overall, there was a total of 9,404 vacancies reported by facilities who answered this question. Table 26[56] below shows data for each occupation including the proportion of facilities with a vacancy, the average number of vacancies at each facility, total vacancies and vacancies as a proportion of jobs.

127. Two thirds (6,212) of the total vacancy count were PCW roles with 50% of facilities reporting vacancies. There were 1,995 RN vacancies with 38% of facilities reporting a vacancy.

[53] Australian Bureau of Statistics, *Job Mobility, February 2021* (Catalogue No 6223.0, 7 July 2021). (**ANMF 14**)

[54] *2016 NILS Report* (n 13) 36.
[55] *2020 Census Report* (n 14).
[56] Ibid 22.

Table 26: RAC - Proportion of facilities with vacant direct care positions and average number of vacancies by role type

Job role	Proportion of facilities with vacancies	Average number of vacancies at facility*	Total vacancies	Vacancies as a proportion of jobs
Nurse Practitioner	1%	1	21	13%
Registered Nurse	38%	2	1,995	7%
Enrolled Nurse	18%	2	829	5%
Personal Care Worker	51%	5	6,212	5%
Allied health Professional	5%	2	202	4%
Allied health Assistant	4%	1	145	5%

**Average vacancies is for facilities reporting at least one vacancy.*
Includes full-time and part-time permanent and casual vacancies

Source: 2020 Aged Care Workforce Census. Facilities reporting any vacancies were aggregated by role type and a proportion taken of the total facilities that responded to this Census question. Vacancies as a proportion of jobs for facilities that answered this Census question, not total jobs in the service care type. *Average vacancies is for facilities reporting at least one vacancy. Includes full-time and part-time permanent and casual vacancies.

Home Care Packages Program

128. In total, HCPP providers reported 6,479 vacancies across direct care roles. Table 27[57] below shows there were 5,817 vacancies for PCW roles with 58% of providers reporting vacancies. There were 297 RN vacancies with 15% of providers with vacant positions.

Table 27: HCPP – Proportion of facilities with vacant direct care positions and average number of vacancies by role type

Job role	Proportion of facilities with vacancies	Average number of vacancies at facility*	Total vacancies	Vacancies as a proportion of jobs
Nurse Practitioner	1%	2	24	62%
Registered Nurse	15%	1	297	10%
Enrolled Nurse	4%	3	124	14%
Personal Care Worker	58%	8	5,817	11%
Allied health Professional	8%	2	197	12%
Allied health Assistant	1%	1	20	5%

**Average vacancies is for facilities reporting at least one vacancy.*
Includes full-time and part-time permanent and casual vacancies

Source: 2020 Aged Care Workforce Census. Providers reporting any vacancies were aggregated by role type and a proportion taken of the 1,299 providers that responded to the question. *Average vacancies is calculated for providers reporting at least one vacancy. The proportion of job roles was taken from the total jobs for each job role that responded to this question in the Census. Both full-time and part-time permanent and casual vacancies are included.

[57] Ibid 35.

Commonwealth Home Support Programme

129. A total of 6,117 vacancies were reported by CHSP providers. Table 28[58] below shows that 87% of vacancies were for PCW roles with 53% of providers reporting vacant positions.

Table 28: CHSP – Proportion of facilities with vacant direct care positions and average number of vacancies by role type

Job role	Proportion of facilities with vacancies	Average number of vacancies at facility*	Total vacancies	Vacancies as a proportion of jobs
Nurse Practitioner	1%	2	20	12%
Registered Nurse	8%	3	282	6%
Enrolled Nurse	2%	6	154	9%
Personal Care Worker	53%	8	5,307	11%
Allied health Professional	11%	2	327	9%
Allied health Assistant	2%	1	27	4%

**Average vacancies is for facilities reporting at least one vacancy.*
Includes full-time and part-time permanent and casual vacancies

Source: 2020 Aged Care Workforce Census. Proportion based on 1,334 providers that responded to this question in the Census. The proportion of jobs was calculated from the total job count for providers that responded to this question. Average vacancies is for providers reporting at least one vacancy. Both full-time and part-time permanent and casual vacancies are included.

RESIDENTS AND CLIENTS OF AGED CARE

Health status and characteristics

130. In the paragraphs below I describe the health status and characteristics of people in residential aged care.

131. I have reviewed data contained in Table 14A.12 of the Report on Government Services 2021, Part f, section 14 Aged care data Tables (**ANMF 15**). The data is collected by the Department of Health and published in the annual Report on Government Services (RoGS). The most recent data available is obtained from the 2021 Report.[59]

132. The data provides statistics on three domains under which aged care residents are assessed under the Aged Care Funding Instrument (**ACFI**). The three domains are Activities of Daily Living (**ADL**), Behaviour and Cognition and Complex Health Care (**CHC**).

133. An initial assessment the "First assessment' is conducted on entry into permanent residential care. A new assessment is conducted every time a resident has a change in condition that affects care needs.

[58] Ibid 45.
[59] *GS Report* (n 6) Table 14A.12.

134. The data collected is used to determine the care needs of residents and the level of funding to be allocated to providers of aged care services. A comparison of the data collected over the period from the 2010/11 year to the 2019/20 year shows changes in the health characteristics of residents across the three domains.

Comparison of health characteristics based on RoGS Reports- 2010/11- 2019/20

135. The table in **Annexure AB 6** sets out data extracted from Table 14A.12 of the annual RoGS reports for the years 2010-11 to 2019-20.

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

- 41% of residents were classified as needing high care in 2010-11
- 63% of residents were classified as needing high care in 2019-20 and conversely
- 26% were assessed as having low care needs in 2010-11 and
- 8% were assessed as having low care needs in 2019-20.

137. In relation to Behaviour and Cognition the percentage of residents classified as needing high care has increased from 48% in 2010-11 to 65% in 2019-20.

138. In relation to Complex health care in 2010-11 only 23% of residents were assessed as having high care needs compared with 54% in 2019-20.

139. 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 (**ANMF 16**) as follows:

> *"During 2015–16, real growth of expenditure per resident per day through the ACFI was 5.2 per cent, compared with a Government budgeted growth of 3.2 per cent. This resulted in an increase to the Government's forecast expenditure over four years of $3.8 billion. The Government responded by announcing changes to the ACFI and indexation following consultation with the sector. These changes took effect on 1 July 2016 and 1 January 2017. The changes to ACFI included a new matrix reducing the rating categories for medication under Question 11 of the Complex Health Care domain and changes to the scoring and eligibility requirements for certain Complex Health Care procedures."*[60]

Residential care needs over time (first assessment)

140. Data from the AIHW (**ANMF 17**)shows that the proportion of people assessed as having high care needs when they first enter permanent residential care has increased. Trends over the decade from 2010–11 indicate that:[61]

[60] Aged Care Financing Authority, *Sixth Report on the Funding and Financing of the Aged Care Sector* (Report, July 2018) 90.
[61] Australian Institute of Health and Welfare, GEN Aged Care Data, Factsheet 2019-20: People's Care Needs in Aged Care (2021) (**ANMF 17**).

- In 2019-20 54% of people were assessed as having high care needs in *activities of daily living* compared to 35% in 2010-11;
- Similarly 49% of people were assessed as having high care needs in *cognition and behaviours* compared to 33% in 2010-11;
- Across all three domains low and nil care need ratings have decreased over the 10 year period with the largest decrease in nil care ratings for *complex health care* (from 14% to less than 1% of people), and the largest decrease in low care ratings for *activities of daily living* (from 33% to 12%).
- There is little change over the same period in the *complex health care* domain noting however that the changes implemented in 2016-17 make it difficult to compare resident high care needs over this period; (**ANMF 18**)

141. **'**Peoples care needs in aged care' shows in graph form, how care needs have changed over the period from 2009-2019. **(ANMF 19**)

142. The five graphs represent the top five most common care needs ratings of people in permanent residential care at 30 June over the period 2009 to 2019 based on ACFI assessment ratings for the three care domains - *Activities of Daily Living; Cognition and behaviour* and *Complex Health Care.*

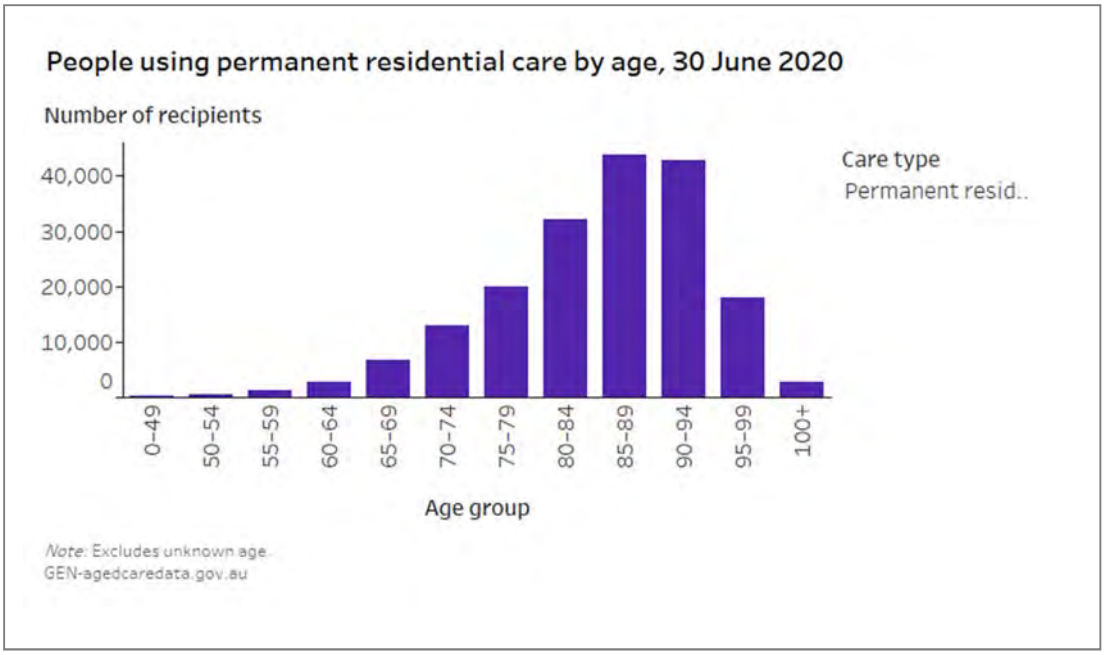
143. The care needs rating is shown as three letters representing the level of need as High (H); Medium (M) or Low (L) in each of the three domains in the order shown above.

144. The graph shows the changes in need ratings at "first assessment" on entry into residential care and changes in need ratings based on the most recent assessment of the resident over a ten year period. A new assessment is conducted every time a resident has a change in condition that affects care needs.

Care needs and characteristics of residents

Age of people using residential aged care

145. At 30 June 2020, 58 percent of people in residential aged care were 85 years and over and just over a third (35%), were 90 years and older. The graph below shows the distribution of residents across the age groupings of people in residential aged care.



146. In comparison with a decade earlier, the AIHW report that the increase in people using permanent residential aged care since 2010 was proportionately higher among older people (17% increase in people aged 85 years or older; 7% increase in people aged under 85 years).

147. This is also evident in data showing an increase in the percentage of residents in the 90 plus age group over the same period. In 2010, 27 percent of residents were 90 years of age and older compared to 35 percent in 2020.

148. **Annexure AB 7** is a series of graphs showing changes in the number of residents using residential aged care across the different age groupings over the period 2010-20.

Residential care needs by Dementia status

149. The AIHW states that people with dementia tend to have higher care needs than those without dementia.[62] The smallest difference in care ratings is in relation to complex health care where there was little difference between those with and without dementia. At 30 June 2020:

- 80% of people with dementia were assessed as having high care needs for *cognition and behaviour* compared with 46% of people without dementia*;*
- 67% of people with dementia had high care needs for *Activities of Daily Living* compared with 58% of those without and
- 52% of people with dementia and 55% of people without dementia had high care needs rating for Complex Health Care.

[62] (**ANMF 17**)

150. AIHW report data on the number of people with dementia in each of the care need ratings across the three domains. In relation to people with high care needs, at 30 June 2019:

- 57% of people with a high care rating in *Activities of Daily Living* had dementia
- 67% of people with a high care rating in *Cognition and behaviour* had dementia
- 52% of people with a high care rating in *Complex Health Care* had dementia (**ANMF 20**)

Residential care needs of people from Culturally and Linguistically Diverse (CALD) backgrounds

151. At June 2020, almost 20% of people in residential aged care were people from culturally and linguistically diverse backgrounds (defined as those who were born overseas in countries other than the United Kingdom, Ireland, New Zealand, Canada, South Africa and the United States of America.[63]

152. The care needs of people from CALD backgrounds at 30 June 2020 is summarised by AIHW below:

- 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.(**ANMF 21**)

Opinion and observation about resident acuity

153. The above data illustrates that there has been a significant increase in what can be described as resident acuity when entering residential aged care.

154. The data also shows that the level of care needs after the initial assessment has increased substantially in the period from 2009 to 2019. The above data shows residents are entering residential aged care with greater higher and more complex health needs and greater levels of dependence. This means that the level of care required to be delivered in residential aged care has increased commensurately.

[63] *GS Report* (n 6) Table 14A.17

Overview of nursing care in aged care

What is nursing?

155. Nursing in Australia has adopted the international definition of nursing agreed by the World Health Organisation and the 130 member organisations of the International Council of Nursing:

> *'Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems of management, and education are also key nursing roles.'* (**ANMF 22)**

156. This definition has been embedded by the Nursing and Midwifery Board of Australia (NMBA) into the Standards for Practice (the Standards) for both registered (**ANMF 23**) and enrolled nurses **(ANMF 24**).

157. Nurses must meet these standards annually to maintain their registration with the Australian Health Practitioner Regulation Agency (**AHPRA**). The Standards outline the role of the registered and enrolled nurse and the expected standards for their practice across all the settings. The Standards are to be read in conjunction with applicable NMBA standards, codes and guidelines, which together comprise the professional practice framework for nurses.

158. The definition of nursing, set out in paragraph 155 above, expresses the holistic, person-centred philosophy which underpins and forms the core of nursing practice.

159. The provision of holistic nursing care includes the provision of personal care, generally regarded by the nursing profession as 'essential', 'basic' or 'fundamental' nursing care. Personal care is the foundational component of all nursing practice. Nursing care is not confined to medical-related interventions. Nursing is a biosocial, psychological, holistic professional practice area which cuts across a whole range of areas, that don't fit neatly into what some people describe as clinical care.

160. Set out in the paragraphs below is an overview of the skills and personal abilities used in the delivery of nursing care in aged care, followed by a brief view of the roles and responsibilities of each member of the nursing team.

Skills and personal abilities of the aged care workforce

161. 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. 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.

162. Effective communication, interaction, and collaboration between and among staff, recipients of care, and their families is vital in aged care. Aged care staff must be capable of communicating respectfully and empathetically in often sensitive situations, potentially involving end-of-life care. This expectation also extends to working as a member of the broader care team, in which communication skills are crucial to the successful delivery of quality care. Successful communication is important tool in building trust and alleviating anxiety or fear, in both residents and their family members.

163. Technical skill and current knowledge of evidence based best-practice is required for the delivery of care to residents. Aged care staff are often required to decide upon and deliver this care independently or under the direction of more senior or qualified staff. Successful delivery of this care requires an understanding of the individual receiving care and will incorporate proactive assessment of health and wellbeing.

164. Senior staff across all levels requires skills in supervising and educating less experienced staff to acquire and master new knowledge to drive best practice. This skill is also required to involve residents and family in care planning processes and is also particularly important in terms of supervising and training new staff and students on placement.

165. Competency in leadership is expected where aged care staff, particularly those in senior roles, are required to plan, organise and manage resources in often intense work environments.

166. Aged care is a multifaceted specialty area that requires expertise, education, experience, and a significant suite of skills to effectively, efficiently, and safely deliver care to a cohort of the population that is particularly frail, vulnerable, and at high risk of complications from all aspects- pharmacological (higher incidence of side-effects and interactions), nurse sensitive adverse events (for example urinary tract infections, chest infection, pressure injuries), acute deterioration and general decline (from worsening chronic conditions and /or additional acute illnesses) and accidents (falls in particular).

The role and responsibilities of the RN

167. In residential aged care, RNs are best placed to lead care. Delivery of holistic care is led by registered nurses and provided by a team of RNs, ENs and PCWs and/or AINs.

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

169. Decisions to delegate particular aspects of nursing care are made by the RN. Which role undertakes, or should undertake, specific elements of nursing care is dependent upon the complexity of the intervention, and the qualifications and skill required to perform the intervention and meet the assessed need, as determined by the RN.

170. The planning and subsequent evaluation of the resident and the outcomes of the care provided, including personal care, is the responsibility of the registered nurse who delegated that care.

171. The RN supervises the care team and is responsible for ensuring the care needs of each resident are met.

172. The registered nurse is central to delivery of safe, quality care in the residential aged care context.

The role and responsibilities of the EN

173. 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 NMBA. The enrolled nurse provides nursing care, working under the direction and supervision of the registered nurse.

The role and responsibilities of the AIN and PCW

174. AINs and PCWs work under the supervision of RNs 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.

The nursing team

175. As described above RNs, ENs, AINs and PCWs work in a team to deliver care to residents. Roles and responsibilities for RNs and ENs are clearly defined and are in line with the standards and conditions for registration.

176. It is the RN who is responsible in a regulatory and professional sense, for the delivery of care. The EN as a registered professional also has a level of responsibility for overseeing and delivering care. AINs and PCWs, have responsibility for delivery of care, particularly with respect to the day to day care of residents.

177. Each member of the care team has responsibility for delivery of care that contributes to the total package of care for the resident that encompasses clinical, social, emotional and wellbeing needs of the resident. Delivery of care through a team based approach embraces the holistic definition of nursing I refer to at paragraph 155 of my statement.

178. Care needs are assessed and how those needs will be met are set out in a care plan.

179. RNs are responsible for the development of care plans for each resident. Care plans are developed when a person enters residential care in conjunction with the resident, family members and other treating health professionals. The care plan will identify all health conditions of the resident and care needs.

180. The plan will set out how health conditions are to be managed and how care needs are to be met. Ongoing assessment is required to ensure the plan is being met and to modify it as required. Each member of the care team contributes to the ongoing assessment of delivery of care and any modifications required in relation to the care plan.

181. Each member of the care team contributes to delivery of the plan, however, it is the RN who has overall responsibility for the plan.

182. Care plans should reflect the individual interests and care wishes of the resident.

183. Care plans provide a framework for the delivery of care that reflects individual wishes, preferences and interests. They also identify who is responsible for delivery of care under the supervision of the RN.

Industrial significance of the care team

184. As outlined above, each member of the nursing care team has an important and skilled role to play in the delivery of care to aged care residents. The scope of each level of responsibility and skill is linked to the training and qualifications required for each classification.

185. For example, an RN as a degree qualified and registered professional has a level of responsibility for the delivery of care that reflects both the content of the degree leading to registration and the standards associated with attaining and retaining registration.

186. The classification structure of the *Nurses Award* recognises levels of responsibility and qualification for each classification level. I have been provided with a copy of Kristen Wischer's statement and refer to paragraphs 50 to 94 which elaborates on the classification structure of the Nurses Award.

187. To a lesser extent, the *Aged Care Award* recognises increasing levels of responsibility and qualification, however, it is maintained in this application that the structure in the *Aged Care Award* should be varied to better reflect the level of responsibility required at each level of the PCW structure.

System changes in aged care affecting work value

188. Against the background of the aged care sector that I have described above there have been a number of significant changes and reforms in the aged care sector that in my opinion, have impacted the nature of work and the conditions under which work is done.

Introduction of the Aged Care Act 1997

Commonwealth Aged Care legislation

189. Prior to the enactment of the *Aged Care Act* there was a distinction between nursing homes and hostels based on the care level required to be delivered. The distinction drawn in the former legislation between nursing homes and hostels was a distinction which identified that residents of nursing homes were persons in need of continuous nursing care, including nursing interventions, whereas residents of hostels were assumed to be more substantially independent and only requiring of intermittent nursing care and assistance to conduct their daily lives.

190. Since the introduction of the Aged Care Act, care needs of those in residential care have increased, as set out in paragraphs 130-154 above. This has had an overall and long term effect on both the nature of work to be performed, the skills and responsibility required to perform the work and the conditions under which work is performed.

Ageing in place

191. The objects of the *Aged Care Act*[64] include 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live'. Ageing in place is an important feature of the system because it avoids the need for people to be relocated when their care needs change.

192. It refers to the capacity of a hostel or low care facility to provide nursing home services or high care services to a resident if their care needs change during the course of their residence in the aged care facility. Since the introduction of the Aged Care Act in 1997, the distinction between hostels, low care facilities and nursing homes has eroded. In practice, now, due to the higher level of acuity and complexity of health conditions of people entering residential care, effectively all residential care is high care.

The rationing of aged care and consequences for acuity- home care

193. Ageing in place is also relevant to home care. As more people choose to stay in their own homes to receive care, even as care needs increase, the provision of home care services have also become more complex in delivery.

194. This is exacerbated by the wait time between assessment for receiving a home care package and release of funding necessary to deliver the package of care. Data provided by the Commonwealth Government indicates, as at May 2021, that for people with a medium priority assessment for a HCP, the wait time for a Level 4 package was 9-12 months. (**ANMF 25)**

Inquiries and reviews into Aged Care

195. In the period between 1982 and 2021 there have been at least 72 inquiries and reports into aged care. **Annexure AB 8** is a compilation of reports, including a brief summary of the report and where possible a link to the report, as prepared by the ANMF in August 2021.

196. Of these reports, I refer in particular to three main reports and a subsidiary report that have identified that the aged care workforce is undervalued.

Caring for Older Australians

197. The first of these is the Productivity Commission 2011 report, *Caring for Older Australians* (**ANMF 26**).[65] The report notes[66]

> '*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.*

[64] *Aged Care Act 1997* (Cth) s2-1 (1)(j)
[65] Productivity Commission, *Caring for Older Australians*, (Final Inquiry Report No 53, 28 June 2011).
[66] Ibid vol 2, 354-355.

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[67]:

'*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.

A Matter of Care

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**).[68] 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[69]:

'*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'.[70]

202. The Taskforce commissioned a report from the Korn Ferry Hay Group titled 'Reimagining the Aged Care Workforce' [71] (**ANMF 28**).

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[67] Ibid vol2, 359.
[68] Aged Care Workforce Strategy Taskforce, *A matter of Care: Australia's Aged Care Workforce Strategy* (Report, June 2018).
[69] Ibid 92 Note midpoint is comparison between Aged care providers' salary v "All organisations market').
[70] Ibid 95.
[71] Korn Ferry Hay Group, *Reimagining the Aged Care Workforce, Report prepared for the Aged Care Workforce Strategy Taskforce, (* Report 2018) ('*Reimagining the Aged Care Workforce').*

Reimagining the Aged Care Workforce

203. The report makes the following observation about the disparity between bargained outcomes for nurses in the aged care sector compared to other sectors:

> *'The taskforce's consultations suggested that, through to the mid-1990s, the rates of pay and key salary-related conditions of registered (the enrolled) nurses across all sectors of employment had historically been accepted by the then Australian Industrial Relations Commission on the basis of evidence that the work was of the same value. This equivalence was gradually eroded by bargaining outcomes that reduced the salary position of nurses in the aged care relative to nurses in other sectors of employment.*
>
> *Analysis undertaken by the taskforce confirms the comparatively low-paid status of nurses employed in aged care*.'[72]

204. The Reimagining the Aged Care Workforce report using the Hay Job Evaluation Methodology to analyse personal care roles, found that the value of the role in the industry is currently underestimated.[73] In relation to the role of PCW the report states in regard to work value[74]:

> '*They require a high level of confidence to deal with new, challenging and unpredictable situations. For example, in Home Care, the PCWs have to operate in new/different working environments multiple times in a day and deal with these situations, operating at a distance from supervisors/managers. In Residential Care, PCWs have to deliver care services to increasingly frail customers with high incidence of complex medical conditions and specific care requirements.*
>
> *PCW roles require a high degree of safety awareness to closely observe the customer's living environment, behaviour and changes thereof. They need to be on their toes to quickly assess any situation of concern that would affect safety and that of the customers.'*

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.[75]

206. Based on analysis of wage data, the Korn Ferry report found that in comparing PCWs and nurses against similar sized roles in the General Australian Market, that PCWs are paid significantly below the market median and nurses below the market median.[76]

The Royal Commission into Aged Care Quality and Safety

207. The Honourable Gaetano (Tony) Pagone QC, Chair and Ms Lynelle Briggs AO, Commissioner submitted the Final Report: Care Dignity and Respect, of the Royal Commission into Aged Care Quality and Safety on 26 February 2021.[77] (**ANMF 29-36**)

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[72] Ibid 92.
[73] Ibid 29.
[74] Ibid 29.
[75] Ibid 42.
[76] Ibid 97-98.
[77] *Royal Commission into Aged Care Quality and Safety*, (Final Report, February 2021)

208. Commissioner Briggs states in her Overview to the Final Report that 'Like older people, the aged care workforce has been undervalued'. [78]

209. Commissioner Briggs goes on to say[79]

> '*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. The pay gap between nurses and personal care workers in aged care and in the health system should be addressed through the Pricing Authority initially, then through structured work value cases led by the Government and employers.'*

210. The Final Report made recommendations and findings relevant to this application. In the Chapter titled 'The Aged Care Workforce, the Final Report makes findings and recommendations with respect to workforce. The report notes under the heading 'Improving pay for the aged care workforce' ;[80]

> '*A wages gap exists between aged care workers and workers performing equivalent functions in the acute health sector*.'

211. The Final Report notes that despite the recommendations of the Taskforce, aside from annual wage review increases, there have been no discernible increases in aged care wage rates in the two and a half years since the Taskforce report was published.[81]

212. The Final Report recommends applications be made to the Fair Work Commission to vary award wages.[82] The ANMF application in this proceeding is made in response to that recommendation.

> ***Applications to the Fair Work Commission***
>
> *Recommendation 84: Increases in award wages Employee organisations entitled to represent the industrial interests of aged care employees covered by the Aged Care Award 2010, the Social, Community, Home Care and Disability Services Industry Award 2010 and the Nurses Award 2010 should collaborate with the Australian Government and employers and apply to vary wage rates in those awards to:*
>
> *a. reflect the work value of aged care employees in accordance with section 158 of the Fair Work Act 2009 (Cth), and/or*
>
> *b. seek to ensure equal remuneration for men and women workers for work of equal or comparable value in accordance with section 302 of the Fair Work Act 2009 (Cth).*

[78] Ibid vol 1, 27.
[79] Ibid vol 1, 41.
[80] Ibid vol 3A, 414.
[81] Ibid 414.
[82] Ibid 415.

Regulatory change in Aged Care

Regulatory change

213. The aged care sector has been subject to a range of reforms over many years. 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, (**ANMF 37-39**) was a catalyst for the introduction of a number of regulatory reforms aimed at improving quality and safety of aged care services.

214. Without providing a comprehensive summary of all regulatory reforms that have impacted the delivery of direct care in aged care, I set out below some key recent reforms, to illustrate how the sector is in a period of change that has and will continue to have an impact on aged care workers delivering direct care.

The National Code of Conduct for Health Care Workers (the Code)

215. The COAG Health Council agreed to the National Code of Conduct for Health Care Workers ('the Code') in 2015 (**ANMF 40**).[83] The Code establishes standards of practice for unregistered health care workers who provide a health service. It is up to the individual States and Territories to determine how the Code is implemented and progressed, and which health occupations are captured under the respective jurisdiction's Code. States and Territories committed to having the Code operational by 2017.

216. Thus far, neither Western Australia, the Northern Territory nor the Australian Capital Territory have implemented the Code. As of September 2021, Tasmania is currently in the process of implementing the Code. A Code of Conduct has been implemented in the other States as follows:

a. In Victoria, a version of the Code was implemented through the *Health Complaints Act 2016*, effective from 1 February 2017.(**ANMF 41**)

b. In New South Wales, a Code of Conduct, as applying to health care workers in the public sector, was made under the *Public Health Act 2010 (***ANMF 42***)* and *Public Health Regulation 2012*, (**ANMF 43**) commencing 1 September 2012; it is enforceable through the *Health Care Complaints Act 1993*.(**ANMF 44)**

c. In South Australia, the Code was made under the *Health and Community Services Complaints Regulations 2019* (A**NMF 45**) and is enforceable through the *Health and Community Services Complaints Act 2004 (***ANMF 46***)*. The Code was effective from 18 March 2019.

d. In Queensland, the Code was effective from 1 October 2015 and made under the *Health Ombudsman Regulation 2014*. (**ANMF 47**) It is enforceable through the *Health Ombudsman Act 2013*. (**ANMF 48**)

[83] COAG Health Council, *A National Code of Conduct for Health Care Workers* (Final Report, 17 April 2015) 10-15.

Accreditation Standards

217. Prior to 1 July 2019, providers of aged care services were required to meet Accreditation Standards, set pursuant to Section 96 of the Aged Care Act, and set out in the Quality of Care Principles 2014 (**ANMF 49**).

218. The Quality of Care Principles sets out the required Accreditation Standards (**ANMF 50)** for residential aged care, home care and flexible care standards for short term restorative care. The Aged Care Quality and Safety Commission was responsible for the implementation and application of the Standards.

219. The Accreditation Standards for residential care comprise four standards:

- Management systems, staffing and organisational development
- Health and personal care
- Care recipient lifestyle and
- Physical environment and safe systems.

220. Each Standard consists of a principle and several expected outcomes. There are 44 expected outcomes across the four Standards. To maintain the status of accredited provider under the Act, providers were required to demonstrate that they had met or partially met the 44 expected outcomes.

221. The Standards and expected outcomes are set out in a two page document (**ANMF 50).**

222. The Home Care Common Standards, comprises three standards and 18 expected outcomes (**ANMF 51**).

223. The flexible care standards for short term restorative care were contained in the Quality of Care Principles 2014. In addition, two standards and 9 expected outcomes were developed by the Aged Care Quality and Safety Commission, in relation to the National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Standards (**ANMF 52).**

Aged Care Quality Standards

224. On 1 July 2019, the Accreditation Standards were replaced with the more complex Aged Care Quality Standards, in accordance with amended Quality of Care Principles (**ANMF 53**) which are applicable to all aged care services.

225. The ACQ Standards (**ANMF 54)** comprise 8 standards, each one about an aspect of care that contributes to ensuring the safety, health and well being of recipients of aged care services. The 8 standards are under the following headings:

- Consumer dignity and choice;
- Ongoing assessment and planning with consumers;
- Personal care and clinical care;
- Services and supports for daily living;
- Organisation's service environment;

- Feedback and complaints;
- Human resources; and
- Organisational governance.

226. Each of the Quality Standards is expressed three ways:

- A statement of outcome for the consumer;
- A statement of expectation for the organisation; and
- Organisational requirements to demonstrate that the standard has been met.

227. The Aged Care Quality and Safety Commission has also published a document to accompany that Quality Standards titled "Guidance and Resources for Providers to Support the Aged Care Quality Standards". (**ANMF 55)**

228. 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.

229. Compared to the Accreditation Standards, the Quality 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.

National Aged Care Mandatory Quality Indicator Program (QI Program)

230. The QI Program became compulsory on 1 July 2019. It is a mandatory program for residential aged care services to collect and report data on the following:

- Pressure injuries;
- Physical restraint; and
- Unplanned weight loss.

231. From 1 July 2021 it also became compulsory to report on:

- Falls and major injury; and
- Medication management including polypharmacy and anti-psychotics.

232. Providers must report this data to the Department of Health on a monthly basis.

233. The Aged Care Quality and Safety Commission prepared a summary of the QI Program (**ANMF 56**) which sets out the expectations of the program.

Serious Incident Response Scheme (SIRS)

234. A serious incident response scheme was introduced by the Aged Care Quality and Safety Commission from 1 April 2021 (**ANMF 57**). The scheme requires aged care providers to have an effective incident management system, and to report a range of serious incidents to the ACQS Commission within 24 hours of becoming aware of them.

235. The SIRS requires a broader range of allegations and suspicions of serious incidents to be reported than was previously the case. It also 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.

Restrictive practices legislation

236. 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. Under the amended legislation:

- the Quality of Care Principles require providers to satisfy a number of conditions before and during the use of any restrictive practice.
- providers are required to document the alternatives to restrictive practices that have been considered and used, and why they have not been successful.
- providers are required to have a clinical governance framework in place to minimise the use of restrictive practices. The Commission expects that where a restrictive practice is used, such a framework will ensure that informed consent for the restrictive practice has been obtained from the consumer or their restrictive practices substitute decision maker.
- where any restrictive practices are used, the consumer must be regularly monitored for signs of distress or harm, side effects and adverse events, changes in wellbeing, as well as independent functions or ability to undertake activities of daily living.
- the use of the restrictive practice must be regularly reviewed by the provider with a view to removing it as soon as possible or practicable.
- from 1 September 2021, providers are required under the Quality of Care Principles to have a behaviour support plan in place for every consumer who exhibits behaviours of concern or changed behaviours, or who has restrictive practices considered, applied or used as part of their care.

238. The Aged Care Quality and Safety Commission has prepared a summary of the Key changes in Restrictive Practices from 1 July 2021 (**ANMF 58**).

239. These reforms are welcome steps towards ensuring safe and quality care. Nevertheless, 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.

ANNIE BUTLER
2 May 2022

CURRICULUM VITAE

ANNIE BUTLER

[redacted]

EDUCATION

Lead Organiser Development Program **2013**

Craft of Organising **2011**

Certificate IV in Training and Assessment **2008**

Bachelor of Nursing (Honours First Class) **2000**
University of Technology, Sydney – *Winner of the Yakult Student Award, Best Honours Research Project*

Bachelor of Health Science (Nursing) **1997**
Charles Sturt University - *Graduated with distinction*

General Nursing Certificate **1985**
Concord General Hospital and Hawkesbury Agricultural College

OTHER QUALIFICATIONS

Governance Training, Australian Council Trade Unions (ACTU)	**2015 & 2018**
Cultural Safety Training, Congress of Aboriginal & Torres Strait Islander Nurses and Midwives	**2018**
Occupational Health & Safety Consultation Course	**2002**
Return-to-Work Coordination Course	**2002**

SPECIAL COMPETENCE AREAS

- Professional and industry leadership and direction
- National representation of nurses, midwives, care-workers and the professions
- Political advocacy and campaigning
- Professional nursing practice
- Education and training
- Legislative and policy analysis, review and development
- Stakeholder and agency network development liaison

KEY APPOINTMENTS AND MEMBERSHIPS

- Australian Nursing and Midwifery Accreditation Council – Board Director - ***Current***
- International Council of Nurses – Australian Technical Adviser, Council of National Nursing Association Representatives - ***Current***
- Commonwealth Nurses and Midwives' Federation – Board Member - ***Current***
- Global Nurses United – Member for Australia - ***Current***
- Australian Council of Trade Unions (ACTU) – Executive member
    - ACTU Finance Committee - ***Current***
    - ACTU Growth & Campaigns Committee – ***Current***
    - ACTU Aged Care Working Party Member - ***Current***
- National Nursing and Midwifery Strategic Reference Group – Member - ***Current***
- Nurse Practitioner 10 Year Plan Steering Committee – Member - ***Current***
- National Rural Nursing Generalist Steering Committee – Member - ***Current***
- Ministerial Advisory Committee on Skilled Migration – Member – ***Current***
- Australian Journal of Advanced Nursing (*AJAN*) Executive Editor and Publisher, and Editorial Board Member - ***Current***
- ACTU Women's Committee – ***2014 - 2017***
- Australian Health Practitioner Regulation Agency Professions Reference Group – Member, ***2014 – 2017***
- National Nursing and Midwifery Education Advisory Network - Member – ***2015 – 2017***
- NSW Community Services and Health Industry Training Advisory Body – Board Director, ***2003 – 2011***
- NSW Nurses and Midwives Board Nurses Practice Committee – Member, ***2005 – 2010***
- Australian Nursing Federation Professional Advisory Committee – Member (NSW Representative), ***2004 – 2010***
- Australian Nursing Federation Vocational Education & Training Advisory Committee – Member (NSW Representative), ***2004 – 2010***
- NSW Nurses' Association Professional Issues Committee – Member, ***2003 - 2010***
- NSW Nurses' Association representative contributing to the development of the National Registration and Accreditation Scheme for Health Professionals in Australia, ***2008 – 2010***.

RECENT PUBLICATIONS & REPORTS

- Peters MDJ, Marnie C, **Butler A.** Royal Commission into Aged Care recommendations on minimum staff time standard for nursing homes. *Aust Health Rev.* [In Press].
- Peters MDJ, Marnie C, **Butler A**. Delivering, funding, and rating safe staffing levels and skills mix in aged care. *Int J Nurs Stud*. 2021; 119(103943). doi.org/10.1016/j.ijnurstu.2021.103943
- Peters MDJ, Marnie C, **Butler A**. Letter to the Editor: Delivering, funding, and rating safe staffing levels and skills mix in aged care (authors' response). *Int J Nurs Stud.* 2021;104042. doi: 10.1016/j.ijnurstu.2021.104042
- Bonner R, Peters MDJ, **Butler A**. Workforce - the Bedrock of Aged Care Reform. *Aust Econ Rev.* 2021; 54(2):285-93. doi.org/10.1111/1467-8462.12427
- Peters MDJ, Marnie C, **Butler A**. Policies and procedures for personal protective equipment: does inconsistency increase risk of contamination and infection? *Int J Nurs.* 2020;109:103653. doi.org/10.1016/j.ijnurstu.2020.103653
- **Butler A**, Buchan J, Peters MDJ. Relaunching the Australian Journal of Advanced Nursing (AJAN). *Aust J Adv Nurs.* 37(1):1-2. doi.org/10.1016/j.colegn.2020.11.002

Reports

- Peters MDJ, **Butler A**. Final Report: National Aged Care Survey 2019 [Online]. Australian Nursing and Midwifery Federation Federal Office. 2019. http://anmf.org.au/pages/anmf-reports
- Peters MDJ, **Butler A**. Final Report: National Aged Care Survey 2019 – Community Member Companion Report [Online]. Australian Nursing and Midwifery Federation Federal Office. 2019. http://anmf.org.au/pages/anmf-reports

EMPLOYMENT HISTORY

Federal Secretary **2018 - Present**
Australian Nursing & Midwifery Federation

As Federal Secretary, I am the principal officer of the Australian Nursing & Midwifery Federation (ANMF), who, with the direction of the ANMF's Federal Council, is responsible for overseeing the activities of the ANMF's Federal Office to promote and protect the interests of ANMF members and to provide professional and industrial leadership for the nursing and midwifery industry and professions and the health and aged care sectors.

Key responsibilities:

- Development of organisational strategy and implementation of agreed objectives in the best interests of ANMF members
- Development of policy and procedures to ensure a framework of good organisational governance, ensuring transparency and accountability
- Oversight and authorisation of campaigns to improve both the industrial and professional conditions of ANMF members and the safety and quality of care delivered to recipients of care
- Leading political advocacy for improvements for ANMF members with all federal politicians and key industry, medical and health organisations and bodies, including the provision of evidence, statements and submissions to relevant inquiries, including Parliamentary, Senate Select Committee and Standing Committee Inquiries and Royal Commissions
- Oversight of surveys of the ANMF's membership employed in health, aged care and other sectors and research investigating a range of areas relevant to ensuring the delivery of safe, quality care in sectors where members work
- National representation of ANMF members at all levels, including through media appearances
- Editorial oversight and management of the publication of the ANMF's member journal, *ANMJ*, and peer reviewed research journal, *AJAN* (Australian Journal of Advanced Nursing)
- Provision of direction, leadership and oversight to ANMF Federal Office employees engaged in a variety of activities.

Assistant Federal Secretary **April 2014 – June 2018**
Australian Nursing & Midwifery Federation

Key responsibilities:

- Contribute to development of organisational strategy and implementation of agreed objectives in the best interests of ANMF members in consultation with Federal Secretary
- Contribute to the development of policy and procedures to ensure a framework of good organisational governance, ensuring transparency and accountability

- Contribute to political advocacy for improvements for ANMF members with all federal politicians and key industry, medical and health organisations and bodies, including the provision of evidence, statements and submissions to key inquiries into aged care, including Parliamentary, Senate Select Committee and Standing Committee Inquiries
- Representative member of the Australian Council of Trade Unions (ACTU) Executive Committee and ACTU Women's Committee
- Liaison with senior personnel and key stakeholders in the health industry
- Liaison with members of parliament and government officials
- Contribute to coordination of national campaigns
- Media appearances as required.

Lead Organiser **Jan 2013 – March 2014**
New South Wales Nurses and Midwives' Association, *Lead Organiser for member organising in Southern NSW*

Key responsibilities:

- Recruitment of members to the NSWNMA
- Develop, lead, mentor and support Organisers in Southern NSW
- Act as a resource for growth organising strategies for Organisers;
- Develop and implement individual and team organising plans with Organisers
- Develop and implement campaign plans with organisers
- Motivate Organisers to implement change.

Organiser **Apr 2011 – Dec 2012**
New South Wales Nurses' Association, *Branch Organiser for the Murrumbidgee Local Health District; public, private and aged care facilities***.**

Key responsibilities:

- Recruitment of members to the NSWNA;
- Develop and achieve targets for membership growth and activism;
- Develop and achieve targets for branch formation and retention;
- Support branches in dealing with collective issues;
- Support development of branches and activists;
- Develop and conduct organising campaigns around collective issues in conjunction with branches.

Professional Officer
New South Wales Nurses' Association **Mar 2003 – Mar 2011**

Key responsibilities:

- Recruitment of members to the NSWNA;
- Representation of professional interest of all members of the NSWNA;
- Identification of emerging professional issues and implementation of action in response to ensure a positive outcome for NSWNA members and the profession;
- Legislative and professional policy review and development;
- Member and community education;
- Establishment and development of key agency and stakeholder networks.

Program Facilitator **Jan 2002 – Mar 2003**
Department of Nursing, Central Queensland University, Sydney International Campus

Key responsibilities:

- Coordinating the Bachelor of Health (Nursing – post registration) program;
- Teaching in the program;
- Academic and administrative management of the program;
- Coordinating clinical placements of students;
- Additional responsibilities as Return-to-Work Coordinator, OHS Chairperson and First Aid Coordinator for the campus.

Sessional Lecturer **2000 – Dec 2001**
Sessional Lecturer, Department of Nursing, Central Queensland University

Key responsibilities:
Teaching in the undergraduate nursing program at the Sydney International Campus

Research Nurse **1996 - 2000**
Australian National Blood Pressure Study, Department of General Practice, Sydney University

Key responsibilities:
Responsible for the recruitment of general practitioners and patients for the study; management of patients; support for general practitioners, with particular attention to their adherence to the study protocol.

Registered Nurse **1992 - 1994**
St. Vincent's Hospital

Key responsibilities:
General nursing practice in oncology, gastroenterology, and cardio-thoracic surgery.

Registered Nurse **1989 - 1990**
King George V Hospital

Key responsibilities:
General nursing practice in gynecology.

Project Officer **1989**
Immunisation Campaign, Central Sydney Area Health Service

Key responsibilities:
Overseeing a health education campaign in immunisation; planning and carrying out educational activities; organising and conducting immunization clinics.

Community Nurse **1988 - 1989**
Sydney Home Nursing Service, Canterbury Centre

Key responsibilities:
Community nursing practice with a dedicated geographical region of the Canterbury district.

Registered Nurse **1985 - 1986**
Concord General Hospital

Key responsibilities:
General nursing practice in colorectal surgery.

Student Nurse **1982 - 1985**
Concord General Hospital

Australian Government
Australian Institute of Health and Welfare

AIHW National Aged Care Data Clearinghouse:

Data request R2021_4256_Richards

Contents

Important notes

Sourcing these data

Please acknowledge the source of these data as follows:

Source: AIHW National Aged Care Data Clearinghouse

Interpreting these data

Please refer to the Data Quality Statement (DQS) on METeOR (see link below) for information on a range of aspects of the quality of the data being reported from the AIHW National Aged Care Data Clearinghouse. Where requests include information on Aged Care Funding Instrument ACFI appraisals, please refer to the DQS on ACFI data.

METeOR Data Quality Statement: NACDC

METeOR Data Quality Statement: ACFI

Note that data presented here may differ from those published elsewhere because of differences in the preparation and analysis of the source data.

Disclaimers

While the AIHW has exercised due care in ensuring the accuracy of these data, the data are made available on the basis that the AIHW is not providing professional advice on a particular matter.

These data are not a substitute for independent professional advice. Nothing contained in these data are intended to be used as medical advice and they are not intended to be used to diagnose, treat, cure or prevent any disease, nor should they be used for therapeutic purposes or as a substitute for your own health professional's advice.

Quality of information

The AIHW makes every effort to ensure the quality of the data provided through the National Aged Care Data Clearinghouse. Before relying on the data, however, users should carefully evaluate the data's accuracy, currency, completeness and relevance for their purposes, and should obtain any appropriate professional advice relevant to their particular circumstances. The AIHW cannot guarantee and assumes no legal liability or responsibility for the accuracy, currency, completeness or interpretation of the data provided through the National Aged Care Data Clearinghouse.

Disclaimer of liability

You acknowledge that your use of any data provided through the National Aged Care Data Clearinghouse is entirely at your own risk and that the data may contain inaccuracies or errors. The AIHW accepts no liability for any injury, loss or damage incurred by use of or reliance on the data, including, but not limited to:

- use of the data for a purpose for which they were not intended,
- any errors or omissions in the data,
- any inaccuracy in the data,
- any interpretations or opinions stated in, or which may be inferred from, the data.

Contacting the National Aged Care Data Clearinghouse

Email: gen@aihw.gov.au

Australian Government
Australian Institute of Health and Welfare

Table 1. Average age of permanent residential aged care residents, by Indigenous status, at 30 June 2020

	Indigenous	Non-Indigenous	Unknown	All
Number of recipients	1,845	181,960	179	183,984
Average age (years)				
Mean	73.9	85.0	77.7	84.9
Median	75	87	77	86

Australian Government
Australian Institute of Health and Welfare

Table 2. Ratio of residential aged care places per 1000 persons aged 70 years and older at 30 June 2020

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Residential aged care places	(No.)	72,269	57,704	42,072	18,509	18,338	5,111	2,583	559	217,145
Ratio of residential aged care places per 1000 older persons[(a)]	('000)	75.7	78.4	73.8	67.4	77.0	67.1	65.2	47.6	74.8

(a) Persons aged 70 years and older.

Table 3. Places in residential aged care, by organisation type and size, at 30 June 2020

	Organisation type		
Size of the facility	**Government**	**Not-for-profit**	**Private**
1–20	1,052	619	14
21–40	2,876	8,082	1,450
41–60	1,876	16,229	6,210
61–80	805	18,652	12,154
81–100	635	20,031	14,934
101+	1,186	55,586	54,677
Total [(a)]	**8,430**	**119,199**	**89,439**

(a) Total number of places in residential aged care excludes 77 places of unknown organisation type.

Appendix 4: All training and skills

Figure A.4.1: RAC – Number of facilities that report having direct care workers with formally obtained specialist skills in all areas

	Nurse Practitioner	Registered Nurse	Enrolled Nurse	Personal Care Worker	Allied Health Professional	Facilities with at least one skilled worker
ICT/IT	56 (39%)	1,112 (47%)	626 (37%)	984 (42%)	614 (34%)	1,199 (50%)
Dementia Care	92 (64%)	1,927 (82%)	1,248 (75%)	1,740 (75%)	887 (49%)	2,011 (85%)
Behaviour Support	93 (65%)	1,750 (74%)	1,098 (66%)	1,511 (65%)	755 (42%)	1,833 (77%)
Palliative Care	73 (51%)	1,806 (77%)	1,061 (63%)	1,333 (58%)	524 (29%)	1,866 (79%)
Medications	94 (66%)	1,929 (82%)	1,228 (73%)	1,362 (59%)	391 (22%)	2,037 (86%)
Mental Health	75 (52%)	1,276 (54%)	661 (40%)	833 (36%)	492 (27%)	1,412 (59%)
Clinical skills for high and complex care needs	63 (44%)	1,704 (72%)	749 (45%)	329 (14%)	410 (23%)	1,750 (74%)
Assessment of the Older Person	70 (49%)	1653 (70%)	790 (47%)	533 (23%)	625 (35%)	1,734 (73%)
IPC	116 (81%)	2,037 (86%)	1,275 (76%)	1684 (73%)	949 (53%)	2,089 (88%)
Parkinson's Care	35 (25%)	1,152 (49%)	569 (34%)	749 (32%)	483 (27%)	1,242 (52%)
Elder Abuse	78 (55%)	1,898 (81%)	1,194 (71%)	1,706 (74%)	931 (52%)	1,954 (82%)
Falls Risk	112 (78%)	1,793 (76%)	1,120 (67%)	1,532 (66%)	973 (54%)	1,874 (79%)
Nutrition and Hydration	91 (64%)	1,733 (74%)	1,054 (63%)	1,408 (61%)	696 (39%)	1,822 (77%)
Oral Hygiene	47 (33%)	1,451 (62%)	886 (53%)	1,290 (56%)	390 (22%)	1,581 (67%)
Hearing Impairment	39 (27%)	1,242 (53%)	731 (44%)	1,097 (47%)	453 (25%)	1,380 (58%)
Diabetes	55 (39%)	1,609 (68%)	901 (54%)	981 (42%)	527 (29%)	1,697 (71%)
Wound Care*	82 (57%)	1,882 (80%)	1,101 (66%)	968 (42%)	562 (31%)	1,930 (81%)
Cultural Safety	49 (34%)	1,379 (59%)	847 (51%)	1,223 (53%)	769 (43%)	1,503 (63%)
Diversity Awareness	49 (34%)	1,442 (61%)	863 (52%)	1,314 (57%)	761 (42%)	1,529 (64%)
Leadership	71 (50%)	1,571 (67%)	573 (34%)	469 (20%)	400 (22%)	1,634 (69%)
Resilience	32 (23%)	934 (40%)	464 (28%)	685 (30%)	440 (24%)	1,010 (42%)
Other	6 (4%)	265 (11%)	140 (8%)	262 (11%)	113 (6%)	329 (14%)
None	11 (8%)	170 (7%)	177 (11%)	251 (11%)	457 (25%)	N/A

*Source: Facilities were asked if staff in each job role held skills in 22 areas that enable them to provide specialised care supports. Note: The percentage represents the proportion of facilities that indicated having staff in that job role and completed this question of the Census and the percentage for all job roles is the proportion of facilities that indicated having one of these job roles and completed this question of the Census. *Wound Care: Wound Assessment/Care, Pressure Injury Risk Assessment & Skin Integrity*

Figure A.4.3: HCPP – Number of providers that report having direct care workers with formally obtained specialist skills in all areas

	Nurse Practitioner	Registered Nurse	Enrolled Nurse	Personal Care Worker	Allied Health Professional	Facilities with at least one skilled worker
ICT/IT	17 (45%)	217 (33%)	90 (32%)	284 (25%)	166 (39%)	377 (32%)
Dementia Care	27 (74%)	460 (69%)	182 (64%)	772 (68%)	161 (38%)	871 (75%)
Behaviour Support	13 (34%)	301 (45%)	119 (42%)	476 (42%)	136 (32%)	602 (52%)
Palliative Care	18 (49%)	388 (58%)	128 (45%)	400 (35%)	113 (27%)	620 (53%)
Medications	23 (61%)	494 (74%)	199 (70%)	707 (62%)	58 (14%)	862 (74%)
Mental Health	16 (43%)	266 (40%)	105 (37%)	381 (33%)	110 (26%)	555 (47%)
Clinical skills for high/complex care needs	16 (44%)	417 (63%)	120 (43%)	186 (16%)	159 (37%)	585 (50%)
Assessment of the Older Person	13 (35%)	437 (66%)	151 (53%)	300 (26%)	194 (45%)	649 (56%)
IPC	30 (80%)	511 (77%)	200 (71%)	810 (71%)	238 (56%)	905 (77%)
Parkinson's Care	7 (19%)	245 (37%)	91 (32%)	252 (22%)	130 (31%)	423 (36%)
Elder Abuse	32 (86%)	434 (65%)	193 (68%)	737 (65%)	189 (44%)	811 (69%)
Falls Risk	20 (55%)	411 (62%)	177 (63%)	564 (49%)	207 (48%)	713 (61%)
Nutrition and Hydration	12 (32%)	370 (56%)	150 (53%)	428 (38%)	146 (34%)	618 (53%)
Oral Hygiene	8 (21%)	302 (45%)	130 (46%)	372 (33%)	55 (13%)	487 (42%)
Hearing Impairment	4 (9%)	239 (36%)	100 (35%)	270 (24%)	97 (23%)	401 (34%)
Diabetes	21 (56%)	411 (62%)	158 (56%)	391 (34%)	84 (20%)	649 (56%)
Wound Care*	23 (61%)	485 (73%)	182 (64%)	271 (24%)	117 (27%)	664 (57%)
Cultural Safety	18 (49%)	379 (57%)	156 (55%)	564 (50%)	194 (45%)	696 (60%)
Diversity Awareness	20 (55%)	385 (58%)	174 (61%)	612 (54%)	200 (47%)	717 (61%)
Leadership	19 (52%)	246 (37%)	71 (25%)	187 (16%)	91 (21%)	437 (37%)
Resilience	8 (21%)	216 (32%)	85 (30%)	249 (22%)	109 (25%)	354 (30%)
Other	2 (6%)	115 (17%)	32 (11%)	200 (18%)	54 (13%)	260 (22%)
None	3 (7%)	45 (7%)	40 (14%)	111 (10%)	93 (22%)	N/A

Figure A.4.5: CHSP – Number of providers that report having direct care workers with formally obtained specialist skills in all areas

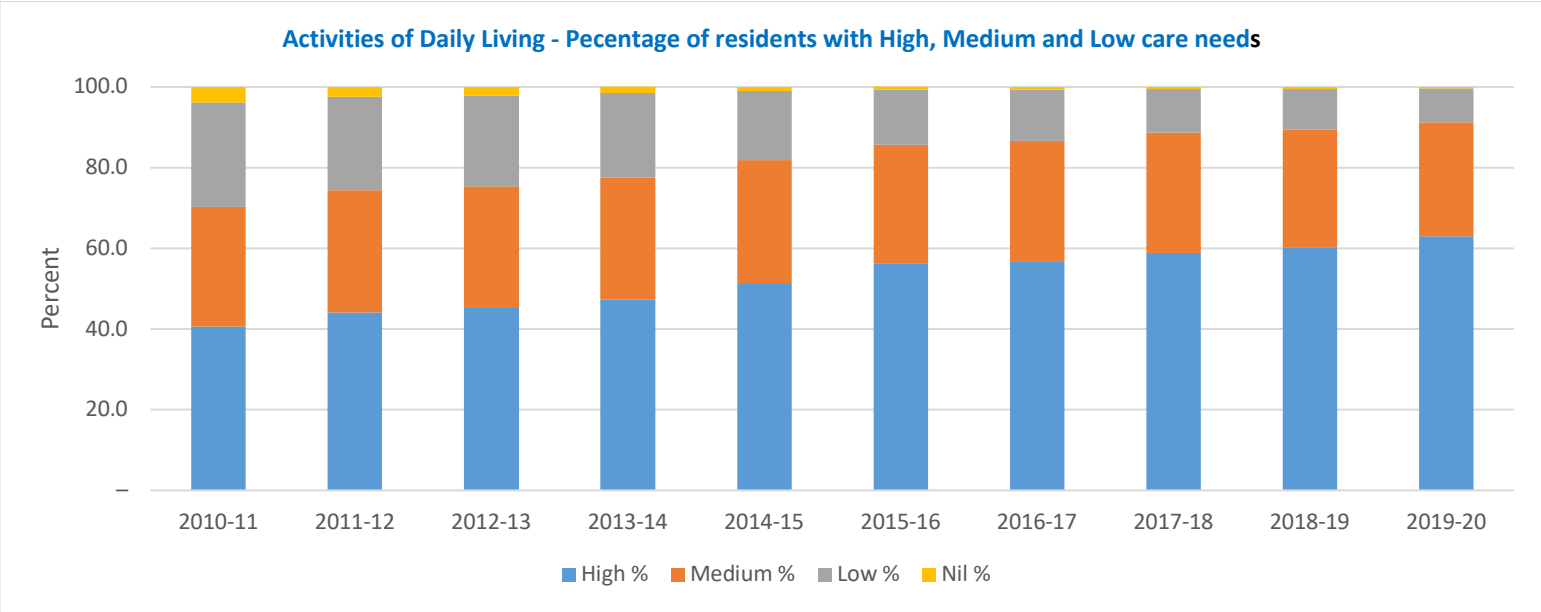
	Nurse Practitioner	Registered Nurse	Enrolled Nurse	Personal Care Worker	Allied Health Professional	Facilities with at least one skilled worker
ICT/IT	42 (66%)	173 (33%)	82 (29%)	315 (30%)	176 (30%)	388 (30%)
Dementia Care	27 (42%)	295 (56%)	143 (51%)	632 (60%)	176 (30%)	790 (61%)
Behaviour Support	5 (8%)	141 (27%)	74 (26%)	349 (33%)	108 (18%)	466 (36%)
Palliative Care	9 (15%)	295 (56%)	109 (39%)	286 (27%)	79 (13%)	521 (40%)
Medications	17 (28%)	372 (70%)	184 (65%)	617 (58%)	68 (11%)	801 (62%)
Mental Health	0 (0%)	115 (22%)	56 (20%)	260 (25%)	121 (20%)	397 (31%)
Clinical skills for high/complex care needs	12 (19%)	288 (54%)	100 (35%)	151 (14%)	210 (35%)	473 (37%)
Assessment of the Older Person	16 (25%)	321 (60%)	129 (46%)	212 (20%)	236 (40%)	571 (44%)
IPC	47 (74%)	397 (75%)	175 (62%)	744 (70%)	299 (50%)	902 (70%)
Parkinson's Care	12 (19%)	128 (24%)	54 (19%)	153 (14%)	127 (21%)	312 (24%)
Elder Abuse	47 (74%)	350 (66%)	168 (59%)	594 (56%)	263 (44%)	773 (60%)
Falls Risk	18 (29%)	304 (57%)	137 (48%)	434 (41%)	266 (45%)	697 (54%)
Nutrition and Hydration	17 (26%)	246 (46%)	122 (43%)	346 (33%)	150 (25%)	564 (44%)
Oral Hygiene	12 (19%)	197 (37%)	96 (34%)	174 (16%)	42 (7%)	340 (26%)
Hearing Impairment	14 (23%)	128 (24%)	63 (22%)	163 (15%)	59 (10%)	279 (22%)
Diabetes	23 (36%)	298 (56%)	124 (44%)	289 (27%)	110 (19%)	580 (45%)
Wound Care*	20 (32%)	362 (68%)	154 (54%)	172 (16%)	165 (28%)	538 (42%)
Cultural Safety	12 (19%)	265 (50%)	135 (48%)	515 (49%)	221 (37%)	666 (52%)
Diversity Awareness	38 (60%)	267 (50%)	127 (45%)	593 (56%)	240 (40%)	739 (57%)
Leadership	37 (59%)	153 (29%)	45 (16%)	151 (14%)	139 (23%)	386 (30%)
Resilience	14 (23%)	136 (26%)	63 (22%)	249 (24%)	126 (21%)	351 (27%)
Other	2 (3%)	113 (21%)	19 (7%)	197 (19%)	131 (22%)	353 (27%)
None	15 (23%)	41 (8%)	46 (16%)	124 (12%)	82 (14%)	N/A

ANNEXURE AB 6

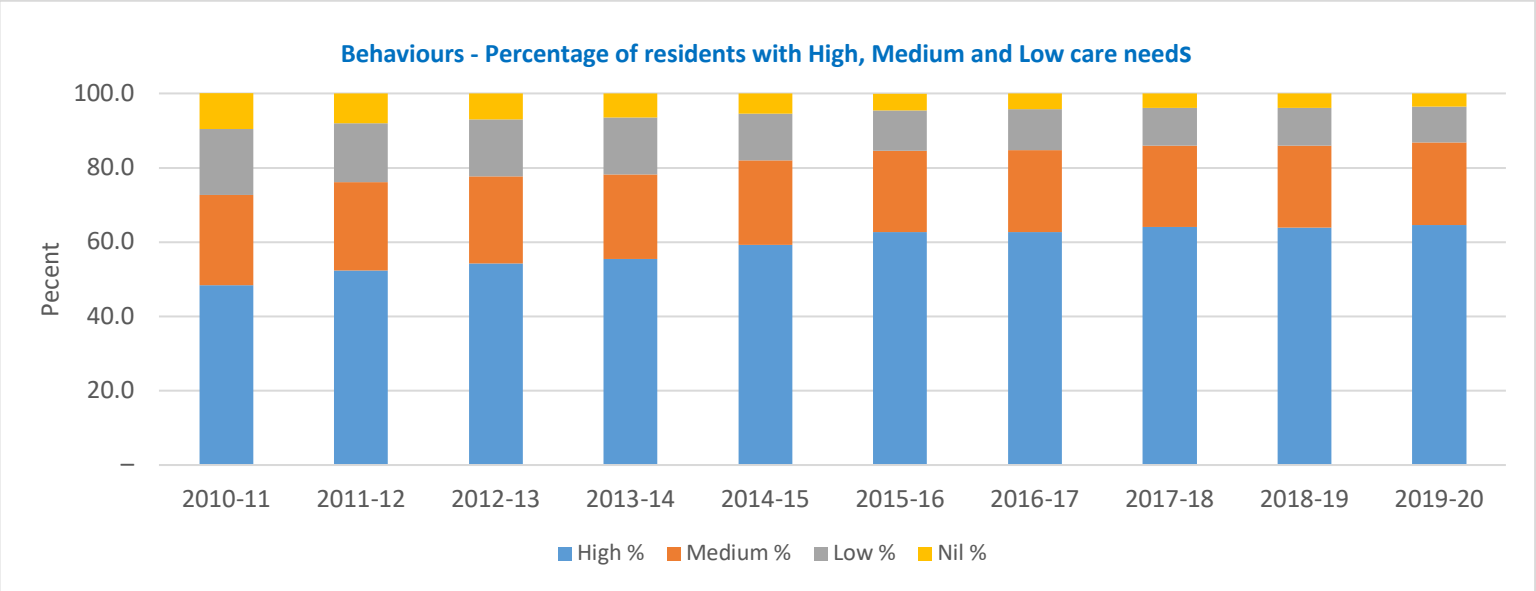
Aged care resident dependency levels across the three domains – 2010-11 to 2019-20

Extracted from Table 14A.12 Report on Government Services -2021 part f. section 14 aged care data tables

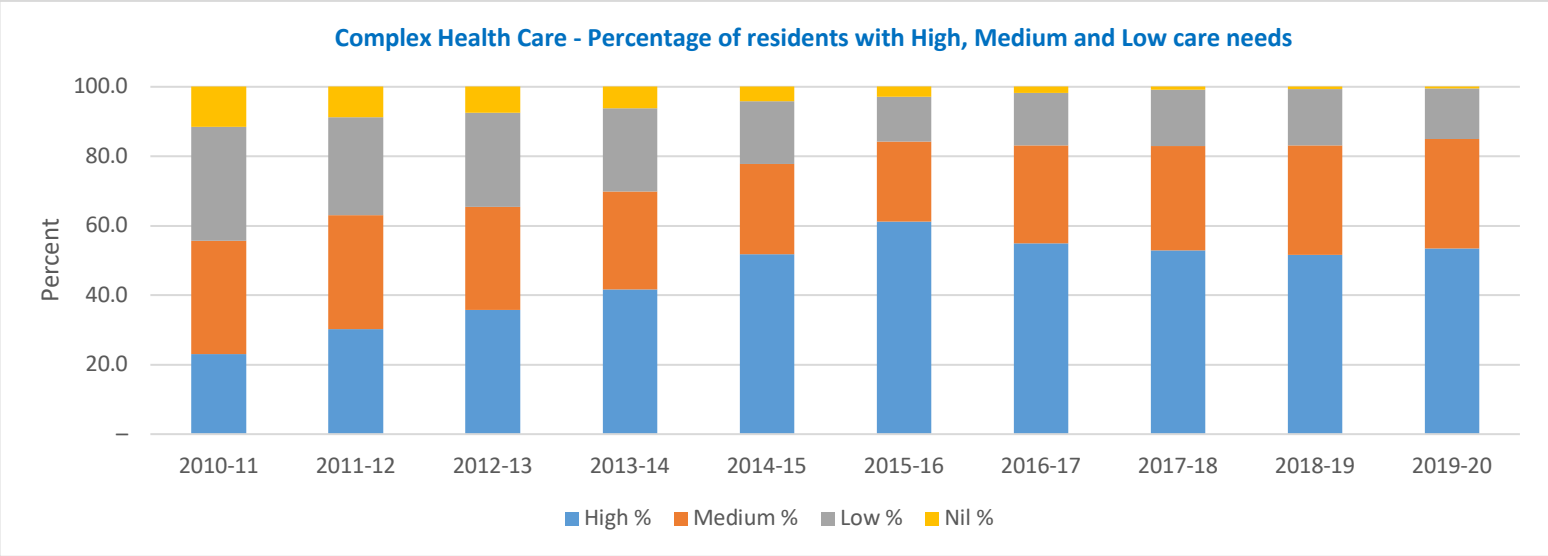
Activities of Daily living										
Proportion of residents										
Aged Care Funding Instrument (ACFI) (a)										
	2010-11	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
High %	40.6	44.1	45.2	47.2	51.4	56.1	56.6	58.9	60.1	62.9
Medium %	29.8	30.4	30.1	30.4	30.4	29.6	30.0	29.7	29.4	28.3
Low %	25.8	23.1	22.6	20.9	17.2	13.7	12.8	10.9	10.0	8.4
Nil %	3.9	2.4	2.0	1.6	1.0	0.7	0.6	0.5	0.5	0.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**



Behaviours										
Proportion of residents										
Aged Care Funding Instrument (ACFI) (a)										
	2010-11	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
High %	48.4	52.3	54.3	55.4	59.3	62.7	62.7	64.1	63.8	64.6
Medium %	24.3	23.7	23.3	22.8	22.6	21.8	22.1	21.9	22.1	22.2
Low %	17.7	15.9	15.4	15.3	12.6	11.0	10.9	10.2	10.2	9.6
Nil %	9.5	8.0	7.0	6.5	5.5	4.4	4.3	3.8	3.9	3.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**



Complex Health Care										
Proportion of residents										
Aged Care Funding Instrument (ACFI) (a)										
	2010-11	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
High %	23.0	30.2	35.8	41.7	51.8	61.2	54.9	53.0	51.6	53.5
Medium %	32.7	32.7	29.8	28.2	26.0	23.0	28.1	30.0	31.5	31.5
Low %	32.8	28.3	27.0	24.0	18.0	13.0	15.1	16.1	16.3	14.5
Nil %	11.6	8.8	7.4	6.1	4.2	2.9	1.8	0.9	0.7	0.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

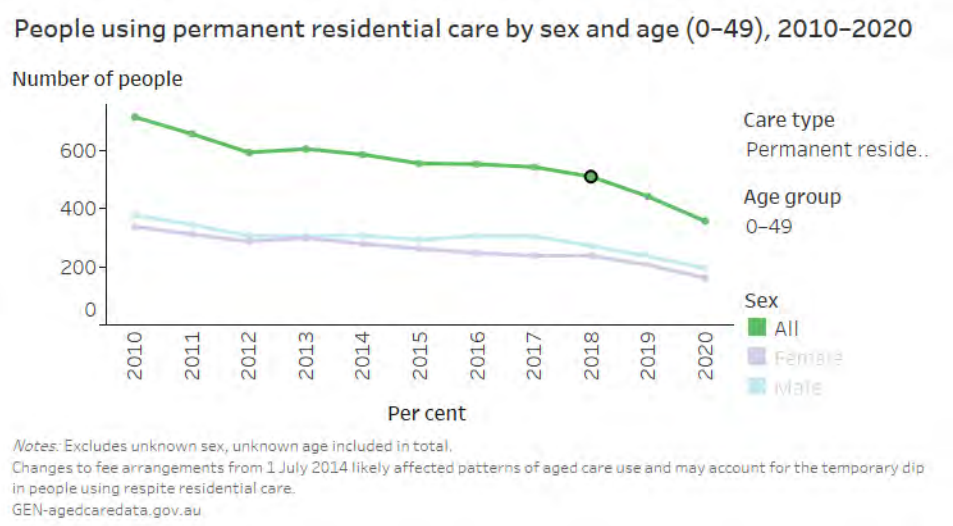


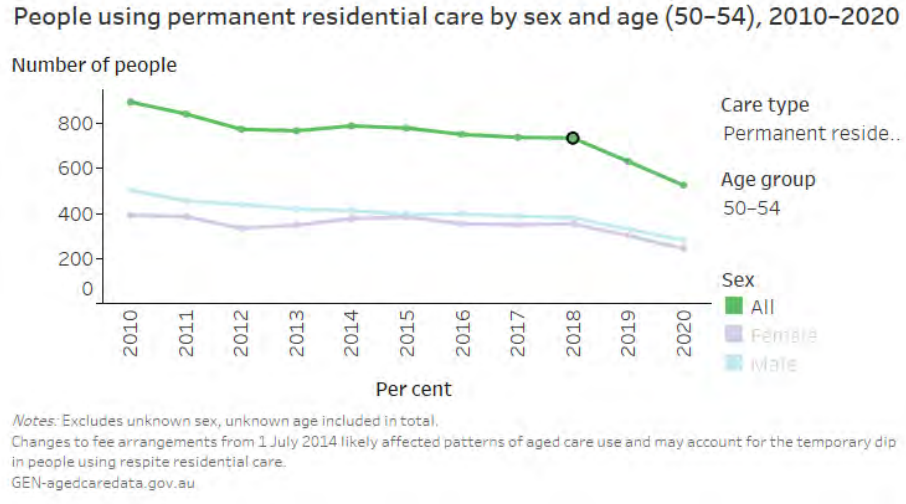
Note: (a) The ACFI proportions are for permanent residents that have an ACFI classification.

Source: https://www.pc.gov.au/research/ongoing/report-on-government-services/2021/community-services/aged-care-services

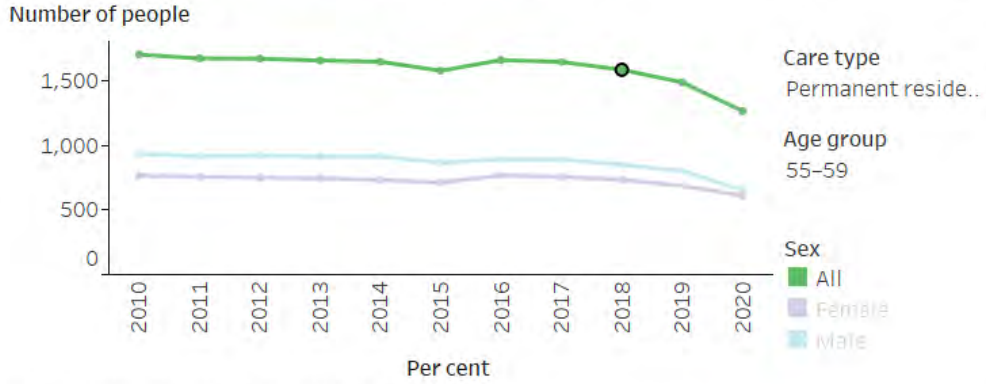
ANNEXURE AB 7

Age of people using residential aged care - changes in the number of residents across the different age groupings over the period 2010 - 2020



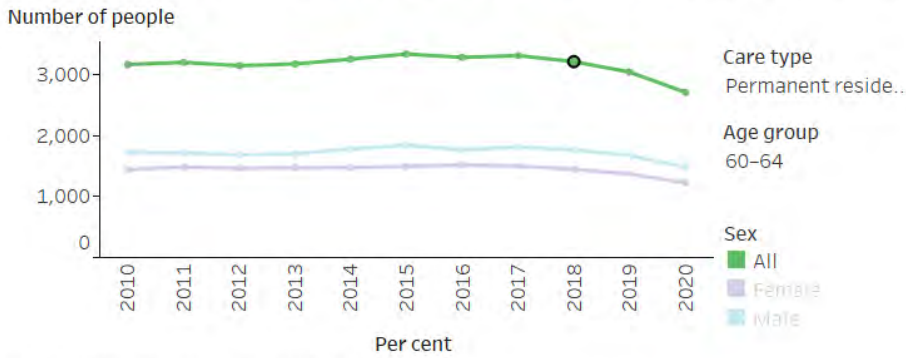


People using permanent residential care by sex and age (55–59), 2010–2020



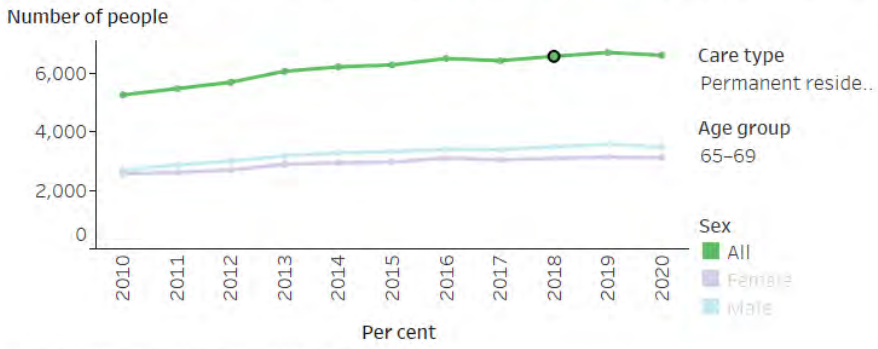
Notes: Excludes unknown sex, unknown age included in total.
Changes to fee arrangements from 1 July 2014 likely affected patterns of aged care use and may account for the temporary dip in people using respite residential care.
GEN-agedcaredata.gov.au

People using permanent residential care by sex and age (60–64), 2010–2020



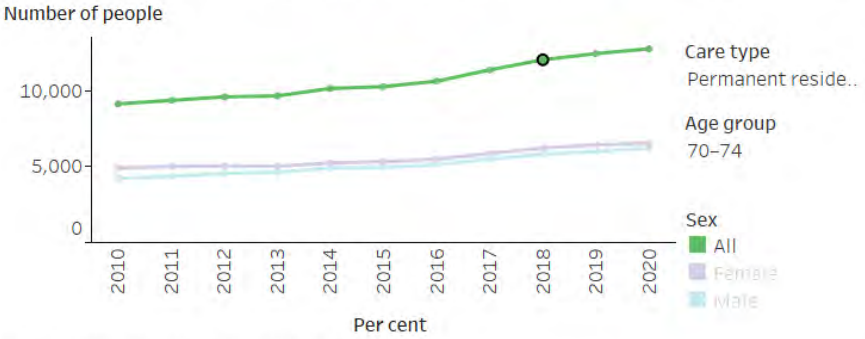
Notes: Excludes unknown sex, unknown age included in total.
Changes to fee arrangements from 1 July 2014 likely affected patterns of aged care use and may account for the temporary dip in people using respite residential care.
GEN-agedcaredata.gov.au

People using permanent residential care by sex and age (65–69), 2010–2020



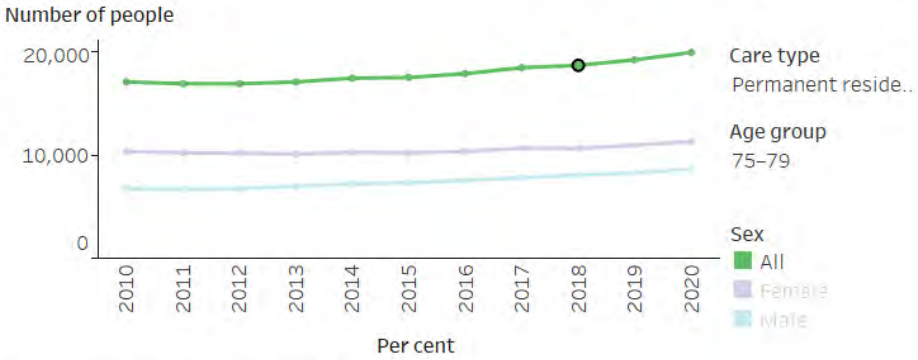
Notes: Excludes unknown sex, unknown age included in total.
Changes to fee arrangements from 1 July 2014 likely affected patterns of aged care use and may account for the temporary dip in people using respite residential care.
GEN-agedcaredata.gov.au

People using permanent residential care by sex and age (70–74), 2010–2020



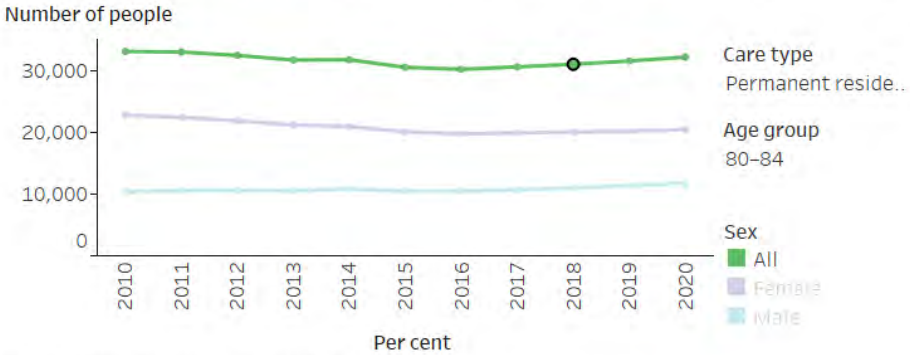
Notes: Excludes unknown sex, unknown age included in total.
Changes to fee arrangements from 1 July 2014 likely affected patterns of aged care use and may account for the temporary dip in people using respite residential care.
GEN-agedcaredata.gov.au

People using permanent residential care by sex and age (75–79), 2010–2020



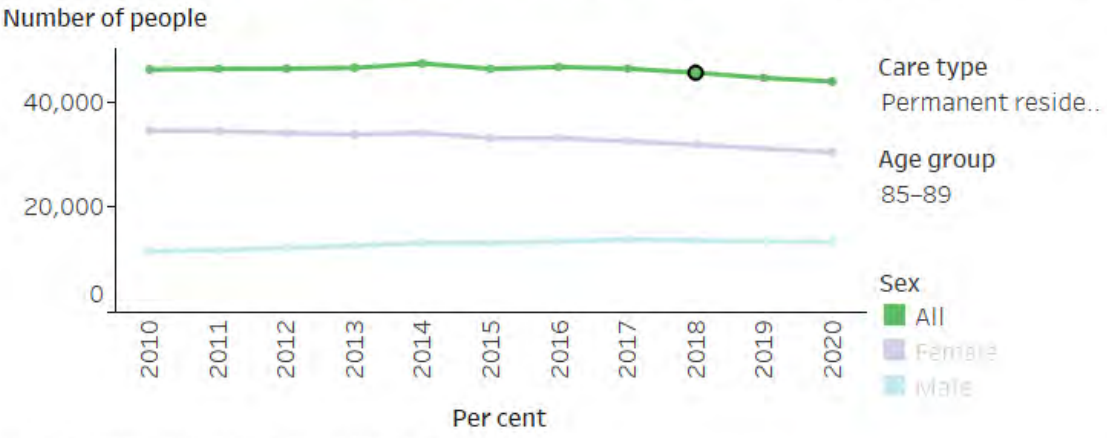
Notes: Excludes unknown sex, unknown age included in total.
Changes to fee arrangements from 1 July 2014 likely affected patterns of aged care use and may account for the temporary dip in people using respite residential care.
GEN-agedcaredata.gov.au

People using permanent residential care by sex and age (80–84), 2010–2020



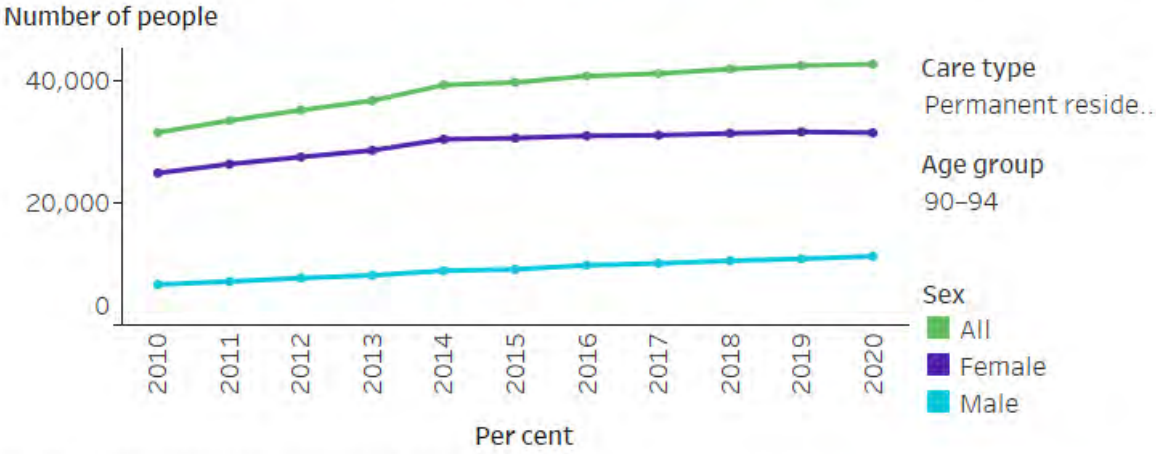
Notes: Excludes unknown sex, unknown age included in total.
Changes to fee arrangements from 1 July 2014 likely affected patterns of aged care use and may account for the temporary dip in people using respite residential care.
GEN-agedcaredata.gov.au

People using permanent residential care by sex and age (85–89), 2010–2020



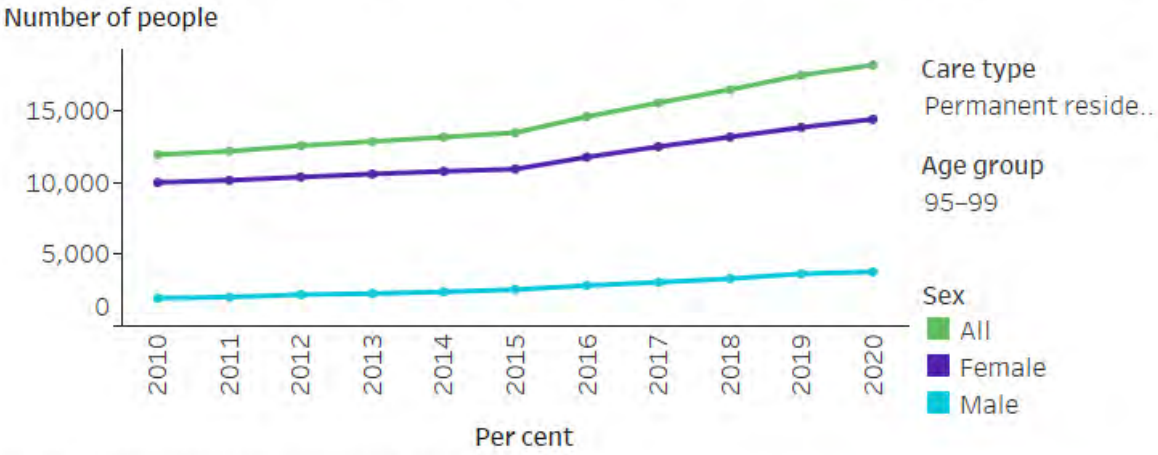
Notes: Excludes unknown sex, unknown age included in total.
Changes to fee arrangements from 1 July 2014 likely affected patterns of aged care use and may account for the temporary dip in people using respite residential care.
GEN-agedcaredata.gov.au

People using permanent residential care by sex and age (90–94), 2010–2020



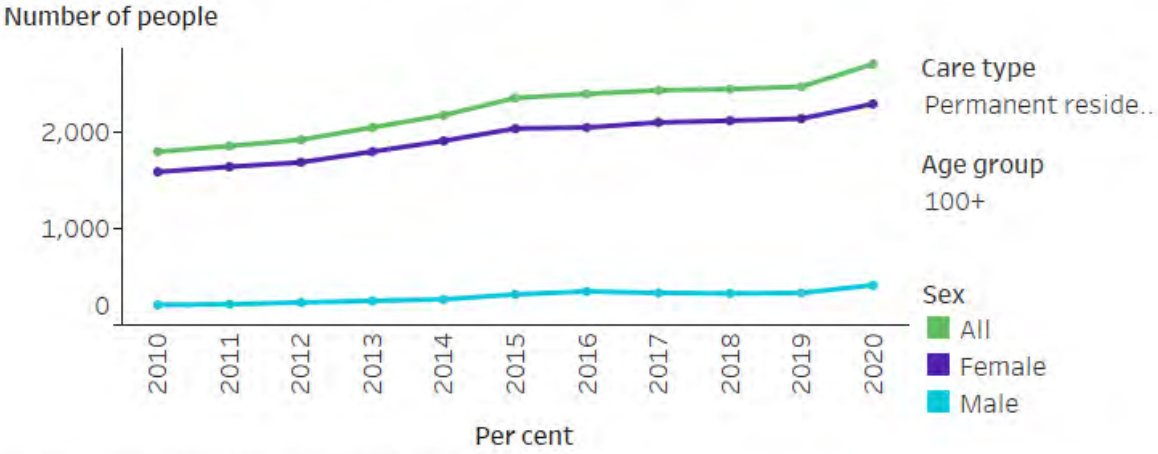
Notes: Excludes unknown sex, unknown age included in total.
Changes to fee arrangements from 1 July 2014 likely affected patterns of aged care use and may account for the temporary dip in people using respite residential care.
GEN-agedcaredata.gov.au

People using permanent residential care by sex and age (95–99), 2010–2020



Notes: Excludes unknown sex, unknown age included in total.
Changes to fee arrangements from 1 July 2014 likely affected patterns of aged care use and may account for the temporary dip in people using respite residential care.
GEN-agedcaredata.gov.au

People using permanent residential care by sex and age (100+), 2010–2020



Notes: Excludes unknown sex, unknown age included in total.
Changes to fee arrangements from 1 July 2014 likely affected patterns of aged care use and may account for the temporary dip in people using respite residential care.
GEN-agedcaredata.gov.au

Source: https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care#Aged%20care%20use%20and%20age

ANNEXURE AB 8

SUMMARY OF AGED CARE INQUIRIES AND REVIEWS LIST

1982	In a home or at home: accommodation and home care for the aged
1984	Private nursing homes in Australia: their conduct, administration and ownership
1986	Nursing homes and hostels review: report
1989	Residents' rights in nursing homes and hostels: final report
1990	CAM review report to the Minister for Aged, Family and Health Services
1991	Aged care reform strategy, mid-term review 1990-91: report
1993	Review of the structure of nursing home funding arrangements, stage 1
1993	Aged care reform strategy mid-term review, stage 2: report
1993	Raising the standard: resident centered nursing home regulation in Australia
1993	Inquiry into the Validation of CAM/SAM Funding for Nursing Homes
1994	Review of the structure of nursing home funding arrangements, stage 2
1997	Aged Care Bill 1997
1997	Funding of Aged Care Institutions
1998	Aged Care Amendment Bill 1998
1998	Review of the Resident Classification Scale
1999	Nursing Home Subsidies
2001	Two Year Review of Aged Care Reforms
2003	Inquiry into long term strategies to address the ageing of the Australian population over the next 40 years
2003	Review of Pricing Arrangements in Residential Aged Care
2004	Economic Implications of an Ageing Australia
2005	Inquiry into Quality and Equity in Aged Care
2007	Inquiry into Aged Care Amendment (Residential Care) Bill 2007
2007	Project to Evaluate the impact of accreditation on the delivery of quality of care and quality of life to residents in aged care homes
2009	Review of the Aged Care Complaints Investigation Scheme
2009	Protection of Residential Aged Care Accommodation Bonds
2009	Inquiry into Residential and Community Aged Care in Australia
2009	Review of the Aged Care Funding Instrument (ACFI)
2009	Review of the Accreditation Process for Residential Aged Care Homes
2010	Education and Training Workforce: Vocational Education and Training
2010	Caring for Older Australians
2011	Options for Regulation of Unregistered Health Practitioners
2011	Australia's Health Consultation on Medication Management in Residential Aged Care Facilities
2011	Consultation on Residential Aged Care Accreditation Standards
2011	Aged Care Complaints Scheme: Proposed Complaints Management Framework
2012	Managing Aged Care Complaints
2012	Inquiry into Dementia - Early Diagnosis and Intervention
2012	Impacts of COAG Reforms - Business Regulation and VET
2012	Senate Inquiry into Palliative Care in Australia

2013	Training for Aged and Community Care in Australia
2013	Aged Care (Living Longer Living Better) Bill 2013
2013	Health Workforce Australia Consultation on Nursing Workforce Retention and Productivity
2015	Registered Nurses in New South Wales Nursing Homes
2015	Inquiry into Elder Abuse in New South Wales
2016	Increasing Choice in Home Care Stage 1 - Proposed Changes to Aged Care Principles and Determination
2016	Senate Inquiry into the Future of Australia's Aged Care Sector Workforce
2016	Aged Care Legislated Review
2016	Australian Law Reform Commission Inquiry into Elder Abuse
2017	Oakden Older Persons Mental Health Service Review
2017	Review of National Aged Care Quality Regulatory Processes
2017	Inquiry into the effectiveness of the Aged Care Quality Assessment and Accreditation Framework forprotecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practiced
2018	Charter of Aged Care Rights Consultation
2018	Consultation on the draft Aged Care Standards Guidance Materials
2018	Aged Care Quality and Safety Commission Bill 2018 and related Bill
2018	A Matter of Care: Australia's Aged Care Workforce Strategy
2018	Financial and Tax Practices of For-Profit Aged Care Providers
2018	Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia
2018	Aged Care Amendment (Staffing Ratio Disclosure) Bill
2019	Proposal for a New Residential Aged Care Funding Model
2019	Draft NSQHS Standards (second edition) Aged Care Module
2019	Residential Aged Care - Proposed Alternative Models for Allocating Places
2019	Streamlined Consumer Assessment for Aged Care
2019	Evaluation of the Aged Care System Navigator Measure
2019	Royal Commission into Aged Care Quality and Safety
2019	Serious Incident Response Scheme for Commonwealth Funded Residential Aged Care: Finer Details of Operation
2020	The Reimagined Personal Care Worker
2020	Aged Care Worker Regulation Scheme Consultation
2020	Aged Care Legislation Amendment (Financial Transparency) Bill 2020
2020	Quality Use of Medicines and Medicines Safety (10th National Health Priority) Public consultation?– Phase1: Aged care
2020	Consultation on the draft National Safety and Quality Health Service Standards (second edition) User Guidefor Multi-Purpose Services Aged Care Module
2021	Serious Incident Response Scheme for In-Home Aged Care Services

Inquiry Name	In a home or at home: accommodation and home care for the aged
Year	1982
Inquiry Report Citation	House of Representatives Standing Committee on Expenditure. In a home or at home: accommodation and home care for the aged. Canberra: Government Printer, 1982

Inquiry Name	Private nursing homes in Australia: their conduct, administration and ownership
Year	1984
Inquiry Report Citation	Senate Select Committee on Private Hospitals and Nursing Homes. Private nursing homes in Australia: their conduct, administration and ownership: report. Canberra: Australian Government Publishing Service, 1984

Inquiry Name	Nursing homes and hostels review: report
Year	1986
Inquiry Report Citation	Department of Community Services. Nursing homes and hostels review: report. Canberra: Government Printer, 1986

Inquiry Name	Residents' rights in nursing homes and hostels: final report
Year	1989
Inquiry Report Citation	Ronalds, Chris; Godwin, Philippa; Fiebig, Jeff. Residents' rights in nursing homes and hostels: final report. Canberra: AGPS, 1989

Inquiry Name	CAM review report to the Minister for Aged, Family and Health Services
Year	1990
Inquiry Report Citation	Department of Community Services and Health. CAM review report to the Minister for Aged, Family and Health Services. Canberra: AGPS, 1990.
Report Summary	The Care Aggregated Module (CAM) arrangements for nursing and personal care funding in non-Government nursing homes were introduced in July 1988.

Inquiry Name	Aged care reform strategy, mid-term review 1990-91: report
Year	1991
Inquiry Report Citation	Department of Health, Housing and Community Services. Aged care reform strategy, mid-term review 1990-91: report. Canberra: AGPS, 1991

Inquiry Name	Review of the structure of nursing home funding arrangements, stage 1
Year	1993
Inquiry Report Citation	Gregory, R.G.; Department of Health Housing, Local Government and Community Services - Aged and Community Care Division. Review of the structure of nursing home funding arrangements, stage 1. Canberra: AGPS, 1993

Inquiry Name	Aged care reform strategy mid-term review, stage 2: report
Year	1993
Inquiry Report Citation	Gregory, R.G.; Department of Health, Housing, Local Government and Community Services. Aged care reform strategy mid-term review, stage 2: report. Canberra: AGPS, 1993

Inquiry Name	Raising the standard: resident centred nursing home regulation in Australia
Year	1993
Inquiry Report Citation	Braithwaite, John; Department of Health, Aged and Community Care Division. Raising the standard: resident centred nursing home regulation in Australia. Canberra: AGPS, 1993

Inquiry Name	Inquiry into the Validation of CAM/SAM Funding for Nursing Homes
Year	1993
Inquiry Report Citation	Senate Community Affairs References Committee. Validation of CAM and SAM funding of nursing homes: final report. Canberra: Parliament of the Commonwealth of Australia, 1994
Inquiry Report Link	Validation of CAM and SAM funding of nursing homes: final report.

Inquiry Name	Review of the structure of nursing home funding arrangements, stage 2
Year	1994
Inquiry Report Citation	Gregory, R.G.; Department of Health, Housing, Local Government and Community Services. Review of the structure of nursing home funding arrangements, stage 2. Canberra: AGPS, 1993

Inquiry Name	Aged Care Bill 1997
Year	1997
Inquiry Report Citation	Parliamentary Library. Bills Digest 132 1996-97 Aged Care Bill 1997. Canberra: Commonwealth of Australia, 1997. There was no final report.
Inquiry Report Link	Bills Digest Aged Care Bill 1997
Report Summary	The purpose of the Bill is to enable the Commonwealth government to reduce its capital funding involvement in the aged care industry; align the classification and funding arrangements for nursing homes and hostels with a view to improvingthe standard of accommodation and care, particularly in respect of nursing homes; place a greater onus on older people with higher income and assets to make a greater contribution to the cost of their care; establish an accreditation system for residential care facilities.

Inquiry Name	Funding of Aged Care Institutions
Year	1997
Inquiry Report Citation	Report on funding of aged care institutions / report of the Senate Community Affairs References Committee. Canberra: The Committee, 1997
Inquiry Report Link	Report on funding of aged care institutions
Report Summary	In regards to nurse staffng: Recommendation 18: The Committee recommends that nursing homes continue to be required to acquit that proportion of their funding expended on nursing and personal care. Recommendation 19: The Committee recommends that the accreditation standards and quality assurance system provide for the employment of appropriately skilled and trained nursing staff to ensure that quality of care is maintained in aged care facilities. Recommendation 20: The Committee recommends that the Aged Care Standards Agency monitor the ratio of trained nursing staff per resident in nursing homes through a transparent reporting procedure which would signal significant change in the ratio.

Inquiry Name	Aged Care Amendment Bill 1998
Year	1998
Inquiry Report Citation	Senate Community Affairs Legislation Committee. Aged care amendment bill 1998: consideration of legislation referred to the Committee. Canberra: Parliament of the Commonwealth of Australia, 1998
Inquiry Report Link	Aged Care Amendment Bill 1998
Report Summary	The Aged Care Act 1997 implemented structural reforms to the aged care system. The Aged Care Amendment Bill provides for the introduction of a number of additional measures, announced by the Government in November 1997, to the structural reforms. The Bill also addresses some administrative and procedural issues.

Inquiry Name	Review of the Resident Classification Scale
Year	1998
Inquiry Report Citation	Cuthbertson, Sandy et al. Review of the resident classification scale. Canberra: Department of Health andFamily Services, 1998.
Inquiry Report Link	Review of the resident classification scale: report
Report Summary	The review was set up to examine the extent to which experience reflects the rating of care needs and funding outcomes predicted in the development of the RCS (Resident Classification Scheme), the extent towhich the RCS adequately describes care needs, its effectiveness in both nursing homes and hostels, its adequacy in reflecting dementia care needs, whether the guidelines are clear and enable the RCS to be used as intended and the adequacy of the training and support materials.

Inquiry Name	Nursing Home Subsidies
Year	1999
Inquiry Report Citation	Productivity Commission. Nursing home subsidies: Inquiry report. Canberra: Ausinfo, 1999
Inquiry Report Link	Nursing home subsidies: Inquiry report
Report Summary	The Commission was asked to report on current and alternative funding methodologies for nursing home subsidy rates. As part of the inquiry, the Commission examined whether the announced process of 'coalescence', under which the different nursing home subsidy rates in States and Territories would gradually move to national rates over a period of seven years, should proceed or be replaced by an alternative structure.

Inquiry Name	Two Year Review of Aged Care Reforms
Year	2001
Inquiry Report Citation	Gray, Len. Two year review of aged care reforms. Canberra: Department of Health and Aged Care, 2001
Inquiry Report Link	Two year review of aged care reforms report
Report Summary	Professor Gray's report on the Two Year Review of Aged Care Reforms was released by the Minister for Aged Care, the Hon Bronwyn Bishop, MP, on 16 May 2001, together with the Government's Response to the Review and its recommendations. Professor Len Gray was appointed in 1998 to conduct a review of the extent to which the reforms under the Aged Care Act 1997 have achieved their objectives in addressing acknowledged deficiencies in the previous aged care system. The Review addressed eight terms of reference, namely: access, affordability, quality, efficiency, industry viability, impact on State and Territory programs, choice and appropriateness, and other considerations, including dementia care. The Response indicates that the Government has accepted all seven recommendations of the Review and sets out the action that is being taken.

Inquiry Name	Inquiry into long term strategies to address the ageing of the Australian population over the next 40 years
Year	2003
Inquiry Report Citation	House of Representatives Standing Committee on Health and Ageing. Future ageing: Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years. Canberra: Commonwealth of Australia, 2005
Inquiry Report Link	Future ageing inquiry report

Inquiry Name	Review of Pricing Arrangements in Residential Aged Care
Year	2003
Inquiry Report Citation	Hogan, Warren. Review of pricing arrangements in residential aged care: final report. Canberra: Departmentof Health and Ageing, 2004
Inquiry Report Link	Review of pricing arrangements in residential aged care: final report
Report Summary	At the heart of the Hogan Review of Pricing Arrangements in Residential Aged Care was a concern about the rise in aged care spending and the potential burden of these costs on the next generation of taxpayers. These concerns had been generated, in part, by a number of demographic studies undertaken during the 1990s and early 2000s showing an ageing population and the associated fiscal pressures set out by the Government in the first Intergenerational Report. From: A history of aged care reviews. Aged Care Royal Commission Background paper 8, 2019

Inquiry Name	Economic Implications of an Ageing Australia
Year	2004
Inquiry Report Citation	Productivity Commission. Economic implications of an ageing Australia: research report. Melbourne: Commonwealth of Australia, 2005
Inquiry Report Link	Economic implications of an ageing Australia research report.
Report Summary	Australia faces a pronounced ageing of its population over the next forty years. One quarter of Australians will be aged 65 years or more by 2044–45, roughly double the present proportion. The proportion of the 'oldest old' will increase even more.

Inquiry Name	Inquiry into Quality and Equity in Aged Care
Year	2005
Inquiry Report Citation	Senate Community Affairs References Committee. Quality and equity in aged care. Canberra: Commonwealth of Australia, 2005
Inquiry Report Link	Quality and equity in aged care
Report Summary	The Committee made 51 recommendations in relation to: workforce shortages and training requirements; improvements to the operation of the accreditation agency (the 'Agency'), accreditation standards and complaints resolution; increased support for community care programs; reducing excessive documentation requirements and improving use of technology; increasing funding to support adequate care for aged care residents with special needs; reducing the numbers of young people in residential aged care; improvements to transitional care. In relation to workforce issues, the Committee concluded that the shortages of nurses, medical practitioners and allied health professionals willing to work in the aged care sector were impacting on the quality of care being delivered in the sector. It noted its recommendations 'reiterate[d] what has been said many times before'. The Committee made a number of specific and detailed recommendations to alleviate workforce shortages. It recommended that the Australian Government further increase the number of undergraduate nursing places at Australian universities to 1000 and that the Australian Government work with aged care providers to ensure they assist enrolled nurses to complete medication management training targets. Both actions had been recommended in the Hogan Review but had only been partially accepted by the Government. The Committee also recommended that the Department of Health take the lead in the development of aged care workforce strategies, including mechanisms to ensure that the conditional adjustment payment proposed in the Budget successfully restored wage parity for nurses, personal carers and other staff in the aged care sector. From: A history of aged care reviews. Royal Commission into Aged Care background paper 8, 2019

Inquiry Name	Inquiry into Aged Care Amendment (Residential Care) Bill 2007
Year	2007
Inquiry Report Citation	Senate Standing Committee on Community Affairs. Aged Care Amendment (Residential Care) Bill 2007 [Provisions]. Canberra: Commonwealth of Australia, 2007
Inquiry Report Link	Aged Care Amendment (Residential Care) Bill 2007 [Provisions]
Report Summary	The purpose of the Bill is to amend the Aged Care Act 1997 (the Act) to introduce a new arrangement for allocating subsidy in residential aged care. Schedule 1 to the Bill amends the Act to support proposed amendments to the Classification Principles 1997 (the Principles) to replace the Resident Classification Scale (RCS) with the Aged Care Funding Instrument (ACFI) as the means for allocating subsidy to providers of residential aged care.

Inquiry Name	Project to Evaluate the impact of accreditation on the delivery of quality of care and quality of life to residents in aged care homes
Year	2007
Inquiry Report Citation	Campbell Research & Consulting; DoHA. Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes: final report. Canberra: C of A, 2007
Inquiry Report Link	Final project report
Report Summary	This is the final report of the project to 'evaluate the impact of accreditation on the delivery of quality of care and quality of life to residents in aged care homes' (the project), which was commissioned by the Australian Government Department of Health and Ageing (the Department) in November 2004. The project was led by Campbell Research & Consulting (CR&C), who worked with associates from DLA Phillips Fox Lawyers and Monash University. The objective of this project was to: '... develop an evaluation methodology and evaluate the impact of accreditation on the delivery of quality of care and quality of life to residents in residential aged care homes and to identify improvement and performance and benchmarking assessment systems to take the provision of world class care for Australian residential aged care into the future.'

Inquiry Name	Review of the Aged Care Complaints Investigation Scheme
Year	2009
Inquiry Report Citation	Walton, Merrilyn. Review of the aged care complaints investigation scheme. Canberra: Department of Health and Ageing, 2009.
Report Summary	In broad terms, the key issues identified throughout this process are: the need for the CIS to improve its communication processes with both consumers and providers; the importance of encouraging a range of options for managing complaints – from resolution at the local provider level, to mediation and investigation by the CIS; the perception that as the funder and regulator of aged care services, the Department is not the appropriate body to manage the complaints investigation process; the need to revise the complex management and accountability structure within the CIS and the Office of Aged Care Quality and Compliance to ensure more effective complaints management; the impact of the workload and competing priorities of CIS staff on the ability to achieve quality outcomes; the need for more specific and ongoing training for CIS staff; and the necessity to amend current CIS processes and practices to achieve a more efficient and effective system which achieves satisfactory outcomes for all parties.

Inquiry Name	Protection of Residential Aged Care Accommodation Bonds
Year	2009
Inquiry Report Citation	Australian National Audit Office; Lack, Steven. Protection of residential aged care accommodation bonds - Department of Health and Ageing. Canberra: Australian National Audit Office, 2009.
Inquiry Report Link	Protection of residential aged care accommodation bonds report
Report Summary	The ageing of the Australian population is expected to result in an increase in demand for quality residential aged care homes and an expansion in building works to meet this growing demand through new and redeveloped infrastructure. Capital funding to support this increased investment in aged care homes will, in part, be sourced from resident contributions in the form of accommodation bonds.

Inquiry Name	Inquiry into Residential and Community Aged Care in Australia
Year	2009
Inquiry Report Citation	Senate Standing Committee on Finance and Public Administration. Residential and community aged care in Australia. Canberra: Commonwealth of Australia, 2009
Inquiry Report Link	Residential and community aged care in Australia: report

Inquiry Name	Review of the Aged Care Funding Instrument (ACFI)
Year	2009
Inquiry Report Citation	Department of Health and Ageing. The review of the Aged Care Funding Instrument: report. Canberra: Commonwealth of Australia, 2011
Report Summary	Report available in pdf

Inquiry Name	Review of the Accreditation Process for Residential Aged Care Homes
Year	2009
Inquiry Report Citation	The report was due end of June 2010. Unable to locate.

Inquiry Name	Education and Training Workforce: Vocational Education and Training
Year	2010
Inquiry Report Citation	Productivity Commission. Vocational education and training workforce: research report. Melbourne: PC, 2011
Inquiry Report Link	Vocational education and training workforce: research report

Inquiry Name	Caring for Older Australians
Year	2010
Inquiry Report Citation	Productivity Commission. Caring for older Australians: inquiry report. Volumes 1 and 2. Melbourne: Commonwealth of Australia, 2011
Inquiry Report Link	Caring for older Australians: inquiry report
Report Summary	In undertaking the inquiry, the Commission had developed options for further structural reform of the aged care system so it can meet the challenges facing it in coming decades. It examined the social, clinical and institutional aspects of aged care in Australia; addressed the interests of special needs groups; developed regulatory and funding options for residential and community aged care; examined the future workforce requirements of the aged care sector; recommended a path for transitioning from the current regulatory arrangements to a new system that ensures continuity of care and allows the sector time to adjust; examined whether the regulation of retirement specific living options should be aligned more closely with the rest of the aged care sector; assessed the fiscal implications of any change in aged care roles and responsibilities.

Inquiry Name	Options for Regulation of Unregistered Health Practitioners
Year	2011
Inquiry Report Citation	Victoria. Department of Health. Options for regulation of unregistered health practitioners: final report. Melbourne: Australian Health Ministers' Advisory Council, 2013
Report Summary	Four options were canvassed. Option 3 to Strengthen statutory health complaints mechanisms – a statutory code of conduct and powers to prohibit those who breach the code from continuing to provide health services, is the recommended options

Inquiry Name	Australia's Health Consultation on Medication Management in Residential Aged Care Facilities
Year	2011
Report Summary	The aim of the revised Guiding Principles is to promote safe, quality use of medicines and appropriate medication management in RACFs. It is intended to assist RACFs to develop, implement and evaluate locally specific policies and procedures, support those involved in assisting residents, and support residents in the medication management process.

Inquiry Name	Consultation on Residential Aged Care Accreditation Standards.
Year	2011
Inquiry Report Citation	Report: Outcomes of National Workshops on draft revised Accreditation Standards for residential aged care.
Report Summary	The purpose of this Report is to provide feedback to the Department of Health and Ageing regarding outcomes of national workshops on the draft revised Accreditation Standards for residential aged care, conducted between 28 March and 5 May 2011.

Inquiry Name	Aged Care Complaints Scheme: Proposed Complaints Management Framework
Year	2011
Inquiry Report Citation	Unable to locate consultation report. This information is available: The proposed framework aims to take forward key recommendations from the Walton Review, including risk assessment and alternative complaint resolution options.

Inquiry Name	Managing Aged Care Complaints
Year	2012
Inquiry Report Citation	Australian National Audit Office. Managing aged care complaints: Department of Health and Ageing. Canberra: ANAO, 2012
Report Summary	The ANAO has made two recommendations relating to the implementation and ongoing administration of the Scheme. The first is aimed at improving access to the Scheme for isolated care recipients and the second is aimed at increasing the level of confidence in feedback obtained from complaints satisfaction surveys.

Inquiry Name	Inquiry into Dementia - Early Diagnosis and Intervention
Year	2012
Inquiry Report Citation	House of Representatives Standing Committee on Health and Ageing. Thinking ahead: report on the Inquiry into dementia: early diagnosis and intervention. Canberra: Commonwealth of Australia
Inquiry Report Link	Thinking ahead: report on the inquiry into dementia

Inquiry Name	Impacts of COAG Reforms - Business Regulation and VET
Year	2012
Inquiry Report Citation	Productivity Commission. Impacts of COAG reforms: business regulation and VET. Melbourne: PC, 2012
Inquiry Report Link	Impacts of COAG reforms: business regulation and VET
Report Summary	This study assesses the impacts of COAG reforms in two areas: aspects of the 'Seamless National Economy' regulatory reform priorities vocational education and training (VET). Vocational education and training reforms are aimed at improving the overall quality of the workforce and encouraging higher workforce participation, through increased VET provision and greater §exibility in courses offered. Attainment of the COAG 2020 targets potentially could raise GDP by two per cent. It would also assist in achieving COAG's broader social inclusion goals.

Inquiry Name	Senate Inquiry into Palliative Care in Australia
Year	2012
Inquiry Report Link	Palliative care in Australia report
Report Summary	Senate Community Affairs References Committee. Palliative care in Australia. Canberra: Commonwealth of Australia

Inquiry Name	Training for Aged and Community Care in Australia
Year	2013
Inquiry Report Citation	Australian Skills Quality Authority. Training for aged and community care in Australia: report. Melbourne: ASQA, 2013
Report Summary	The Certificate III in Aged Care remains the most common qualification for new entrants to the aged and community care industry. Most registered training organisations have difficulty complying with assessment requirements. Following time to rectify areas where they were not compliant, most registered training organisations became compliant with the national standards. Training programs are largely too short and with insufficient time in a workplace for su¨cient skills development. Changes to the national standards for training organisations are required.

Inquiry Name	Aged Care (Living Longer Living Better) Bill 2013
Year	2013
Inquiry Report Citation	Senate Community Affairs Legislation Committee. Aged Care (Living Longer Living Better) Bill 2013 [Provisions] and related bills. Canberra: Commonwealth of Australia, 2013
Inquiry Report Link	Aged Care (Living Longer Living Better) Bill 2013 [Provisions] and related bills: Report
Report Summary	Collectively, the five Bills would introduce the legislative aspects of the Government's proposed Living Longer Living Better aged care reforms.

Inquiry Name	Health Workforce Australia Consultation on Nursing Workforce Retention and Productivity
Year	2013
Inquiry Report Citation	Health Workforce Australia. Nursing workforce sustainability: improving nurse retention and productivity. Canberra: Commonwealth of Australia, 2014
Inquiry Report Link	Nursing workforce sustainability report
Report Summary	Recommendations focus on change in three major areas which could significantly mitigate the risk of theforecast nursing shortage: 1. Leadership – build workplace capacity. 2. Retention – early career preparation and workplace support 3. Productivity – enable innovation in the workplace

Inquiry Name	Registered Nurses in New South Wales Nursing Homes
Year	2015
Inquiry Report Citation	New South Wales. Parliament. Legislative Council General Purpose Standing Committee No. 3. Registered nurses in New South Wales nursing homes. Sydney: the Committee, 2015
Inquiry Report Link	Registered nurses in NSW nursing homes.
Report Summary	Central to this inquiry is the development of aged care legislation over the last two decades that has re§ected a gradual shift in responsibility from the states to the Commonwealth. For New South Wales, however, that shift has never been absolute, resulting in layers of legislation at both the state and Commonwealth level that have become intrinsically linked over time. At the core of this legislative arrangement is section 104(1)(a) of the Public Health Act 2010 which requires a registered nurse to be on duty in a nursing home at all times. The committee received extensive evidence from a range of stakeholders regarding the retention of this state provision and grappled with numerous issues and concerns raised from all perspectives.

Inquiry Name	Inquiry into Elder Abuse in New South Wales
Year	2015
Inquiry Report Citation	New South Wales. Parliament. Legislative Council General Purpose Standing Committee No. 2. Elder abuse in New South Wales. Sydney: The Committee, 2016
Inquiry Report Link	Elder abuse in New South Wales

Inquiry Name	Increasing Choice in Home Care Stage 1 - Proposed Changes to Aged Care Principles and Determinations
Year	2016
Inquiry Report Citation	No final report
Report Summary	The Department is now seeking comment on proposed amendments to the delegated legislation (Aged Care Principles and Determinations). A consultation paper and an exposure draft of the instruments listed below are currently available for feedback. The consultation paper provides further detail and explanation of the proposed amendments and seeks feedback on the implementation arrangements. Prioritised Home Care Recipients Principles 2016 Aged Care Legislation Amendment (Increasing Consumer Choice) Principles 2016 Aged Care (Subsidy, Fees and Payments) Amendment (Increasing Consumer Choice) Determination 2016 Aged Care (Transitional Provisions) (Subsidy and Other Measures) Amendment (Increasing Consumer Choice) Determination 2016.

Inquiry Name	Senate Inquiry into the Future of Australia's Aged Care Sector Workforce
Year	2016
Inquiry Report Citation	Senate Community Affairs References Committee. Future of Australia's aged care sector workforce. Canberra: Commonwealth of Australia, 2017
Inquiry Report Link	Future of Australia's aged care sector workforce
Report Summary	The aged care sector has experienced the impacts of significant changes in recent years. These changesrange from the ageing of the Australian population and the corresponding ageing of the workforce, the increased use of technology in service delivery, the increased complexity of health needs of individuals entering aged care, and the shift in policy approaches to aged care, with much service delivery now occurring at home to allow people to 'age in place' for longer rather than enter institutions at the first sign of age-related frailty. All of these developments are placing significant pressure on the aged care workforce.

Inquiry Name	Aged Care Legislated Review
Year	2016
Inquiry Report Citation	Tune, David. Legislated review of aged care. Canberra: Department of Health, 2017
Inquiry Report Link	Legislated Review of Aged Care 2017 Report
Report Summary	The review report includes 38 recommendations and an overview of aged care. The review concluded that: The LLLB reforms successfully made the aged care system more consumer driven and sustainable, and, more reforms are needed in particular areas

Inquiry Name	Australian Law Reform Commission Inquiry into Elder Abuse
Year	2016
Inquiry Report Citation	Australian Law Reform Commission. Elder abuse: a national legal response: final report (ALRC Report 131). Sydney: ALRC, 2017
Inquiry Report Link	Elder abuse final report
Report Summary	The ALRC was asked to consider Commonwealth laws and legal frameworks and how they might better protect older persons from misuse or abuse, and safeguard their autonomy. The Report includes 43 recommendations for law reform. The overall effect will be to safeguard older people from abuse and support their choices and wishes through: improved responses to elder abuse in residential aged care; enhanced employment screening of care workers; greater scrutiny regarding the use of restrictive practices in aged care; building trust and confidence in enduring documents as important advanced planning tools;protecting older people when ‘assets for care’ arrangements go wrong; banks and financial institutions protecting vulnerable customers from abuse; better succession planning across the self-managed superannuation sector; adult safeguarding regimes protecting and supporting at-risk adults.

Inquiry Name	Oakden Older Persons Mental Health Service Review
Year	2017
Inquiry Report Citation	Groves A; Thomson D; McKellar D; Procter N. The Oakden report. Adelaide: SA Health, Department for Health and Ageing, 2017 Lander, Bruce. Oakden: a shameful chapter in South Australia's history. Adelaide: ICAC, 2018
Inquiry Report Link	The Oakden Report Oakden: A shameful chapter in South Australia's history - ICAC report
Report Summary	A review of the Oakden Older Persons Mental Health Service was undertaken by the Chief Psychiatrist, an independent statutory officer under s90 of the Mental Health Act 2009. The Review Report and the Response to the Review of the Oakden Older Persons Mental Health Service were released on Thursday 20 April 2017.

Inquiry Name	Review of National Aged Care Quality Regulatory Processes
Year	2017
Inquiry Report Citation	Carnell, Kate; Paterson, Ron. Review of national aged care quality regulatory processes. Canberra: Department of Health, 2017
Inquiry Report Link	Review of national aged care quality regulatory processes
Report Summary	This review looked at why aged care processes did not address the failures of care described in the 2017 Oakden review. The review report made 10 recommendations to improve processes. The Australian Government has responded with a range of measures.

Inquiry Name	Inquiry into the effectiveness of the Aged Care Quality Assessment and Accreditation Framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised
Year	2017
Inquiry Report Citation	Senate Community Affairs References Committee. Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices: final report. Canberra: Commonwealth of Australia, 2019
Inquiry Report Link	Effectiveness of the Aged Care Quality Assessment and accreditation framework - Report
Report Summary	This inquiry was initially established in June 2017 in response to incidents of poor quality care and abuse of residents at the Makk and McLeay wards of the Oakden Older Persons Mental Health Facility (Oakden) in South Australia (SA). These two wards were classified as aged care facilities, and were therefore regulated by the Commonwealth aged care regulation frameworks. The inquiry was intended to review the critical care failures at Oakden in relation to the level of accountability that may lie with the Commonwealth aged care regulatory frameworks, which have a responsibility to ensure vulnerable aged Australians receive quality care and are protected from abuse. Throughout this inquiry, the standard of clinical care provided to people in RACFs stood out as a key issue of concern for the committee, particularly as an area which has lacked sufficient investigation to date.

Inquiry Name	Charter of Aged Care Rights Consultation
Year	2018
Inquiry Report Citation	Department of Health. Report on the outcome of public consultation on the draft Charter of aged care rights. Canberra: Australian Government, 2018
Inquiry Report Link	Consultation report
Report Summary	The draft Charter of Aged Care Rights Consultation Paper outlines the basis for developing a single Charter of Aged Care Rights and how the draft Charter has been developed to date.

Inquiry Name	Consultation on the draft Aged Care Standards Guidance Materials
Year	2018
Inquiry Report Citation	Australian Aged Care Quality Agency. Pilot for the draft Aged care quality standards and development of guidance material. Canberra: Australian Government, 2018
Inquiry Report Link	Pilot process final report
Report Summary	Following the release of the draft Aged Care Quality Standards (Quality Standards) in 2017, the former Aged Care Quality Agency (Quality Agency) consulted with aged care providers, consumers and their representatives, peak bodies and subject matter experts to develop guidance material to support implementation of the Quality Standards.

Inquiry Name	Aged Care Quality and Safety Commission Bill 2018 and related Bill
Year	2018
Inquiry Report Citation	Senate Community Affairs Legislation Committee. Aged Care Quality and Safety Commission Bill 2018 and related Bill: report. Canberra: Commonwealth of Australia, 2018

Inquiry Report Link	Aged Care Quality and Safety Commission Bill 2018 and related Bill - Report
Report Summary	This bill gives effect to the government's announcement in the 2018-19 budget to establish this new independent commission [ACQSC], as part of providing for better quality of care for consumers of aged-care services in Australia. The introduction of this commission is also a direct response to the findings and recommendations of the Review of national aged care regulatory processes undertaken byKate Carnell and Ron Paterson

Inquiry Name	A Matter of Care: Australia's Aged Care Workforce Strategy
Year	2018
Inquiry Report Citation	Pollaers, John. A matter of care: Australia's aged care workforce strategy: report of the Aged Care Workforce Strategy Taskforce. Canberra: Department of Health, 2018
Inquiry Report Link	A matter of care: report
Report Summary	The strategy sets out 14 actions for industry to change attitudes to caring, attract and retain a skilled aged care workforce, and ensure the workforce can meet aged care needs now and into the future. It was developed by the Aged Care Workforce Taskforce and released in September 2018.

Inquiry Name	Financial and Tax Practices of For-Profit Aged Care Providers
Year	2018
Inquiry Report Citation	Senate Economic References Committee. Financial and tax practices of for-profit aged care providers. Canberra: Commonwealth of Australia, 2018
Inquiry Report Link	Financial and tax practices of for-profit aged care providers
Report Summary	Australians have high expectations for [residential aged] care. They rightly expect that they, and those they love, will be treated with dignity and decency at the end of their lives. The nation faces increasing challenges in meeting those expectations as Australia's ageing population places further demands on our aged care system. Providers have been publicly vocal for some time that a further public investment of funds will be needed. These views were repeated during the course of this inquiry. In light of this, it is more important than ever to ensure that each dollar that is currently spent on care is used effectively and efficiently. The report published by the Tax Justice Network-Australia this year raises a series of legitimate questions about how for-profit aged care providers are using this public money. They are questions that merit investigation. Australians would be rightly appalled if it transpired that public money that had been provided to fund care for older Australians had been improperly diverted to other corporate purposes.

Inquiry Name	Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia
Year	2018
Inquiry Report Citation	House of Representatives Standing Committee on Health, Aged Care and Sport. Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia. Canberra: Commonwealth of Australia, 2018
Inquiry Report Link	Report on the Inquiry into the Quality of Care in RAC Facilities in Australia
Report Summary	The inquiry examined the delivery and regulation of the current aged care system and the prevalence of mistreatment. The Committee Chair, Mr Trent Zimmerman MP, stated that 'while many Australians experience high quality aged care, the community is justifiably concerned about the many examples of abuse and mistreatment that have been exposed through recent inquiries and reporting.' From: Parliament of Australia media release, 22 October 2018

Inquiry Name	Aged Care Amendment (Staffing Ratio Disclosure) Bill
Year	2018
Inquiry Report Citation	House of Representatives Standing Committee on Health, Aged Care and Sport. Advisory Report on the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018, Canberra: Commonwealth of Australia, 2018
Inquiry Report Link	Advisory Report on the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018
Report Summary	The Bill proposes the quarterly reporting of the ratio of aged care recipients to aged care staff (staffing ratio) by aged care providers. The Bill proposes this reporting also require the break-down of staff (employed by aged care service providers) by category and where applicable, level. (E.g. Registered Nurse, Enrolled Nurse, Personal Care Attendant, Allied Health Staff and Other Staff). In addition, the Bill proposes to require that any change to the staffing ratio which is greater than 10 percent (and occurs between quarterly reports) to be notified (within 28 days of a change) for the purpose of being made public.

Inquiry Name	Proposal for a New Residential Aged Care Funding Model
Year	2019
Inquiry Report Citation	Australian Health Services Research Institute, University of Wollongong. Resource utilisation and classification study (RUCS) reports. Wollongong: UoW, 2019. Series of seven reports.
Inquiry Report Link	Resource Utilisation and Classification Study (RUCS) Reports 1-7
Report Summary	The Australian Government is the major funder of residential aged care in Australia. Since 2017 it has been examining options for a new funding tool and system to replace the current Aged Care Funding Instrument. From 14 March to 31 May 2019, we held a consultation on a proposed new residential aged care funding model and system. The model, Australian National Aged Care Classification (AN-ACC), will remove flaws in the Aged Care Funding Instrument (ACFI). The Australian Health Services Research Institute (AHSRI) at the University of Wollongong developed the model.

Inquiry Name	Draft NSQHS Standards (second edition) Aged Care Module
Year	2019
Inquiry Report Citation	Australian Commission on Safety and Quality in Health Care. Aged care module and user guide for multi-purpose services. Sydney: ACSQHC, 2021
Inquiry Report Link	NSQHS Standards Aged care module and User Guide for Multi-Purpose Services
Report Summary	The Multi-Purpose Services Aged Care Module (the MPS Aged Care Module) has been developed by the Commission in collaboration with the Australian Government, state and territory departments of health, and the Commission's Multi-Purpose Services Project Advisory Committee. The MPS Aged Care Module describes, in six actions, the requirements of the Aged Care Quality Standards not covered by the National Safety and Quality Health Service (NSQHS) Standards. It is only applicable to eligible MPS and was endorsed by the Australian Health Minister's Advisory Council on 7 February 2020.

Inquiry Name	Residential Aged Care - Proposed Alternative Models for Allocating Places
Year	2019
Inquiry Report Citation	Department of Health. Consultation forums: Alternative models for allocating residential aged care places: summary of feedback. Canberra: DoH, 2020
Inquiry Report Link	Alternative Models for Allocating Residential Aged Care Places - Consultation Summary
Report Summary	As part of the 2018-19 Budget More Choices for a Longer Life package, in principle support was provided to move from the current approach of allocating residential aged care places, to providers through the Aged Care Approvals Round (ACAR), to alternative arrangements that support greater consumer choice. Prior to progressing to an alternative model, a detailed analysis of the potential impacts of such an arrangement on all stakeholders is to be completed.

Inquiry Name	Streamlined Consumer Assessment for Aged Care
Year	2019
Inquiry Report Citation	Department of Health. Streamlined consumer assessment for aged care summary report: key insights from consultation. Canberra: DoH, 2019
Inquiry Report Link	Streamlined Consumer Assessment for Aged Care Summary report – Key insights from consultation
Report Summary	In the 2018-19 Budget, the Government announced that it will design and implement a new framework for streamlined consumer assessments for all aged care services, to be delivered by a new national assessment workforce from 2020. The measure addresses an issue identified in the Legislated Review of Aged Care 2017 (Tune Review), that there is duplication and inefficiency within the current assessment process.

Inquiry Name	Evaluation of the Aged Care System Navigator Measure
Year	2019
Inquiry Report Citation	Australian Healthcare Associates. Evaluation of the aged care system navigator measure: final report. Canberra: Department of Health, 2021
Inquiry Report Link	Evaluation of the Aged Care System Navigator Measure – Final Report
Report Summary	The evaluation was undertaken by Australian Healthcare Associates (AHA) and is based on its analyses of data collected from the trials between 28 February 2019 and 5 February 2021. The evaluation's Final Report includes updates to the findings that were provided in the Interim Report's Executive Summary (published 9 October 2020). The final evaluation: looks at the outcomes of the trials; reviews other system navigator models; reports on stakeholder views; identifies important principles, service delivery elements and implementation considerations for future aged care navigation services.

Inquiry Name	Royal Commission into Aged Care Quality and Safety
Year	2019
Inquiry Report Citation	Royal Commission into Aged Care Quality and Safety. Final report: Care, dignity and respect. Canberra: Commonwealth of Australia.
Inquiry Report Link	Royal Commission into Aged Care - Interim Report Royal Commission into Aged Care - Final Report
Report Summary	Royal Commissioners Tony Pagone QC and Lynelle Briggs AO call for fundamental reform of the aged care system: "The extent of substandard care in Australia's aged care system reflects both poor quality on the part of some aged care providers and fundamental systemic flaws with the way the Australian aged care system is designed and governed. People receiving aged care deserve better. The Australian community is entitled to expect better."

Inquiry Name	Serious Incident Response Scheme for Commonwealth Funded Residential Aged Care: Finer Details of Operation
Year	2019
Inquiry Report Citation	The consultation intended to publish a summary of key themes identified. This was not available.
Report Summary	Australians have a right to live free from abuse and neglect as a matter of human rights, current law and a reasonable community expectation. Older Australians also have specific rights and expectations when receiving Commonwealth funded aged care services.

Inquiry Name	The Reimagined Personal Care Worker
Year	2020
Inquiry Report Citation	Report not yet available. Responses to the discussion paper will be collated to inform Training Package products for the sector.
Inquiry Report Link	SkillsIQ Reimagined PCW Discussion Paper
Report Summary	The discussion paper is seeking to ask questions of stakeholders framed around three key areas: The breadth of care recipients' needs; The range and complexity of the skills and capabilities required to meet those needs; The extent to which an individual worker can meet those needs versus the scope of the role as part of a multi-disciplinary team.

Inquiry Name	Aged Care Worker Regulation Scheme Consultation
Year	2020
Inquiry Report Citation	MP Consulting. Aged care worker regulation scheme. Canberra: Department of Health, 2020
Inquiry Report Link	Aged Care Worker Regulation Scheme Final Report
Report Summary	Over the last five years, various inquiries and reports have recommended implementation of a worker screening or registration scheme in aged care. Most recently, the Royal Commission into Aged Care Quality and Safety has been exploring this issue, with a focus on a registration scheme specific to personal care workers (PCWs).

Inquiry Name	Aged Care Legislation Amendment (Financial Transparency) Bill 2020
Year	2020
Inquiry Report Citation	Senate Community Affairs Legislation Committee. Aged Care Legislation Amendment (Financial Transparency) Bill 2020: report. Canberra: Commonwealth of Australia, 2021
Inquiry Report Link	Aged Care Legislation Amendment (Financial Transparency) Bill 2020 Report
Report Summary	Amends the Aged Care Act 1997 to require residential aged care providers to disclose their income, costs of food and medication, staff and staff training, accommodation, administration and monies paid to parent bodies in annual financial transparency reports to the Aged Care Quality and Safety Commissioner; and Corporations Act 2001 to ensure residential aged care providers include detailed financial information in annual financial statements.

Inquiry Name	Quality Use of Medicines and Medicines Safety (10th National Health Priority) Public consultation?– Phase 1: Aged care
Year	2020
Inquiry Report Citation	'Phase 1 - Aged Care' of the National Baseline Report on Quality Use of Medicines and Medicines Safety will be published on the Commission's website when finalised in 2021.
Report Summary	In November 2019, the Council of Australian Governments (COAG) Health Council made Quality Use of Medicines and Medicines Safety the 10th National Health Priority Area. The Commission was subsequently engaged to develop a national baseline report on the Quality Use of Medicines and Medicines Safety, with an initial focus on aged care.

Inquiry Name	Consultation on the draft National Safety and Quality Health Service Standards (second edition) User Guide for Multi-Purpose Services Aged Care Module
Year	2020
Inquiry Report Citation	Australian Commission on Safety and Quality in Health Care. National safety and quality health service standards: Aged care module and user guide for multi-purpose services. Sydney: ACSQHC, 2021
Inquiry Report Link	NSQHS Standards Aged care module and User Guide for Multi-Purpose Services
Report Summary	The Multi-Purpose Services Aged Care Module (the MPS Aged Care Module) has been developed by the Commission in collaboration with the Australian Government, state and territory departments of health, and the Commission’s Multi-Purpose Services Project Advisory Committee. The MPS Aged Care Module describes, in six actions, the requirements of the Aged Care Quality Standards not covered by the National Safety and Quality Health Service (NSQHS) Standards. It is only applicable to eligible MPS and was endorsed by the Australian Health Minister’s Advisory Council on 7 February 2020.

Inquiry Name	Serious Incident Response Scheme for In-Home Aged Care Services
Year	2021
Inquiry Report Citation	Report not yet available.
Report Summary	In preparation for implementing the SIRS for in-home aged care services, the Department has undertaken preparatory work, including procuring a prevalence and options study which was completed in June 2021. This study has informed development of a consultation paper that sets out the proposed operation of the scheme. This consultation aims to assist in the development of specific design elements to expand the SIRS from residential aged care to a home setting.

IN THE FAIR WORK COMMISSION

Matter No.: **AM2020/99, AM2021/63 & AM2021/65**

Re Applications by: **Australian Nursing and Midwifery Federation and others**

AMENDED STATEMENT OF HAZEL BUCHER

I, Hazel Bucher of [redacted] in the State of Tasmania, say:

1. I am a member of the Australian Nursing and Midwifery Federation.

Personal details

2. My date of birth is [redacted].

3. I live in [redacted] and work across the North and South of Tasmania.

4. I live with my husband, and we rely on my income to contribute to our daily expenses and save for life when I finish full time work.

Work history and qualifications

5. I am qualified as a Nurse Practitioner (**NP**). I was employed full time in my role as General Manager Clinical Services Nurse Practitioner by Southern Cross Care Tasmania Inc., until 22 April 2022. My hourly rate of pay was slightly higher than the rate paid to a Nurse Practitioner employed by the Tasmanian Government. I am now engaged as an NP by Access Aged Care to provide consulting services to residents in residential aged care facilities in Tasmania in co-operation with local "virtual" medical specialists. These residents generally have specialist care needs.

Lodged by:	Telephone:	03 9603 3035
The ANMF		
Address for Service:	Fax:	03 9603 3050
Level 22, 181 William St	Email:	nwhite@gordonlegal.com.au
Melbourne VIC 3000		

6. I commenced working for Southern Cross Care in November 2020. Southern Cross Care is an aged care provider operating nine Residential Aged Care Facilities (**RACFs**) throughout Tasmania. It is the biggest provider of residential aged care in Tasmania.
7. I also have two of part time/casual jobs. I am employed by the University of Tasmania as a Casual Tutor in the role of Unit Coordinator for Mental Health Wellbeing and Dementia Care Post Graduate Unit in Tasmania University's nursing programme. In this role I offer support, advice and grade papers for the post graduate student nurses from Tasmania and the University's NSW campus. My second part time work is in a private memory clinic I run. In this role I receive self-referrals and referrals from GP practices in Hobart to assess and advise the patients referred on their cognitive status and on approaches to care. I am a health practitioner member of the Tasmanian Nursing and Midwifery Board.

8. My work in the aged care sector in Tasmania spans about 40 years. In the 1980s after graduation I was employed at the Medea Park Nursing Home in St Helens and the small nursing home in St Mary's for about year. In the 1990s I was employed at Bishop Davies Court another nursing home for about two years.

9. In 2006 I began employment at the Royal Hobart Hospital (**RHH**) in its Aged Care Service (ACS). The Service predominately provided in-reach services to the RHH aged patient cohort. The service developed with the establishment of the RHH Older Persons Unit and provided outreach services to RACFs. During this period I undertook study to become a NP in Aged Care.

10. Upon qualifying as a NP Aged Care in June 2010 I was employed by the Tasmanian Mental Health Service in its Older Persons Mental Health Service (OPMHS)/Dementia Behaviour and Management Advisory Service (DBMAS), providing an out-reach consultation service to RACF's as a Nurse Practitioner Aged Care/Mental Health. OPMHS and DBMAS integrated in 2008, I was in this role in the period 2010 - 2017. During this time, I completed a graduate nursing diploma – mental health. The OPMHS team received referrals from GP's managing older people in RACFs and the community who were developing dementia or mental health issues, behavioural issues, delirium and the end stage of life for some residents. In that role I worked closely with staff, GP's and specialist and residents at RACFs in assisting and advising on their management and care.

11. In 2017 the DBMAS service then became Dementia Support Australia (DSA)conducted by Hammond Care in 2018 and I was employed by them for 6 months as a Dementia Consultant. However the NP role was not developed in that setting.

12. From 2017 to 2020 I undertook independent NP work with a GP. As part of this GP's RACF specific work I worked in a shared care model, managing infections, geriatric syndromes, palliative care, behavioural challenges, depression and anxiety. I left this work after 3 years to join the Community Rapid Response Service for 6 months until I started working with Southern Cross Care.

13. In addition to basic qualifications for registration I hold the following qualifications:
    - Master of Nursing Science (Nurse Practitioner);
    - Graduate Diploma Nursing Aged Care & Graduate Diploma Mental Health;
    - Graduate Certificate (Geriatric Rehabilitation).

14. My qualifications for registration as a Nurse Practitioner in Aged Care/Mental Health require two graduate diplomas' (Aged Care & Mental Health) in addition to the Master's degree – Nurse Practitioner. A NP has Medicare billing and PBS rebatable rights subject to a verbal or written collaboration with a medical practitioner. My authorisation enabled me to order pathology, prescribe and treat conditions within my scope of practice independently without a collaborative agreement in place, however, my patients or employer pay privately.

15. My curriculum vitae and current position description are **Annexures HB 1** and **HB 2**. The Tasmanian Department of Health publishes Guidelines for Nurse Practitioner Authorisation to Prescribe Scheduled Substances (see **ANMF 106**).

16. As a result of my employment and roles since 2010 I have visited in a professional capacity almost every RACF in Tasmania. In the course of that work I have observed the residents and staff and worked closely with many of the facilities. While working with the GP in 2017 to 2020 I worked at six facilities in Southern Tasmania whilst OPMHS, DBMAS and DSA were state wide services involving outreach to RACFs.

Description of my current role and work

17. I work across each of Southern Cross Care Tasmania's (SCC Tas) nine RACFs in Tasmania which have a total of 728 beds and three Memory Support Units (known elsewhere as dementia units) located in Rivulet, Fairway Rise and Glenara Lakes. The RACFs are named

    Rivulet, South Hobart:
    Rosary Gardens, New Town:
    Fairway Rise Aged Care Home, Lindisfarne:
    Guilford Young Grove, Sandy Bay
    Sandown Apartments, Sandy Bay
    Glenara Lakes, Youngtown
    Mt Esk, St Leonards
    Ainslie Low Head, Low Head
    Yaraandoo, Somerset

18. I also provide clinical support to SCC Tas regarding home care packages by attending monthly meetings. As the home care packages expand to include more clinical duties, I will provide further support as required.

19. A key objective of my role with SCC Tas is to contribute to and further develop my own and their nurses' palliative expertise. I generally spent one day a week at each of SCC Tas's RACFs to embed the use of the Palliative Care Outcome Collaborative tools, improve our palliative care outcomes and generally provide clinical advice. I have commenced a research project with University of Tasmania to research current gaps in palliative care knowledge and confidence of SCC Tas nursing and care staff. I am also mentoring a NP student for the next 2 years who is specialising in Palliative Care/Aged Care.

20. When I visit a RACF my work entails responding to RN/EN queries in relation to issues such as:
    a. updating medication charts as appropriate
    b. management of venous leg ulcers
    c. behavioural management
    d. infection control
    e. referral processes.

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. The role is to act as a resource for the resident's clinical needs as well as a mentor and resource for the RNs involved in the care. Medication charts sometimes require updating in circumstances where GPs have prescribed but not attended or accessed the relevant digital system. Under a shared care model the GP will authorise me as NP to update the medication chart on their behalf. This ensures timely access by the resident to the changed medication regime, rather than delay pending the GPs attendance.

22. For the last 2 months I have been appointed by SCC Tas as an advisor to one of our RACF's – Rivulet, which has a Notice to Agree from the Aged Care Quality and Safety Commission (ACQSC). Such a notice obliges a RACF to agree to take steps to address a failure to meet standards. This arose due to some unmet Quality and Safety Standards following a visit in January this year 6 weeks after SCC assumed responsibility for the RACF and then again when revisited in August. These standards were unmet in January as SCC Tas were initiating the move from paper based notes to a new digital platform only 6 weeks into the transition. Additionally in August Rivulet had just employed 3 – 4 graduate RN's with little clinical confidence.

23. Matters of special emphasis in my role are ensuring communication is clear and consistent when introducing new programs such as Palliative Care Outcomes Collaborative (PCOC) and that clinical care is of a good standard. Many younger RN's from Non-English speaking backgrounds require further education both theory and practice for the aged care setting. I have been developing a SCC Graduation Program with the Clinical Nurse Educator (CNE) and Pharmacists which will support the new Graduates and provide them with clinical experience whilst supporting their transition into practice. The program is a 6-month program which includes elements addressing wound care, pain management, skin care, deliriums and governance. The plan is these RN's then provide the teaching to the next intake of new nurses with the support of myself and the CNE and they then commenced the next block with different topics. By teaching what they have just learnt and in which they have become

competent, they become leaders for the next intake of RN's and the 'referring out to specialists' approach is a reduced as they see expertise is evident within the organisation.

24. As General Manager of Clinical Services – Nurse Practitioner I have oversight across 9 RACF's and home packages supporting Clinical Care Co-ordinators (CCC) and RN's across these sites. I generally hold monthly Clinical Committee meetings which the Facility Managers and Clinical Care Co-ordinators attend. With a current shortage of experience RN's the focus is maintained on the education and support of these new nurses. The meeting minutes are then reviewed by the governance committee of SCC.

25. The Clinical Nurse Educator' role is a new role developed by SCC this year in response to the trend for Graduate nurses employment, with associated need to develop clinical confidence and expertise. The CNE who has 10 years clinical experience in aged care and acute care, with a specialty in palliative care currently works 4 days a week and will then become a state wide role in March 2022.

26. The Clinical Care Co-ordinators role is to support the Facility Manager (usually an experienced RN) with staffing allocations and support, whilst primarily providing clinical support to the RN and EN working on the floor. The CCC's are generally new nurses with only a couple of years of experience but who have settled into a career in Aged Care. To date the nurses in the CCC roles have no post graduate specialist qualifications and often only a few years experience. There is a trend for non-clinical Facility Managers developing, which places the CCC role as more clinically important.

27. My role generally supports the development of resident care plans and programs, I am not directly involved in the creation of these plans. In my experience it is more beneficial for the RN's on the floor to develop and review the residents care plan so they learn about the care needs of the resident, liaising directly with the families. Additionally, providing supervision to the EN's and carers becomes more fluid and the care more meaningful. I work with the CNE to develop assessment forms such as the wound care assessment and to mentor clinical reasoning, clinical decision making and clinical leadership.

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.

29. In my role I consistently engage with other health professionals via emails, telephone calls and meetings face to face.

30. In residential aged care, residents enter RACF's for the nursing care and oversight provided for their chronic illnesses and often due to carer fatigue. It is a huge and difficult step, generally not taken by choice, but driven by illness. There is an adjustment period for the residents and their families. Kindness from staff is key and skilled clinical leadership important. I enjoy working with elderly people, learning about their lives and understanding what makes them who they are, hearing their stories and by listening informing them that their lives mattered and their contribution to this world valued. I have a strengths-based approach to the care and advice I provide, and acknowledge that although frail, the residents I work with are generally resilient. With the chronic/terminal disease of dementia being an increasing cause of RACF placement, there are different challenges but nevertheless I see the strength and good nature of the resident's shine through as they face the difficulties of their declining cognition. I feel working with people as they enter the palliative stages of life a humbling experience and knowing a resident is comfortable and their families well supported at this vulnerable time is important to me.

The work of RNs, ENs and Carers in aged care

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.

32. The current public scrutiny on the sector although very needed, results in further external pressures and attracting experienced nurses to the sector more difficult, particularly as the nursing work has historically been viewed as less important than nursing in acute care. Aged care work is often the second choice for graduate nurses if they are unable to gain a graduate position in a acute hospital, and is also evidenced by the lower pay rate for nurses in this sector. Aged care bodies such as Aged & Community Services Australia (ACSA) provide a transition to practice program to support graduate nurses working in Aged Care, however, attendance to the sessions are generally low due to clinical shortages on the day and resident needs take priority over learning. This trend contributes to a task orientated focus of care in Aged Care of 'Doing the right thing' versus developing clinical reasoning skills which result in 'doing things right' as does the public media surrounding RACF care. See Sturmberg J, (2019) *'False accountability' – The harmful consequences of bureaucratic rigour for aged care residents* (**ANMF 107**).

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.

34. Due to the historic over prescribing of antipsychotic medications, the onus of responsibility imposed by the Aged Care Quality and Safety Commission (ACQSC) for the management of this prescribing now rests more and more on the RACF staff not the prescriber. Insufficient acknowledgement is given to the clinical confidence required to manage external GP's directions in respect of medications. For instance, a GP may commence an antipsychotic medication and when the review of this medication is required, the RACF RN's are often faxing and calling multiple times for the GP to attend to complete the task.

35. When transferring residents between RACFs and hospitals there is often a lack of clear communication from Hospitals, for example, discharge summaries often only go to the treating GP not the RACF staff and copies of pathology results to RACF are also often provided in an ad hoc manner. The effect of this is disempowering for the RN on the floor, which means they are often working clinically blind for a couple of days before the GP provides a copy of the discharge summary.

36. The unannounced visits from the ACQSC to assess our adherence to the Aged Care Standards are important albeit stressful for staff especially junior staff. Due to the transient nature of the work force, it is rare to have staff on the floor who have previous experience with the ACQSC visits.

37. Often in my experience new graduate nurses move after a few months working in Aged Care to the Acute sector or see Aged Care as a second job with a likely contract in acute care their preferred focus.

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. 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.

39. 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. Official data supports my own observation of these changes. See:
    a. Australian Institute of Health and Welfare, (2021) *Dementia in Australia 2021 Summary Report* (**ANMF 108**) at page 13.
    b. Australian Institute of Health and Welfare, (2018) *Older Australia at a Glance* (**ANMF 94**).
    c. Gibson D, (2020) *Who uses residential aged care now, how has it changed and what does it mean for the future?* (**ANMF 109**).
    d. Reierson F, (2021) *Trends in Medication Use 2016-2021* (**ANMF 110**).

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.

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.

42. There are a range of challenging areas of care provision in aged care and many of these areas have involved changes over the last ten years including :
    a. wound care complexity with increased documentation required for each wound;
    b. medication administration becoming more challenging with multiple medications (polypharmacy) to manage co-morbidities and prn medications;
    c. pain management and particularly the delivery of timely prn pain relief, monitoring for increased risks of falls;
    d. antimicrobial stewardship, infection control and prevention needing a high level of vigilance and supervision;
    e. ensuring appropriate food, nutrition, and hydration attending to referrals to dieticians, prescribing high protein diets and supplemental drinks;
    f. continence care: diagnosing and managing incontinence, managing constipation and loose bowels;
    g. dementia care: assisting with development of behavioural plans, diagnosing depression, delirium and management of same – non-pharmacological and pharmacological treatments;
    h. mobility and falls risk prevention and assessments post fall, history taking and risk reduction;
    i. social supports: providing support to families, often complex with guilt issues or high expectations of what is possible;
    j. quality of life: partnering with residents to elicit what is important to them for their quality of life;
    k. end of life / palliative care: is a specialty and I am establishing ‘palliative care needs rounds’, which will provide education for palliative care support, build collaborative relationships with Palliative Care specialists and their teams, completing thorough pain assessments mentoring new graduate nurse into this specialist care.

and

l. dealing with increased co-morbidity and higher levels of acuity, substantially due to the ageing population and people staying at home understandably as long as possible, often and the decision to move into aged care a result of a presentation to hospital.

43. The work of aged care RNs, ENs and nursing Assistants/PCWs has in my experience been profoundly influenced by changes in the following areas since I resumed work in the sector in 2010:

    a. Changes in the staffing levels and staffing profile or skills mix. There are fewer RNs and ENs and an increased proportion of carers. Further there has been a reduction in the hours of care staff available;
    b. There has been an increase in the complexity and acuity of residents at the time of admission and ongoing. This has been reflected in such matters as levels of frailty, co-morbidities, poly-pharmacology, falls risks and the number and severity of cognitive and dementia related conditions;
    c. The regulation of the sector ranging from the abolition of the "Low care/high care" distinction, the introduction of ageing in place, the application of Care Standards and the introduction of the Aged Care Quality Standards, regulation in respect of restraint, increased documentation and reporting and the demands of the Aged Care Funding Instrument;
    d. The expectations of residents, families and the community generally have changed such as to require, rightly, greater levels of accountability and reporting and communication about the delivery of care; and
    e. Increasing need for good palliative care provision.

    There are many other changes, but these areas summarise the major influences on change I have observed.

44. These influences have had a direct impact on the work of RNs, ENs and carers in the RACFs. This has been evident in such matters as:

    a. The 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;

b. An increase in the intensity and complexity of the work performed. Each item in the list of care work required in paragraph 37 above has been changed as a result of the changes imposing greater demands on staff in their daily work. Further, there is a sense of rushed care with the potential for missed care; and
c. The difficulty of the physical settings in which care is provided. A home like environment and older facilities present difficulty and dangers in delivering care to frail, obese or cognitively impaired residents.

45. 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.

46. New graduate RN's from Australia and other countries need time to develop and build their clinical experience, and confidence, in order work to the full scope of practice in the practice setting. The transition to practice programs currently offered and paid for by employers are often poorly attended due to the demands of providing nursing hours on shift.

47. Interaction with other health providers within the RACF is robust where the team work regularly with the provided, for examples, collaborating with the team of physiotherapists is regular and productive. Interaction with external providers such as dieticians, speech pathologists and GP's can be problematic when their visits are ad hoc, notes can be buried in the electronic system and if they are not proactive, communication with nursing staff can be unsatisfactory.

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.

49. This year, beginning in the memory support unit at Rivulet, SCC Tas has begun to train our care and nursing staff in the Montessori model of care. The memory support unit is a closed unit for residents with dementia or dementia related disease. This model of dementia care is primarily about providing purposeful tasks for residents living with dementia, targeted at their level of engagement and cognitive ability, improving their sense of self, quality of life and thereby reducing boredom and likely aggressive incidents. The Montessori program was first developed for people living with dementia by Dr Cameron Camp 20 – 30 years ago.

50. Covid 19 has increased the isolation of residents and the wearing of masks challenging for residents with dementia (and staff) who rely heavily on facial expressions for communication.

Additional comments

51. I do not feel my NP role or experience is as yet valued very well by health professions who generally don't understand it. What I bring to the sector is focussed experience and expertise plus a desire to provide timely interventions and improve the quality of life of older Australians and thus their families.

52. I feel there is a lot of social rhetoric about the value of older people, but when it comes to spending money to better their world, there is less commitment from the Federal Government. The need for improvement to aged care was identified after the Royal Commission and the many commissions prior to that, however, the response is delayed.

53. I aim to work for around 2 more years in aged care before I leave full time work. I will likely continue with my part time memory clinic and supporting new students with their post graduate studies for a couple of years more.

54. I hope to see the sector better funded and supported, with Nurses and Nurse Practitioners empowered to be less dependent on external medical services.

55. An increase in the minimum wage would hopefully encourage carers and nurses to prioritise their work, we would have better retention and therefore provide improved care.

HAZEL BUCHER
10 May 2022

CURRICULUM VITAE

HAZEL F BUCHER

August 2021

Personal Details

Name: Hazel Bucher

Address: [redacted]

Mobile:

Email:

EDUCATION QUALIFICATIONS

Completed studies

2017	Immunisation for Registered Nurses Australian College of Nursing
2012	Graduate Diploma Nursing – Mental Health/Psychiatric University of Tasmania
2010	Master of Nursing Science (Nurse Practitioner) Queensland University of Technology
2008	Graduate Diploma Nursing - Aged Care University of Tasmania
2008	Dementia – Education Course Australian Evidence Based Aged Care Consortium
2007	Graduate Certificate in Rehabilitation Bendigo Health Services Victoria
1980	General Nursing Certificate Royal Hobart Hospital, Tasmania

RECENT EXPERIENCE:

Dec 2019 to current	Health Practitioner Member Tasmanian Board of the Nursing and Midwifery Board of Australia
28th June 2019	Expert Witness NSW Coroners Case
19th July 2019	Expert Witness NSW Coroners Case

CURRENT EMPLOYMENT

Nov 2020 to current	**General Manager Clinical Services /**Nurse Practitioner Southern Cross Care Tasmania
2020 to Nov 2020	Nurse Practitioner - **Community Rapid Response Service** Tasmanian Health Service (THS) – Complex, Chronic & Community Service
Nov 2017 to March 2020	Nurse Practitioner Aged Care/Mental Health Hobart Aged Care
1st May 2013 to current	Nurse Practitioner Aged Care/Mental Health Hazel Bucher Nurse Practitioner Consultancy

[redacted]

Conferences attended

Nov 2020	AAG Conference	Virtual
Nov 2020	Palliative Care Nurses Conference	Virtual
Feb 2020	Tasmania Nursing and Midwifery Conference	Hobart
Nov 2019	AAG Conference	Melbourne
Sep 2019	ACNP 14th National Conference	Melbourne
Aug 2019	ACN National Nursing Forum	Hobart
Sep 2018	ACNP 13th National Conference	Canberra
Sep 2017	ACNP 12th National Conference	Alice Springs
Sep 2016	ACNP 11th National Conference	Brisbane

PROFESSIONAL DEVELOPMENT

June 2021 to current	Upskilling to include Palliative Care into NP Scope Program of Experience in the Palliative Approach (PEPA) THS Mentored by [redacted] University of Wollongong
June 2021 to current	Unit Coordinator Utas
Feb 2019 to Nov 2019	Unit coordinator/Tutor Gerontological Nursing University of Tasmania
2012 – 2017	Research Associate Wicking Centre
July 11 – May 2015	On-line Tutor Aged Care/Dementia *School of Nursing and Midwifery University of Tasmania*
2011	Tutorial Development – Aged Care *HealthStaffEd Canberra*
July 10 – June 12	Clinical Mentor - Nurse Practitioner Student Queensland University of Technology
July – Oct 10	On-line Tutor - Perspectives on Ageing Unit School of Nursing and Midwifery University of Tasmania

Publications

Stirling C., Campbell B., Bentley M., Bucher H. & M. Morrissey (2013) A Qualitative study of patients' experiences of a nurse-led memory clinic. *Sage Publications.*

Minstrell M., Bentley M., Bucher H., Morrissey M., Higgs C., Robinson R., & Stirling C. (2014) Open referral policy within a nurse-led memory clinic: client demographic, assessment score and diagnostic profiles. *International Psychogeriatrics* pp1-13.

Bentley M., Minstrell M., Bucher H., Morrissey M., Robinson A., Stirling C. (2014) A case study evaluation protocol to assess processes, effectiveness and impact of a nurse practitioner-led memory clinic. *Health.* 6(8):748-756.

Nurse Practitioners Leading Change in the Specialty of Psychogeriatrics (2013)
IPA with A Moorehead

Aged Care Focus Article - ANJ Aged Care Publication 2013
GPSouth – article summarizing a meeting with Dr Geoff Chapman

Poster and oral presentations

Coronial Inquests: An expert report Sep 2019
Australian College of Nurse Practitioners Conference
What Tsunami? Aged Care NP roles Sep 2019
Australian College of Nurse Practitioners Conference
Australian Nurse Practitioners? August 2019
Trail blazing to tried and true – how far have we come?
Australian College of Nurses National Nursing Forum
Tasmanian Nurse Practitioners: changing the health care landscape August 2019
Australian College of Nurses National Nursing Forum

Aged Care Nurse Practitioners in Primary Care **MEMBERSHIPS**

Australian College of Nurse Practitioners
Member since 2009
Tasmanian Chair Sep 2015 – Sept 2017
National Secretary February 2019 to current
The Psychogeriatric Nurses Association Australia Inc.
Palliative Care Nurses Australia
Australian Association of Gerontology (AAG)
Australian Nursing Midwifery Federation

GENERAL MANAGER CARE SERVICES (Nurse Practitioner)

POSITION DETAILS:

Position Title:	General Manager Care Services	**Reports To:**	Executive Manager Care Services
Department/Division:	Care Services	**Direct Reports:**	Infection Control Manager

POSITION SUMMARY:

Reporting directly to the Executive Manager Care Services (EMCS), the General Manager Care Services (GMCS) oversees all aspects of clinical care, including assessments, treatments, and consultations. Deputising for the EMCS as required, and supporting the Executive and General Managers, the GMCS is responsible for leading and managing the clinical practices at SCC, clinical policy development, infection control management and educating staff and consumers about preventative care and prescribed treatments.

KEY RESPONSIBILITIES:

- Establish, lead, and manage an integrated clinical services framework across SCC.
- Oversite of clinical practices across the state – including clinical training and education of nurses and care staff.
- Oversite of palliative care program, including education and training for all staff.
- Participate in performance management where related to clinical practice
- Prepare SCC for clinical compliance, quality reporting and accreditation visits across residential and home care.
- Ensure standards of nursing care & clinical practice delivered are evidence based & current best practice.
- Analyse and interpret clinical data for the purpose of reporting, trending and improved clinical practice and residents' outcomes.
- Develop high level reports for the Executive and Board meetings
- Develop clinical policies, procedures, and processes for the organisation.
- Oversee all compulsory reporting, serious incident response investigations and management.
- Act as a mentor/support person by assisting, advising & supporting staff in all aspects of duties performed.
- Identify potential adverse outcomes or clinical risk & implements proactive strategies to achieve risk minimisation, ensuring consumer & workplace safety.
- Provide expert nursing knowledge to the Executive, provide direct clinical care, guidance & support on clinical case management of consumers.
- Set and monitor pharmaceuticals and medical supplies impress to ensure best practice and quality with regard to clinical treatments and budgetary delegations.
- Demonstrate active exemplar leadership in SCC's clinical practice & model of care development as well as active participation in education activities with staff.
- Champion, lead and communicate the strategic direction and standards expected of SCC clinical services
- Develop and maintain external specialist clinical networks and partnerships
- Any other duties reasonably requested by the Executive Manager Care Services

SOUTHERN CROSS CARE VALUES

POSITION DESCRIPTION

GENERAL MANAGER CARE SERVICES (Nurse Practitioner)

Compassion

- We respond willingly and positively to help meet the needs of those around us
- We promote a sense of belonging and community
- We demonstrate and foster empathy and sensitivity towards residents, clients, their families, our colleagues and the whole community

Integrity

- We look for the good in all people and recognise the contribution of each individual as we work together
- We demonstrate honesty and trustworthiness in all that we do
- We are conscientious and ethical in our decision making and take responsibility for our own actions

Respect

- We believe in the sanctity of life and that each life is unique and has special individual worth and dignity
- We recognise and respect individuality and diversity
- We treat all people with courtesy and respect regardless of gender, ethnic background, religious belief or economic circumstances
- We manage our resources wisely to minimise the impact on the environment

KEY PERFORMANCE INDICATORS:

- Demonstrate regular clinical audits, reviews of clinical practice & reviews associated with clinical incidents & nursing service delivery.
- Develop appropriate KPIs for areas relevant to clinical practice.
- Monitor and manage compliance with all mandatory clinical assessments.
- Demonstrate support in education program development & delivery/facilitation.
- Monitor and manage improved clinical outcomes for residents through data collection and interpretation
- Monitor and manage pharmaceutical budgets
- Monitor and manage infection control processes

SELECTION CRITERIA:

ESSENTIAL SELECTION CRITERIA

- Endorsement by AHPRA Nurses and Midwifery Board to practice as a Nurse Practitioner (or actively working towards endorsement)
- Demonstrated high level of communication skills (written and verbal) with high level interpersonal skills.
- Demonstrated ability to work autonomously, think critically, problem solve and make sound clinical decisions.
- Demonstrated understanding of evidence-based best practice and contribution to best practice models of care/principles.
- Demonstrated ability to lead multi-disciplinary teams.
- Computer literacy.

DESIRABLE

- Post graduate qualifications in Aged Care and/or Palliative Care and extensive work experience in Aged Care.
- The Nurse Practitioner will have strong knowledge of working in the community setting with family inclusive practice a core element of their care.

SPECIAL EMPLOYMENT CONDITIONS

1. Required to provide a satisfactory National Criminal History Record (Police Check) that is not more than three years old on employment and that complies with the requirements of the *Aged Care Act 1997* prior to commencement of employment
2. Required to sign the organisation's Confidentiality Agreement

POSITION DESCRIPTION

GENERAL MANAGER CARE SERVICES (Nurse Practitioner)

WORK HEALTH AND SAFETY REQUIREMENTS/CONTINUOUS IMPROVEMENT

Maintain a safe working environment and adopt safe work practices by:

- Adhering to Southern Cross Care Workplace Health and Safety Policy and Procedures.
- Working in a responsible manner and encouraging others do so to ensure the safety of oneself, other staff members, residents and visitors to Southern Cross Care facilities.
- Implementing correct fire, emergency and safety procedures, and attending prescribed training as required.
- Perform all resident care tasks in accordance with SCC established procedures.
- Reporting, and documenting incidents, risks and hazards in a timely manner in accordance with SCC policy and procedures.
- Reporting maintenance and repair requirements of buildings, plant, equipment, furnishings and fittings promptly using approved SCC procedures.
- Using all equipment and supplies appropriately to complete duties to minimise wastage and/or abuse.

AUTHORISATION:

Manager Signature:		Date:	
Employee Signature:		Date:	

POSITION DESCRIPTION

IN THE FAIR WORK COMMISSION

Matter No: **AM2020/99, AM2021/63 & AM2021/65**

Re Applications by: **Australian Nursing and Midwifery Federation and others**

AMENDED STATEMENT OF KRISTEN WISCHER

I, **Kristen Wischer**, of Level 1, 365 Queen Street, Melbourne in the State of Victoria, Union Official, state as follows:

BACKGROUND

1. This statement is made further to my witness statement in this matter dated 14 September 2021 dealing with the Award history (**Award History statement**). This statement is to be read and understood in conjunction with my Award history statement.

2. This statement addresses the following topics:

    - Part 1: Industrial instrument coverage and comparative wage data.
    - Part 2: The Nurses Award and aged care
    - Part 3: The Aged Care Award
    - Part 4: The Social, Community, Home Care and Disability Services Industry Award and the Equal Remuneration Order 2012.

3. This statement has been prepared on the basis of my own knowledge and from the records of the ANMF available to me as Senior Federal Industrial Officer and from records available on various industrial and legal research sites.

PART 1: INDUSTRIAL INSTRUMENT COVERAGE AND COMPARATIVE WAGE DATA

Overview

Industrial instrument coverage

4. The ANMF represents the industrial interests of nurses, midwives and assistants in nursing (however titled) in all states and territories in Australia.

5. In this statement I refer to assistants in nursing (**AINs**), when referring to Nursing Assistants as classified under the *Nurses Award 2010* (**ANMF 59**) and its successor, the *Nurses Award 2020* (**ANMF 4**), which came into operation on 9 September 2021. I use the term Personal Care Worker (**PCW**) when referring to employees covered by the *Aged Care Award* **(ANMF 3)**. Both classifications may be referred to by a range of other titles, such as personal care attendant.

6. The Nurses Award covers employers throughout Australia in the health industry and their employees in the classifications listed in Schedule B — Classification Definitions and employers who employ a nurse/midwife, principally engaged in nursing/midwifery duties comprehended by the classifications listed in Schedule B.

7. The Aged Care Award is an industry award which covers employers throughout Australia in the aged care industry and their employees listed in clause 14 of the award. The aged care industry means 'the provision of accommodation and care 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.'

Industrial instrument analysis

8. The ANMF has established a database of enterprise agreements covering a range of employers of nurses, midwives are carers throughout the health and aged care sectors. The data base includes all non-public sector residential aged care agreements covering nurses, AINs and some agreements as they apply to PCWs. I refer to this as the aged care agreement data base.

9. The data for the aged care agreement data base is collected via monitoring enterprise agreements approved by the Fair Work Commission and then collating that information in the data base. The data collected is mapped against publicly available facility data to provide the information set out below. The publicly available facility data is sourced from the Australian Government, Department of Health, *Aged Care Service List* as at 30 June 2020 (**ANMF 60**).

10. The ANMF publishes a document on a quarterly bases, titled *Nurses and Midwives' Paycheck* which is based on the data collated in the aged care agreement data base referred to above. A copy of the June 2021 edition of Paycheck is **Annexure KW 1**. Since the publication of the June–August Paycheck it should be noted there have been further wage increases in States and Territories in accordance with the relevant instrument.

11. In Paycheck, the ANMF identifies agreements in the non-public residential aged care sector and reports average wages data based on rates of pay extracted for key classifications in the aged care agreements.

12. Average wage data is a simple average based on the rates contained in state and territory agreements. The data comes from the complete set of current and most recently expired agreements. Administrative increases (where known), have been applied to older agreements and agreements which expired before December 2019 were excluded from the sample used to calculate averages. National averages are a simple average of all these agreements. State and territory averages are derived in the same way for agreements in the respective states and territories.

13. The national average for public sector rates is derived from the following public sector instruments:

    - **NSW**
      Public Health System Nurses' and Midwives' (State) Award 2021 IRC 2021/0018806

Wage rates applicable 1/07/2021 **(ANMF 61)**

- **VIC**
  Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2016–2020 [AE422722] **(ANMF 62)**
  Wage rates applicable 1/12/2020

- **QLD**
  Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018 [No. CB/2020/44] **(ANMF 63)**
  Wages rates applicable 1/03/2020

- **SA**
  Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2020 [ET-20-02747] **(ANMF 64)**
  Wage rates applicable 1/01/2021

- **WA**
  WA Health System – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses – Industrial Agreement 2020 [AG 8 of 2021] 2021 WAIRC 00144 **(ANMF 65)**
  Wage rates applicable 12/10/2020

  WA Health System – United Workers Union (WA) – Enrolled Nurses, Assistants in Nursing, Aboriginal and Ethnic Health Workers Industrial Agreement 2020 [AG 7 of 2021 **(ANMF 66)**
  Wage rates applicable 7/10/2020

- **TAS**
  Nurses and Midwives (Tasmanian State Service) Agreement 2019 [T14763 of 2020] **(ANMF 67)**
  Wage rates applicable 1/12/2020

- **ACT**
  ACT Public Sector Nursing and Midwifery Enterprise Agreement 2017–2019 [AE503830] **(ANMF 68)**
  Wage rates applicable (including administrative increases) 1/12/2020

- **NT**
  Northern Territory Public Sector Nurses and Midwives' 2018–2022 Enterprise Agreement [AE501953] **(ANMF 69)**
  Wage rates applicable 20/08/2020

14. The data contained in Paycheck is relied upon in the paragraphs below.

Agreement coverage and award reliance

15. The ANMF estimates there are approximately 707 agreements applicable to nurses and AINs/PCWs working in non-public sector residential aged care facilities.

16. As at 15 May 2021, mapping against the Aged Care Services List, provides the information set out in the following paragraphs in relation to agreement coverage in residential aged care facilities.

17. Across Australia, we estimate 86.2% of all aged care facilities have their entire nursing workforce covered by enterprise agreements, being 2138 out of 2479 facilities.

18. 84% of these fully covered facilities are covered by a single agreement setting out wages and conditions for all classifications of nursing staff (RN, EN and AIN/PCW).

19. In 4.9% of facilities, nursing classifications are partially covered by agreements and partially covered by the Nurses Award.

20. Nationally, we estimate 8.9% of facilities are totally award reliant. On a State/Territory basis, the percentage share of facilities that are totally reliant on awards is 5.7% in NSW; 2.8% in VIC; 3.2% in SA: 1.5% in TAS; 8.0% in ACT; 22.0% in QLD and 18.3% in WA. In the Northern Territory, all facilities are fully covered by agreements.

21. Agreement coverage varies markedly across the States and Territories:

- In the Northern Territory all 12 facilities are fully covered by agreements.
- In Victoria, 97.2% or 580 out of 597 facilities are fully covered by enterprise agreements.
- In NSW, 94.3 % (814 out of 863) of all facilities are fully covered by agreements.
- In Tasmania, 92.6% (64 out of 68) are fully covered by agreements.
- In Queensland, 78.0% (353 out of 454) are fully covered by agreements.
- In South Australia, 48.6% of all facilities are fully covered by agreements, however, 48.2% of AINs and PCWs are not covered by enterprise agreements, while RNs and ENS are covered in 96.8% (213 out of 220) of facilities.

22. Set out below is a table showing the above data in percent share of facilities by status of coverage and state.[1]

Table 1: Percent share of facilities (services) by status of agreement coverage and state

Industrial Instrument Coverage	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
Complete - Single Agreement	91.7%	91.6%	71.4%	14.5%	12.1%	58.8%	91.7%	88.0%	72.4%
Complete - Multiple	2.7%	5.5%	6.4%	34.1%	65.8%	33.8%	8.3%	0.0%	13.8%
Sub Total Complete Coverage	**94.3%**	**97.2%**	**77.8%**	**48.6%**	**77.9%**	**92.6%**	**100.0%**	**88.0%**	**86.2%**
Partial - RNs only	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.1%
Partial - RNs & ENs	0.0%	0.0%	0.0%	48.2%	0.0%	5.9%	0.0%	0.0%	4.4%
Partial - ENs & AINs/PCWs	0.0%	0.0%	0.0%	0.0%	2.5%	0.0%	0.0%	0.0%	0.2%
Partial - AINs only	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	4.0%	0.1%
Sub Total Partial Coverage	**0.0%**	**0.0%**	**0.2%**	**48.2%**	**3.8%**	**5.9%**	**0.0%**	**4.0%**	**4.9%**
Agreement coverage (complete or partial)	**94.3%**	**97.2%**	**78.0%**	**96.8%**	**81.7%**	**98.5%**	**100.0%**	**92.0%**	**91.1%**

[1] Australian Nursing and Midwifery Federation, *Nurses and Midwives' Paycheck* (Report, Volume 20 No 3, June–August 2021) 34 ('*Paycheck*').

Complete Award Reliance	**5.7%**	**2.8%**	**22.0%**	**3.2%**	**18.3%**	**1.5%**	**0.0%**	**8.0%**	**8.9%**
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Wage Data Comparison

Average Wage Data

23. As set out above, the ANMF conducts quarterly analysis of agreement outcomes in residential aged care. The data provides wage data which can be compared with public sector rates and award rates.

24. Set out below is a Table providing average wages data for aged care enterprise agreements as at May 2021.[2]

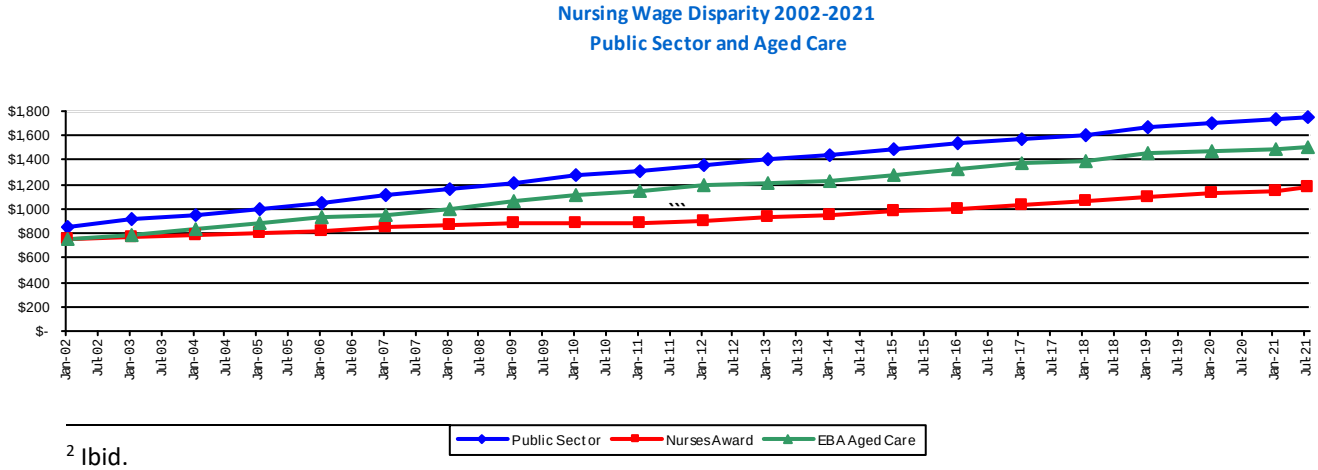
Table 2: Average wage data – May 2021

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
AIN/PCW entry	21.93	24.49	23.34	22.69	24.12	23.12	23.81	22.26	23.00
AIN/PCW thereafter	23.49	25.14	24.09	23.35	24.61	23.73	24.26	23.93	24.10
AIN/PCW Cert 3 entry	23.71	25.54	24.60	23.79	24.52	24.09	24.44	23.72	24.40
AIN/PCW Cert 3 thereafter	23.80	26.21	25.19	24.71	25.10	24.67	25.38	24.27	24.79
EN min	27.37	27.06	27.45	26.45	27.83	28.18	25.84	28.23	27.24
EN max	29.99	30.86	29.77	30.12	29.35	30.99	30.61	31.41	30.27
RN level1 entry	32.69	31.17	31.21	29.02	33.45	30.28	28.65	33.43	31.68
RN level 1 thereafter	41.02	38.51	37.14	39.18	42.35	39.91	35.64	40.56	39.70

Comparison with public sector rates of pay

25. While the level of agreement coverage in residential aged care is reasonably high, as seen in Table 1 above, the following shows the difference between agreement outcomes (as discussed above) when compared to the public sector rates and award rates.

26. The graph below shows the wage disparity for an RN Level 1 top pay point from 2002 to 2021 between the Nurses Award, enterprise agreements in aged care and public sector agreements:



[2] Ibid.

Comparison of rates

27. Set out below are narrative comparisons of RNs Level 1 Top, EN maximum and Certificate III Top between public and private sector rates, and between award rates and both public and private sector rates. For comparison purposes, the rates contained in the Nurses Award as at 1 July 2021 are used, and for PCWs with a Certificate III, the rate in the Aged Care Award as at 1 July 2021 is used.

28. At a state and territory level, the range of difference between public sector averages and the Nurses Award rates varies. This variation is set out for illustrative purposes and has been prepared for the purposes of this Statement. Comparison with average enterprise agreement rates and rates under the Nurses Award is not included in Paycheck.

29. All amounts are base wage rates. Weekly rates are based on a 38-hour week.

30. The comparison data discussed here and below, is set out more fully and with additional comparisons for all key classifications in **Annexure KW 2** to my statement. The data used in the Annexure is drawn from the data contained in Paycheck and the wage rates in the Nurses Award and Aged Care Award. The Annexure is in three parts as follows:

    - **Annexure KW 2(A)** – Comparison between average wages in aged care and the public sector; average wages in aged care and the Nurses Award and wages in the public sector and the Nurses Award – Nationally and by State and Territory
    - **Annexure KW 2(B)** – Comparison between average wage rates in aged care and the public sector; average wages in aged care and the Nurses Award; wages in the public sector and the Nurses Award and average wages in aged care and the Aged Care Award – Nationally and by State and Territory
    - **Annexure KW 2(C)** – Comparison of public sector rates of pay with the Nurses Award – nationally and by State/Territory

31. Percentage wage comparisons have been rounded to the nearest whole number.

Registered nurse comparison of rates

32. The national average public sector hourly rate for an RN Level 1 at the top of the scale is $45.90 or $1,744.20 [3] per week.

33. The national average aged care enterprise agreement rate for an RN Level 1 at the top of the scale is $39.70 or $1508.60, being 16% lower or $235.60 less than the national public sector average.[4]

[3] Ibid 35.
[4] Ibid.

34. Under the Nurses Award, the wage rate for an RN Level 1 pay point 8 is $30.99 an hour or $1177.80 per week. When compared to the national public sector average, the wage rate in the Nurses Award is 48% lower, or $566 per week less.

35. When compared to the national enterprise agreement average, the Nurses Award rate is 28% lower, or $330.80 per week less.

36. On a State/Territory basis the difference for an RN Level 1 at the top of the level one classification structure varies considerably across each of the comparisons made with respect to the national average.

37. For example, the comparison between an RN Level 1 at the top of the level 1 classification structure in the public sector in NSW and the equivalent in the Nurses Award is 50%, or $589.90 a week. In Tasmania, the difference is 40%. Across each State and Territory, the range of difference is between 51% and 40%.

Enrolled nurse comparison of rates

38. The national public sector average hourly rate for an EN at the top of the scale, (excluding advanced practice or special grade EN rates), is $33.69, or $1,280.22 per week.[5]

39. The national average aged care enterprise agreement rate for an EN at the top of the scale is $30.27 or $1150.26, being 11% lower or $129.96 less than the national public sector average.[6]

40. Under the Nurses Award, the wage rate for an EN pay point 5 is $25.36 an hour or $963.80 per week. When compared to the national public sector average, the wage rate in the Nurses Award is 33% lower, or $316.42 per week less.

41. When compared to the national enterprise agreement average, the Nurses Award rate is 19% lower, or $186.46 per week less.

42. On a State/Territory basis the difference between the average wage for an EN at the top of the scale in the public sector and under the Nurses Award varies between 28% lower in NSW and 39% lower in the Northern Territory, or $376.58 less per week.

43. On a State/Territory basis the difference between the average wage for an EN at the top of the scale in the public sector and under the Nurses Award varies between 28% in NSW and 39% in the Northern Territory, being $376.58 per week less.

Assistant in nursing/personal care workers comparison of rates

44. For the purposes of the average wage data base, where the agreement contains an AIN classification that is the classification used, if there is no such classification, the PCW classification is used for collecting wages data for the purposes of collating average wage data, as set out below.

[5] Ibid.
[6] Ibid.

45. The national public sector average hourly rate for an AIN/PCW with a Certificate III at the top of the scale, is $28.55 or $1,084.90 per week.[7]

46. The national average aged care enterprise agreement rate for an AIN/PCW at the top of the scale is $24.79 or $942.02, being 15% lower or $142.99 less per week than the national public sector average.[8]

47. Under the Nurses Award, the wage rate for an AIN (or PCW under the Aged Care Award) with a Certificate III is $23.67 an hour or $899.50 per week. When compared to the national public sector average, the wage rate in the Nurses Award is 21% lower, or $185.40 per week less.

48. When compared to the national enterprise agreement average, the Nurses Award and Aged Care Award rate is 5% lower, or $42.53 per week less.

49. On a State/Territory basis the difference between the average wage for an AIN/PCW at the top of the scale in the public sector and under the Nurses Award or Aged Care Award for this classification, varies between 10% in NSW and 34% in Queensland.

PART II: THE NURSES AWARD AND AGED CARE

The Nurses Award classification structure and aged care

50. Schedule A – Classification Definitions of the Nurses Award 2020 sets out the classifications covered by the award. The classification structure comprises six classifications as follows:

    Nursing assistant

    Student enrolled nurse

    Enrolled nurse

    Registered nurses

    Occupational health nurses and

    Nurse Practitioner.

51. With the exception of the classification 'Occupational health nurses', all of the classifications listed work across aged care settings, both residential, home and community aged care.

52. Part 4 of the Nurses Award 2020 – Wages and Allowances sets out the minimum weekly and hourly rates of pay for each pay point or grade within each of the above classifications.

Nursing Assistant

53. The classification of nursing assistant is defined as:

    Nursing assistant means an employee, other than one registered with the Nursing and Midwifery Board of Australia or its successor or one who is in training for the purpose of

[7] Ibid.
[8] Ibid.

such registration, who is under the direct control and supervision of a Registered or Enrolled nurse and whose employment is solely to assist an RN or EN in the provision of nursing care to persons.[9]

54. The term 'nursing assistant' as used in the award, also defines the work of employees performing the same work under this classification, but with other titles.

55. The main alternative title, is Assistant in nursing (AIN), which is the term adopted by the ANMF in this matter.

56. AINs work in aged care as part of the nursing team.

57. Wages for an AIN are provided for in clause 15.2 of the Nurses Award 2020.

58. Clause 15.2 sets out minimum wages for 1st year, 2nd year, 3rd year and thereafter, and Experienced (the holder of a relevant Certificate III qualification).

59. The top of the scale requires a Certificate III. A person holding a relevant certificate can be appointed directly to this pay point.

Student enrolled nurse

60. Student enrolled nurse means a student undertaking study to become an enrolled nurse.[10]

61. In the context of aged care, a student may work in aged care if part of a placement program forming part of a course of study.

62. A person undertaking a course of study to become a nurse, who is otherwise employed in aged care, will fall under the nursing assistant classification.

63. Clause 15.3 provides pay points for student enrolled nurses who are either less than 21 years of age or 21 years of age and over.

Enrolled nurse

64. The classification of enrolled nurse does not provide a definition. Schedule A.4 sets out five pay points for enrolled nurses with a description of the training, experience and skills associated with each pay point.

65. Enrolled nurses are appointed based on training and experience to the appropriate pay point on the classification scale.

66. An EN can be appointed on entry to the profession at either pay point 1 or pay point 2.

67. An EN appointed to pay point one is required to have satisfactorily completed a course of training leading to enrolment as an EN on a register maintained by the Nursing and Midwifery Board of Australia (NMBA) and having practical experience of up to but not more than 12 months in the provision of nursing care and/or services.

[9] Nurses Award 2020 [MA000034] Schedule A.1 (formerly B.1).
[10] Ibid Schedule A.3 (formerly B.3).

68. An EN appointed to pay point two is required to have satisfactorily completed a hospital based course of general training in nursing of more than 12 months duration and/or 500 hours or more theory content of a course accredited at advanced certificate, diploma or advanced diploma level leading to enrolment as an EN; or Not more than one further year of practical experience in the provision of nursing care/and or services in addition to the experience, skill and knowledge requirements of pay point 1.

69. Pay point 1 recognises ENs who qualified for registration with the NMBA prior to the diploma level qualification becoming the minimum education level required for registration.

70. Progression to a higher pay point is based on attaining a further year of practical experience in the provision of nursing care and/or services, in addition to the experience, skill and knowledge requirements of the previous pay point.

71. Clause 15.3 (b) provides wages for each of pay points 1-5.

Registered nurses

72. The classification of registered nurse is not defined in the Nurses Award, but means nurses who are registered with the NMBA as registered nurses.

73. The classification structure at Schedule A.5 makes provision for five levels of registered nurse.

Level 1 (RN1)[11]

74. A registered nurse who meets the requirements for registration with the NMBA commences at Level 1. The classification sets out that an employee at this level is required to perform general nursing duties which include substantially, but are not confined to:

- *delivering direct and comprehensive nursing care and individual case management to patients or clients within the practice setting;*
- *coordinating services, including those of other disciplines or agencies, to individual patients or clients within the practice setting;*
- *providing education, counselling and group work services orientated towards the promotion of health status improvement of patients and clients within the practice setting;*
- *providing support, direction and education to newer or less experienced staff, including EN's, and student EN's and student nurses;*
- *accepting accountability for the employee's own standards of nursing care and service delivery; and*
- *participating in action research and policy development within the practice setting*.

75. Clause 15.4(a) provides eight pay points for an RN1. Appointment to a pay point is based on experience and qualifications. A registered nurse with a four-year degree is appointed at and

[11] Ibid Schedule A.5.1 (formerly B.5.1).

progresses from pay point 4 and a registered nurse with a Master's degree is appointed at and progresses from pay point 5.

76. There is no further progression at Level RN1 beyond pay point 8.

Registered nurse- levels 2 -5

77. Under the award, appointment to RN levels 2- 5 requires the employee to hold any other qualification for working in the employee's particular practice setting and to be appointed as such either by selection process or by reclassification when that employee is required to perform the duties detailed in the relevant subclause on a continuing basis.

78. At levels 4 and 5, appointment is to a grade within the level and is based on the level of complexity associated with the duties described in the clause and the number of beds in the facility will be a relevant consideration.

Registered nurse- level 2 (RN2)[12]

79. A nurse at this level may also be known as a Clinical nurse.

80. The award classification sets out the duties of a Clinical nurse will substantially include, but are not confined to:

- *delivering direct and comprehensive nursing care and individual case management to a specific group of patients or clients in a particular area of nursing practice within the practice setting;*
- *providing support, direction, orientation and education to RN1's, EN's, student nurses and student EN's;*
- *being responsible for planning and coordinating services relating to a particular group of clients or patients in the practice setting, as delegated by the Clinical nurse consultant;*
- *acting as a role model in the provision of holistic care to patients or clients in the practice setting; and*
- *assisting in the management of action research projects, and participating in quality assurance programs and policy development within the practice setting.*

81. Clause 15.4 (a) makes provision for four wage pay points alt RN – Level 2.

Registered nurse- level 3 (RN3)[13]

82. A nurse at this level may also be known as a Clinical nurse consultant, Nurse manager or Nurse educator.

83. The award classification sets out the duties of a Clinical nurse consultant will substantially include, but are not confined to:

[12] Ibid Schedule A.5.2 (formerly B.5.2).
[13] Ibid Schedule A.5.3 (formerly B.5.3).

- *providing leadership and role modelling, in collaboration with others including the Nurse manager and the Nurse educator, particularly in the areas of action research and quality assurance programs;*
- *staff and patient/client education;*
- *staff selection, management, development and appraisal;*
- *participating in policy development and implementation;*
- *acting as a consultant on request in the employee's own area of proficiency; for the purpose of facilitating the provision of quality nursing care;*
- *delivering direct and comprehensive nursing care to a specific group of patients or clients with complex nursing care needs, in a particular area of nursing practice within a practice setting;*
- *coordinating, and ensuring the maintenance of standards of the nursing care of a specific group or population of patients or clients within a practice setting; and*
- *coordinating or managing nursing or multidisciplinary service teams providing acute nursing and community services.*

i. Duties of a Nurse manager will substantially include, but are not confined to:

- *providing leadership and role modelling, in collaboration with others including the Clinical nurse consultant and the Nurse educator, particularly in the areas of action research and quality assurance programs;*
- *staff selection and education;*
- *allocation and rostering of staff;*
- *occupational health;*
- *initiation and evaluation of research related to staff and resource management;*
- *participating in policy development and implementation;*
- *acting as a consultant on request in the employee's own area of proficiency (for the purpose of facilitating the provision of quality nursing care);*
- *being accountable for the management of human and material resources within a specified span of control, including the development and evaluation of staffing methodologies; and*
- *managing financial matters, budget preparation and cost control in respect of nursing within that span of control*.

ii. Duties of a **Nurse educator** will substantially include, but are not confined to:

- *providing leadership and role modelling, in collaboration with others including the Clinical nurse consultant and the Nurse manager, particularly in the areas of action research;*

- *implementation and evaluation of staff education and development programs;*
- *staff selection;*
- *implementation and evaluation of patient or client education programs;*
- *participating in policy development and implementation;*
- *acting as a consultant on request in the employee's own area of proficiency (for the purpose of facilitating the provision of quality nursing care); and*
- *being accountable for the assessment, planning, implementation and evaluation of nursing education and staff development programs for a specified population.*

84. Clause 15.4 (a) provides for four wage pay points for RN level 3.

Registered Nurse- level 4 (RN4)[14]

85. An employee at this level may also be known as an Assistant director of nursing (clinical), Assistant director of nursing (management) or Assistant director of nursing (education). Appointment to grades within this level will depend on the level of complexity associated with the duties described in the award and the number of beds in a facility are a relevant consideration.

86. In addition to the duties of an RN3, an employee at this level will perform the following duties:

a. Duties of an **Assistant director of nursing (clinical)** will substantially include, but are not confined to:

- *providing leadership and role modelling, in collaboration with others including the Assistant director of nursing (management) and Assistant director of nursing (education), particularly in the areas of selection of staff within the employee's area of responsibility;*
- *provision of appropriate education programs, coordination and promotion of clinical research projects;*
- *participating as a member of the nursing executive team;*
- *contributing to the development of nursing and health unit policy for the purpose of facilitating the provision of quality nursing care;*
- *managing the activities of, and providing leadership, coordination and support to, a specified group of Clinical nurse consultants;*
- *being accountable for the establishment, implementation and evaluation of systems to ensure the standard of nursing care for a specified span of control;*
- *being accountable for the development, implementation and evaluation of patterns of patient care for a specified span of control;*

[14] Ibid Schedule A.5.4 (formerly B.5.4).

- *being accountable for clinical operational planning and decision making for a specified span of control; and*
- *being accountable for appropriate clinical standards, through quality assurance programs, for a specified span of control.*

b. Duties of an **Assistant director of nursing (management)** will substantially include, but are not confined to:

- *providing leadership and role modelling, in collaboration with others including the Assistant director of nursing (clinical) and Assistant director of nursing (education), particularly in the areas of selection of staff within the employee's area of responsibility;*
- *coordination and promotion of nursing management research projects;*
- *participating as a member of the nursing executive team;*
- *contributing to the development of nursing and health unit policy for the purpose of facilitating the provision of quality nursing care;*
- *managing the activities of, and providing leadership, coordination and support to, a specified group of Nurse managers;*
- *being accountable for the effective and efficient management of human and material resources within a specified span of control;*
- *being accountable for the development and coordination of nursing management systems within a specified span of control; and*
- *being accountable for the structural elements of quality assurance for a specified span of control.*

c. Duties of an **Assistant director of nursing (education)** will substantially include, but are not confined to:

- *providing leadership and role modelling, in conjunction with others including the Assistant director of nursing (clinical) and the Assistant director of nursing (management), particularly in the areas of selection of staff within the employee's area of responsibility;*
- *coordination and promotion of nurse education research projects;*
- *participating as a member of the nursing executive team, and contributing to the development of nursing and health unit policy for the purpose of facilitating the provision of quality nursing care;*
- *managing the activities of, and providing leadership, coordination and support to a specific group of Nurse educators;*
- *being accountable for the standards and effective coordination of education programs for a specified population;*
- *being accountable for the development, implementation and evaluation of education and staff development programs for a specified population;*

- *being accountable for the management of educational resources including their financial management and budgeting control; and*
- *undertaking career counselling for nursing staff.*

87. Clause 15.4(a) provides three wage grades for the RN level 4.

Registered nurse level 5 – (RN5)[15]

88. As with level 4, appointment within this level is to a particular grade dependent upon the level of complexity associated with the duties described in the clause and the number of beds in the facility are a relevant consideration. An employee at this level may also be known as a Director of nursing.

89. In addition to the duties of an RN4, an employee at this level will perform the following duties:

- *being accountable for the standards of nursing care for the health unit and for coordination of the nursing service of the health unit;*
- *participating as a member of the executive of the health unit, being accountable to the executive for the development and evaluation of nursing policy, and generally contributing to the development of health unit policy;*
- *providing leadership, direction and management of the nursing division of the health unit in accordance with policies, philosophies, objectives and goals established through consultation with staff and in accordance with the directions of the Board of Directors of the health unit;*
- *providing leadership and role modelling, in collaboration with others, particularly in the areas of staff selection, promotion of participative decision making and decentralisation of nursing management and generally advocating for the interests of nursing to the executive team of the health unit;*
- *managing the budget of the nursing division of the health unit;*
- *ensuring that nursing services meeting changing needs of clients or patients through proper strategic planning; and*
- *complying, and ensuring the compliance of others, with the code of ethics and legal requirements of the nursing profession*.

90. Clause 15.4 (a) provides six wage grades for RN Level 5.

Nurse Practitioner

91. Schedule A.7 provides for the role of Nurse Practitioner. The position is defined:

A nurse practitioner:

- *is a registered nurse/midwife appointed to the role;*
- *has obtained an additional qualification relevant to the NMBA to enable them to become a licensed Nurse practitioner.*

[15] Ibid Schedule A.5.5 (formerly B.5.5).

A Nurse practitioner is authorised to function autonomously and collaboratively in an advanced and extended clinical role.[16]

92. The classification description for a nurse practitioner is as follows:

(a) *The nurse practitioner is able to assess and manage the care of clients/residents using nursing knowledge and skills. It is dynamic practice that incorporates application of high level knowledge and skills, beyond that required of a registered nurse /midwife in extended practice across stable, unpredictable and complex situations.*

(b) *The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers.*[17]

93. The award sets out the scope of practice for a Nurse Practitioner.[18]

The scope of practice of the Nurse practitioner is determined by the context in which:

(a) *The nurse practitioner is authorised to practice. The nurse practitioner therefore remains accountable for the practice for which they directed; and*

(b) *The professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability.*

The Nurse practitioner is authorised to directly refer clients/residents to other health professionals, prescribe medications and order diagnostic investigations including pathology and plain screen x-rays.

Nurse practitioners exhibit clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service.

94. Clause 15.5 of the award makes provision for wages for a 1st year and 2nd year nurse practitioner.

Progression through pay points

95. Clause 15.7 of the Nurses Award 2020 provides as follows:

a. Progression through pay points

i. Progression will be:

1. for full-time employees – by annual movement; or

2. for part-time or casual employees – 1786 hours of experience.

ii. Progression to the next pay point for all classifications for which there is more than one pay point will have regard to:

1. the acquisition and use of skills described in the definitions contained in Schedule A – Classification Definitions; and

[16] Ibid Schedule A.7 (formerly B.7).
[17] Ibid Schedule A.7.1 (formerly B.7.1).
[18] Ibid Schedule A.7.2 (formerly B.7.2).

2. *knowledge gained through experience in the practice settings over such a period.*

96. The above clause makes provision for AINs, ENs and RNs at levels 1-3 to progress to the next pay point on an annual basis, or for casual and part-time employees on completion of 1786 hours of experience, having regard to the acquisition and use of skills.

97. Paragraphs 179 to 194 of the Award History deal with the history of the progression clause in the context of decisions relating to work value. The history demonstrates that the progression clause describes the basis of progression as experience gained rather than being based simply on years of service.

Benchmarks and relativities in the Nurses Award

98. Paragraph 244 in the Award History set out that an AIN with a Certificate III is set at the benchmark of C10 in what was known as the Metals Award.

99. In the **Federal AIN Decision**,[19] a new rate for an unqualified Assistant in Nursing was set at 89% of the C10 rate, (see paragraph 243 of the Award History).

100. The current award rate for an AIN and PCW with a Certificate III qualification is matched with C10 in *Manufacturing and Associated Industries and Occupations Award 2020*,[20] (**ANMF 70**) which is the successor award to the Metals Award.

101. **Annexure KW 3** to my statement is a table aligning Nurses Award and Aged Care Award rates of pay and qualification with the C10 classification structure in the Manufacturing and Associated Industries Award.

102. The Manufacturing and Associated Industries and Occupations Award does not cover employees with a degree qualification, therefore employees at RN Level 1 and above are not aligned with this award.

103. In the **South Australian Rates Review Q7661** it was noted that nurses rates had been properly fixed and had a range of 117.3% to 148.6% within the range established for professional employees. (see paragraph 163 of the Award history statement).

104. A comparison of the current range of nurses' wages relative to C10, currently set at $899.50, shows this relativity now sits at the following indicative relativities:

Classification	Award rate as at 1 July 2021	% of C10 $899.50
AIN 1st year	$843.40	94%
AIN Experienced (the holder of a relevant Certificate III qualification	$899.50	100%
EN PP1	$916.20	< 102%
RN Level 1 PP1	$980.10	109%

[19] *Australian Nursing Federation: Re Classification Structure* [2005] AIRC 1000 PR965496.
[20] Manufacturing and Associated Industries and Occupations Award 2020 [MA000010].

RN Level 1 PP8	$1177.80	131%

Compression of rates in the Nurses Award

105. The current award rates in the Nurses Award relative to C10, when compared to rates that were set in Q7661 and the Federal AIN Decision, show that there has been compression in the rates over time.

106. The reasons for compression of wage rates in the Nurses Award can, at least in part be attributed to the methods by which wage rates have been increased in Annual Wage Reviews. The Fair Work Commission made the following observation about the impact of previous annual wage review outcomes being expressed in flat dollar, rather than percentage terms in the 2013-14 Annual Wage Review decision (**ANMF 71**):[21]

As to the form of the increase, past flat dollar increases in award minimum rates have compressed award relativities and reduced the gains from skill acquisition. The position of the higher award classifications has reduced relative to market rates and to average earnings and has fallen in terms of real purchasing power. These considerations led the Panel to determine a uniform percentage increase.

107. The current rates in the Manufacturing and Associated Industries Award, while not having maintained the original relativities with C10, for the reasons described above arising from Annual Wage Reviews, have maintained a greater margin of relativity. For example, a C5 with a Diploma sits at 117% of C10. **Annexure KW 3** sets out this comparison in more detail.

PART III: THE AGED CARE AWARD AND CLASSIFICATION STRUCTURE

108. Schedule B of the Aged Care Award 2010 sets out the classification covered by the award. The classification structure comprises seven classifications, as follows:

Aged care employee—level 1

Aged care employee—level 2

Aged care employee—level 3

Aged care employee—level 4

Aged care employee—level 5

Aged care employee—level 6

Aged care employee—level 7

109. An aged care employee at level 1 is considered to be an entry level employee "who has less than three months' work experience in the industry and performs basic duties."[22]

110. An employee at this level:[23]

[21] *Re Annual Wage Review 2013–14* (2014) 245 IR 1, 14 [60].
[22] Aged Care Award 2010 [MA000018] Schedule B.1.
[23] Ibid.

- *works within established routines, methods and procedures;*
- *has minimal responsibility, accountability or discretion;*
- *works under limited supervision, either individually or in a team; and*
- *requires no previous experience or training.*

115. An employee at Aged care employee — level 2:[24]

- *is capable of prioritising work within established routines, methods and procedures;*
- *is responsible for work performed with a limited level of accountability or discretion;*
- *works under limited supervision, either individually or in a team;*
- *possesses sound communication skills; and*
- *requires specific on-the-job training and/or relevant skills training or experience.*

116. The Award states that indicative tasks performed at this level are that of a Personal Care Worker Grade 1.

117. An employee at Aged care employee — level 3:[25]

- *is capable of prioritising work within established routines, methods and procedures (non-admin/clerical);*
- *is responsible for work performed with a medium level of accountability or discretion (non-admin/clerical);*
- *works under limited supervision, either individually or in a team (non-admin/clerical);*
- *possesses sound communication and/or arithmetic skills (non-admin/clerical);*
- *requires specific on-the-job training and/or relevant skills training or experience (non-admin/clerical); and*
- *In the case of an admin/clerical employee, undertakes a range of basic clerical functions within established routines, methods and procedures.*

118. The Award states that indicative tasks performed at this level are that of a Personal Care Worker Grade 2.

119. An employee at Aged care employee — level 4:[26]

- *is capable of prioritising work within established policies, guidelines and procedures;*
- *is responsible for work performed with a medium level of accountability or discretion;*
- *works under limited supervision, either individually or in a team;*
- *possesses good communication, interpersonal and/or arithmetic skills; and*

[24] Ibid Schedule B.2.
[25] Ibid Schedule B.3.
[26] Ibid Schedule B.4.

- *requires specific on-the-job training, may require formal qualifications and/or relevant skills training or experience.*
- *in the case of a personal care worker, holds a relevant Certificate 3 qualification (or possesses equivalent knowledge and skills) and uses the skills and knowledge gained from that qualification in the performance of their work.*

120. The Award states that indicative tasks performed at this level are that of a Personal Care Worker Grade 3.

121. An employee at Aged care employee — level 5:[27]

- *is capable of functioning semi-autonomously, and prioritising their own work within established policies, guidelines and procedures;*
- *is responsible for work performed with a substantial level of accountability;*
- *works either individually or in a team;*
- *may assist with supervision of others;*
- *requires a comprehensive knowledge of medical terminology and/or a working knowledge of health insurance schemes (admin/clerical);*
- *may require basic computer knowledge or be required to use a computer on a regular basis;*
- *possesses administrative skills and problem solving abilities;*
- *possesses well developed communication, interpersonal and/or arithmetic skills; and*
- *requires substantial on-the-job training, may require formal qualifications at trade or certificate level and/or relevant skills training or experience.*

122. The Award states that indicate tasks performed at this level are that of a Personal Care Worker Grade 4.

123. An employee at Aged care employee — level 6:[28]

- *is capable of functioning with a high level of autonomy, and prioritising their work within established policies, guidelines and procedures;*
- *is responsible for work performed with a substantial level of accountability and responsibility;*
- *works either individually or in a team;*
- *may require comprehensive computer knowledge or be required to use a computer on a regular basis;*
- *possesses administrative skills and problem solving abilities;*
- *possesses well developed communication, interpersonal and/or arithmetic skills; and*
- *may require formal qualifications at post-trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience.*

[27] Ibid Schedule B.5.
[28] Ibid Schedule B.6.

124. An employee at Aged care employee — level 7:[29]

- *is capable of functioning autonomously, and prioritising their work and the work of others within established policies, guidelines and procedures;*
- *is responsible for work performed with a substantial level of accountability and responsibility;*
- *may supervise the work of others, including work allocation, rostering and guidance;*
- *works either individually or in a team;*
- *may require comprehensive computer knowledge or be required to use a computer on a regular basis;*
- *possesses developed administrative skills and problem solving abilities;*
- *possesses well developed communication, interpersonal and/or arithmetic skills; and*
- *may require formal qualifications at trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience.*

125. The Award states that indicate tasks performed at this level are as that of a Personal Care Worker Grade 5.

126. The Award prescribes minimum wages per week at each classification level as:[30]

Classification	Per week
	$
Aged care employee—level 1	821.40
Aged care employee—level 2	855.50
Aged care employee—level 3	889.00
Aged care employee—level 4	899.50
Aged care employee—level 5	930.00
Aged care employee—level 6	980.10
Aged care employee—level 7	997.70

127. As can be seen, the Award structure refers only to levels and the personal care worker grades are not defined, despite being referred to within the classification. The classification levels themselves are drafted in broad terms.

128. Only the classification of Aged care employee — level 4 relates directly to that of personal care workers in requiring that PCW's hold a relevant Certificate 3 qualification (or possesses equivalent knowledge and skills) and uses the skills and knowledge gained from this qualification in the performance of their work.

[29] Ibid Schedule B.7.
[30] Ibid cl 14.1.

PART 4: THE SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010 (SCHADSI AWARD) AND THE EQUAL REMUNERATION ORDER 2012

129. On 22 June 2012, a Full Bench of Fair Work Australia made an Equal Remuneration Order (**ERO**)[31] (**AMNF 72**) with respect to the *SCHADSI Award 2010*. (**ANMF 73**)

130. The ERO applies to employers throughout Australia in the Social, Community and Disability Services Industry and their employees in the classifications listed in Schedules B and C of the Award.

131. Schedule B applies to employees in the social and community services sector, defined under the Award as ***social and community services sector*** *means the provision of social and community services including social work, recreation work, welfare work, youth work or community development work, including organisations which primarily engage in policy, advocacy or representation on behalf of organisations carrying out such work and the provision of disability services including the provision of personal care and domestic and lifestyle support to a person with a disability in a community and/or residential setting including respite centre and day services.*

132. Schedule C applies to employees in the crisis assistance and supported housing sector, defined as 'the provision of crisis assistance and supported housing services'.

133. The ERO does not apply to employees under Schedule A, in the home care sector, defined as provision of personal care, domestic assistance or home maintenance to an aged person or a person with a disability in a private residence.

134. The effect of the ERO is to increase minimum award wages by the percentage amount ordered on 22 June 2012. The ERO made provision for phasing in of the increases and reached its final implementation in December 2020.[32]

135. The table below is an extract from the ERO showing the additional percentage amount to be added to award rates at the relevant classification level.[33]

Classification in Schedules B and C of the Award	Final Equal Remuneration Payment Percentage
Social and community services employee level 2	23%
Social and community services employee level 3 Crisis accommodation employee level 1	26%
Social and community services employee level 4 Crisis accommodation employee level 2	32%
Social and community services employee level 5 Crisis accommodation employee level 3	37%
Social and community services employee level 6 Crisis accommodation employee level 4	40%

[31] *Equal Remuneration Order*, following from Equal Remuneration Case Australian Municipal, Administrative, Clerical and Services Union and others (22 June 2012) PR525485.
[32] Ibid [5.5](h).
[33] Ibid [6.2]–[6.4].

Social and community services employee level 7	42%
Social and community services employee level 8	45%

The Final Rate in clause 6.2 of this Order is equal to the following percentage of the applicable minimum wage in clause 15 of the Award:

Classification in Schedules B and C of the Award	Final Rate Percentage
Social and community services employee level 2	123%
Social and community services employee level 3 Crisis accommodation employee level 1	126%
Social and community services employee level 4 Crisis accommodation employee level 2	132%
Social and community services employee level 5 Crisis accommodation employee level 3	137%
Social and community services employee level 6 Crisis accommodation employee level 4	140%
Social and community services employee level 7	142%
Social and community services employee level 8	145%

The payments in clause 6.2 of this Order shall be regarded as part of the ordinary rate of pay for all purposes.

136. Under the SCHADSI Award, a social and community services employee with a Certificate III has an entry level of Level 2 pay point 1 and is paid $899.50, being the C10 equivalent and the same rate paid to PCWs and AINs with a Certificate III under the Aged Care Award and Nurses Award respectively.

137. Pursuant to the ERO, a social and community services employee with a Certificate III is entitled to an additional 23% to be added to the Award minimum rate, bringing total weekly salary to $1,106.38.

138. Under the SCHADSI Award, a social and community services employee with an Advanced Certificate or Diploma has an entry level of Level 2, pay point 2 with a minimum award rate of $927.70. Pursuant to the ERO, this employee is entitled to an additional 23% to be added to the Award minimum rate, bringing the total weekly salary to $1,141.07.

139. In comparison, an Enrolled Nurse, under the Nurses Award has a rate of $928.30 per week at pay point two, being the entry level for a diploma qualified EN.

140. Under the SCHADSI Award, a graduate with a three-year degree classified under Schedule B has a minimum entry level of Level 3, pay point 3 of $1031.30. Pursuant to the ERO, employees at Level 3 are entitled to an additional 26%, bringing the total minimum weekly wage to $1299.43.

141. An employee classified under Schedule C- Crisis Accommodation commences at the equivalent of Level 3 under Schedule B.

142. In comparison, under the Nurses Award, a Level 1 RN qualified with a three-year degree is paid $980.10 at entry level and at the top of the eight point Level 1 scale, $1177.80.

KRISTEN WISCHER
9 May 2022

KW 1

Australian Nursing & Midwifery Federation

NURSES & MIDWIVES' PAYCHECK

A quarterly publication providing a comprehensive analysis of wages for nurses and midwives

June - August 2021
Volume 20 No. 3

To obtain a copy of this publication please contact Anna:

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ISSN 2208-6595

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CONTENTS

INTRODUCTION

Nurses' wages in Australia are set out predominately in the growing number of nursing industrial agreements reached between the Australian Nursing and Midwifery Federation[1] and employers. The overall growth in agreements since 1996 reflects a move from a centralised industrial relations system to one which is decentralised and where agreements have progressively replaced awards as the principle vehicle for wage movements. Changes to the federal industrial relations laws proclaimed on 27 March 2006[2] further decentralised the system and significantly reduced the role of awards in providing a safety net of wages and conditions of employment. However, new laws proclaimed during 2008 and 2009[3] re-established the role of awards in providing a safety net for all new agreements.

The Nurses Award 2010 commenced on 1 January 2010, and together with the National Employment Standard forms the safety net of wages and conditions for all nurses employed in the national system except for nurses employed in primary and secondary schools. Further information about the Nurses Award 2010 can be found at pages 14 to 18.

Nursing employment conditions are in the main regulated by federal laws with the major exception being nurses employed in the public sectors in New South Wales, South Australia, Western Australia, Tasmania and Queensland, and some nurses employed in the private sector in Western Australia which are regulated by the relevant State industrial bodies.

Under the current industrial system it is expected that collective agreements will continue to be the primary mechanism for determining wages and conditions for nurses in both the public and private sectors and there will be a significant expansion of agreements to cover other areas of nursing employment. Ready access to reliable and accurate wages information is increasingly difficult in this environment.

Nurses and Midwives' Paycheck, a quarterly publication of nurses' wage rates, seeks to provide an analysis of nursing wage movements across a selection of key classification levels in the public hospital, private hospital and residential aged care sectors.

1 The Australian Nursing & Midwifery Federation is made up of the following state and territory branches: ANMF ACT, ANMF QLD (QNMU), ANMF NSW (NSWNMA), ANMF WA, ANMF VIC, ANMF SA, ANMF NT and ANMF TAS. Branch contact details can be found at page 43.

2 The Workplace Relations Amendment (Work Choices) Act 2005 and the Workplace Relations Regulations 2006.

3 The Workplace Relations Amendment (Transition to Forward with Fairness) Act 2008; Fair Work Act 2009; Fair Work (Transitional Provisions and Consequential Amendments) Act 2009.

Who are nurses?*

Nurses form the largest health profession, providing health care to people across their lifespan. They work independently or as collaborative members of a health care team in settings which include hospitals, rural and remote nursing posts, Indigenous communities, schools, prisons, residential aged care facilities, the armed forces, universities, TAFE colleges, mental health facilities, statutory authorities, general practices, businesses, professional organisations and people's homes.

Nurses provide professional and holistic care, working to promote good health, prevent illness, and provide care for the ill, disabled and dying. Nurses also work in non-clinical roles to educate undergraduate and newly graduated nurses, conduct research into nursing and health related issues and participate in developing health policy and systems of health care management. Nursing is a regulated profession. By law, before nurses may practice, they must be registered or enrolled by the Nursing and Midwifery Board of Australia (NMBA).

The Nursing Profession in Australia

Australia has two levels of regulated nurse -registered nurses and enrolled nurses. Registered nurses working at an advanced level and holding a recognised post-graduate qualification may be eligible to seek endorsement as a nurse practitioner.

The four titles protected by legislation are: 'registered nurse', 'enrolled nurse', 'registered midwife' and nurse practitioner'. These titles may only be used when permitted by the NMBA. Another group of health care worker, assistants in nursing (AINs), also deliver aspects of nursing care. Assistants in nursing do not yet have consistent educational preparation or competency standards as they are not regulated by the NMBA. The ANMF supports the regulation of AINs. There are over 100,000 AINs in Australia, who are mostly employed in aged care.

Nursing Education

Registered nurses must complete a three year bachelor degree at university before they are eligible to be registered with the NMBA. They undertake a period of post-registration graduate support in a health or aged care setting. Usually this transition period is 12 months. They may also undertake post-graduate study to specialise in one of many clinical practice areas.

Enrolled nurses are educated in the vocational education and training (VET) sector for one year to eighteen months to Diploma level, before being qualified to enrol with the NMBA. They may also undertake additional study to work at a more advanced level. The Diploma qualification enables enrolled nurses to administer some medicines to patients.

* Unless stated, all references to nurses and nursing in this publication encompass the work of midwives and midwifery services.

A SNAPSHOT OF NURSING CAREERS, QUALIFICATIONS AND EXPERIENCE

Assisting in Nursing (AIN)	No national standard formal qualification mandated. Varies from minimal educational preparation to traineeships in aged care through to Certificate III in aged care in the vocational education and training (VET) sector	Do not have a scope of practice. Variety of personal care activities, with the supervision of a registered nurse	Aged and disability care and some areas of the acute health sector
Enrolled Nurse (EN)	Diploma qualification in the VET sector	Variety of clinical activities around direct patient care, with the supervision of a registere nurse	All areas of health and aged care
Advanced Practice Enrolled Nurse	Diploma qualification in the VET sector + post enrolment education and experience in the role	Broader variety of clinical activities around direct patient care, requiring less supervision by a registered nurse	All areas of health and aged care
Registered Nurse (RN)	Bachelor of Nursing qualification in the university sector	Wide variety of clinical activities around direct patient care including patient assessment, care planning, coordination of care and medicines management	All areas of health and aged care
Advanced Practice Registered Nurse	Bachelor of Nursing + postgraduate qualification in a specialist area of clinical practice	Wide variety of activities in a general or specialist areas of nursing practice which may include direct patient caqre, day to day clinical and staff management and clinical education of nursing colleagues	All areas of health and aged care
Registered Midwife (RM)	Bachelor of Nursing with postgraduate midwifery qualification OR Bachelor of Midwifery (direct entry) in the university sector	Pregnancy, labour, birth and post natal care for women and their babies	Health care facilities, general practice and community health settings and in private practice
Nurse Practitioner (NP)	Bachelor of Nursing + Masters qualification in specialist area of clinical practice + endorsement from Nursing and Midwifery Board of Australia to practice as a NP	Nurse Practitioner is the most advanced clinical nursing role. Each NPs scope of practice is determined by the context in which they are endorsed to practice and may involve referral of patients to other health professionals, prescribing medicines and ordering diagnostic investigations	All areas of health and aged care

DEMOGRAPHICS ON THE EMPLOYMENT OF NURSES AND MIDWIVES

The following data is based on the National Health Workforce Dataset (NHWDS) 2020 published by the Australian Government Department of Health.[4]

According to the NHWDS, in 2019 there were a total of 404,896 nurses registered in Australia. 399,364 nurses were registered to practice and of these, 337,083 (84%) were registered nurses, midwives and dual registrants and 62,281 (16%) were enrolled nurses.[5]

Not all nurse and midwife registrants are in the nursing workforce. In 2019 there were a total of 373,514 nurses and midwives in the workforce. This number includes those employed; those on extended leave; those employed outside the profession and looking for work in nursing or midwifery and those not employed and looking for work in nursing or midwifery.

92.2% of registered nurses and midwives are in the nursing workforce. Of these, 92.4% were employed in nursing; 4.8% were on extended leave and 2.9% were looking for work in nursing. Of those nurses not in the nursing workforce, 24% were not employed and not looking for nursing work; 25% were working elsewhere and not looking for work in nursing; 23.6% were employed overseas in nursing and not looking for work in Australia; 13.7% were employed overseas in nursing and looking for work in Australia and 14.1% were retired.[6]

Table 1
Registered nurse, midwife and enrolled nurse workforce Australia 1993-2019

YEAR	RN/Midwife	EN
1993	175 392	57 211
1994	184 761	57 466
1995	178 996	52 167
1996	180 454	50 065
1997	183 060	48 832
1999	186 294	47 688
2001	189 674	46 888
2003	196 091	49 440
2004	202,994	50,598
2005	206,873	48,083
2007	223,313	53,984
2008	230,192	52,895
2009	236,305	54,941
2011	247,502	55,508
2012	255,549	55,627
2013	262,730	55,258
2014	268,242	55,469
2015	275,235	55,780
2016	283,784	56,473
2017	288,782	56,838
2018	302,606	58,683
2019	314,473	59,041

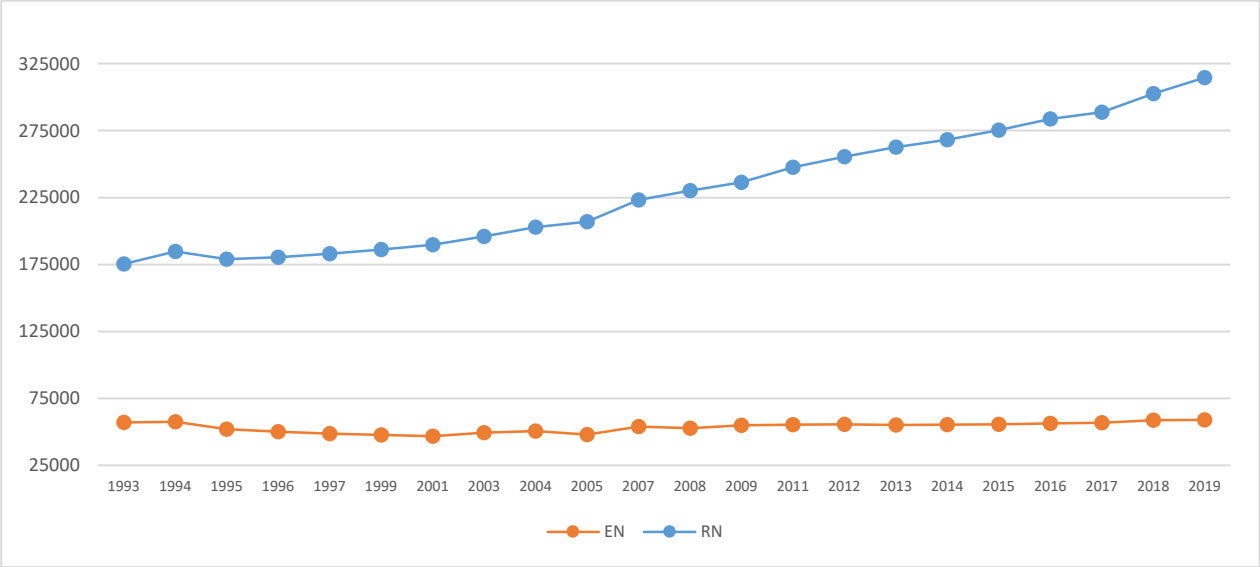
Source:
AIHW Nursing Labour Force 1997, 1998, 2001, 2003, 2005, 2006, 2008-2016, NHWDS 2017-2020

[4] http://data.hwa.gov.au/ (The Health Department took over this function from the AIHW in 2016)

[5] NHWDS Ibid

[6] For purpose of Table 1, the 2016 to 2018 figures for RNs include nurses with the dual registrations of RN & EN, RN & midwife, EN & midwife, RN, EN & midwife. The number for EN is those registered as EN only.

Figure 1
Registered nurse, midwifery and enrolled nurse workforce Australia 1993-2019



Source: AIHW Nursing Labour Force 1997, 1998, 2001, 2003 and AIHW Nursing and Midwifery Labour Force 2005, 2006, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, NHWDS 2017-2020

Table 2
Nursing and Midwifery Workforce 1993-2019

Year	1993	1994	1995	1996	1997	1999	2001	2003	2004	2005
In workforce	232,603	242,225	231,163	230,519	231,892	233,982	236,562	245,531	253,592	254,956
Not in Workforce	38,117	26,745	27,996	25,085	23,659	22,956	23,513	27,846	29,110	30,663
% of RNs & ENs not in workforce	14.1	9.9	10.8	9.8	9.3	8.9	9.0	10.2	10.3	10.7
Year	**2007**	**2008**	**2009**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
In Workforce	277,297	283,087	291,246	303,010	311.176	317,988	323,711	331,015	340,257	348,928
Not in Workforce	28,538	29,649	29,735	23,659	22,902	26,202	29,127	28,993	29,683	25,288
% of RNs & ENs not in workforce	9.3	9.5	9.3	7.2	6.9	7.6	8.3	8.05	8.02	6.9
Year	**2018**	**2019**								
In Workforce	361,289	373,514								
Not in Workforce	30,749	31,381								
% of RNs & ENs not in workforce	8	7.9								

The 2019 data shows that the largest proportion of nurses and midwives were employed in clinical practice (91.5%). Of these, 26% were employed in the clinical practice areas of medical and surgical nursing; 14.3% were employed in aged care; 12.4% in critical care and emergency; 9% in operating theatres; 7% in mental health; 4.6% in general and medical practice nursing and 4.2% in community nursing.

Overall, 28,599 nurses were authorised as midwives. Of these, 5205 were registered midwives only. A total of 26,371 midwives were employed and working in midwifery.

Approximately 61.3% of employed nurses and midwives work in public and private acute hospitals;12.8% in residential health care facilities; 7.3% in community health care services; 3.8% in GP practice and the rest in other nursing areas including government departments, schools, universities, industry, defence force facilities, correctional services and private practice.

About 72.6% of all employed nurses work in major cities; 10% in regional centres; 15.5% in large, medium and small rural towns and 1.9% in remote and very remote communities. Large rural towns had the highest supply of employed nurses, with 1524.6 full time equivalent nurses per 100,000 population. Small rural towns had the lowest supply at 643.3 full time equivalent nurses per 100,000 population.

It was estimated in 2016 that there were 108,126 unlicensed nursing and personal care assistants employed in the residential aged care sector to assist nurses in the provision of nursing care. Around 80.3 % are employed part time, 8.9% full time and 10.8% casual.[7]

Overall the supply of employed nurses and midwives in 2019 was 1,215.2 FTE per 100,000 population, using the Modified Monash Model (MMM2019).

Average hours worked by all nurses and midwives was 33.5 hours per week, similar to 2018 and 2017. Average hours worked by RNs was 33.5 hours per week. For Enrolled nurses average hours worked remained the same at 31.6 per week and for midwives, average midwifery hours were 20 hours per week, similar to the previous year.

In 2019, the average age for all nurses and midwives was 43.6; for registered nurses 43.4; midwives 47.3 and for enrolled nurses it was 45.3 years. Almost 50% of the nursing workforce is aged 45 years and over with 25% aged 55 years and over.

These figures have implications for nursing education and for workforce planning as almost 50% of nurses will be contemplating retirement within the next 10-15 years and it is likely they will be those with the most experience and with specialist qualifications or expertise.

There has been little change over time in the number of males employed in nursing and midwifery, with males comprising 11% of the employed nursing and midwifery workforce in 2019 (up from 8.4% in 2001).

Patient separations in acute public hospitals have remained relatively stable. The latest figures show that there were 42.4 patient separations per full time equivalent nurse in 2018-2019.[8] This is similar to the previous year which was 42.7 separations per full time equivalent nurse.

[7] Mavromaras K, Knight G, Isherwood L, etal 2017. The Aged Care Workforce 2016.

[8] Admitted Patient Care 2018-19 –Australian Hospital Statistics
https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients
Hospital Resources 2018-19 – Australian Hospital Statistics

In 2019, half of all employed nurses and midwives worked less than 35 hours per week. Approximately 60% of enrolled nurses worked less than 35 hours per week compared with 48% of registered nurses and midwives. For those registered as midwife only, 52% work less than 35 hours per week.

The number of students commencing undergraduate nursing and midwifery courses leading to initial registration as a registered nurse or midwife dropped slightly from 26,645 to 26,493 in 2019. However, commencements have increased 48%. Over the same period, the proportion of commencing students on temporary entry permits increased from 13% in 2012 to 21% in 2019.

Table 3

Number of commencements for initial registration as a nurse, by citizenship, 2012-2019

A general nursing course required for initial registration

State/Territory/citizenship/ detailed field of education	2012	2013	2014	2015	2016	2017	2018	2019
TOTAL	17,862	18,989	20,266	22,049	23,645	24,362	26,645	26,493
Australian citizen	14,141	15,108	16,174	17,617	18,874	19,071	20,222	19,197
New Zealand citizen	164	200	196	214	266	275	271	284
Permanent resident	922	867	959	984	980	1,106	1,201	1,290
Temporary entry permit	2,357	2,576	2,717	3,023	3,343	3,770	4,758	5,543
Other overseas	115	93	93	76	74	7	0	13
Permanent humanitarian visa	163	145	127	135	108	133	193	166

Source: https://docs.education.gov.au/node/55059

The demand for undergraduate nursing or midwifery courses remains strong. The data consistently shows there are many more people wanting to undertake nursing or midwifery courses than there are places available. In relation to domestic applicants, Table 4 below highlights the gap between the number of applicants and offers of university places in nursing or midwifery courses from 2010 to 2019. In 2019, 36,057 people applied while 26,120 applicants were offered a place.

Table 4

Undergraduate applications, offers and acceptances 2010-2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Applications	24,185	24,230	24,603	24,999	27,537	30,886	34,706	35,871	36,517	36,057
Offers	17,579	17,796	18,859	19,750	21,001	24,130	26,788	26,247	26,694	26,120
*Acceptances	13,285	13,284	14,494	14,759	16,387	19,105	21,190	20,547	20,773	20,360,

Source: Undergraduate Applications Offers and Acceptances Publications, Australian Government Department of Education and Training

The number of students completing undergraduate nursing or midwifery courses has also continued to grow with 13,686 domestic students completing undergraduate courses leading to initial registration as a nurse or midwife in 2019.

The breakdown of graduates by citizenship in Table 5 shows a 62% increase in the number of graduates since 2012, with 17,178 in total graduating in 2019.

Table 5

Number of completions for initial registration as a nurse, by citizenship, 2012-2019

A general nursing course required for initial registration

State/Territory/ citizenship/detailed field of education	2012	2013	2014	2015	2016	2017	2018	2019
TOTAL	10,635	11,084	11,640	12,041	13,443	14,010	15,270	17,178
Australian citizen	8,063	8,481	8,991	9,254	10,399	10,849	11,717	12,806
New Zealand citizen	67	77	93	105	121	119	177	152
Permanent resident	342	431	467	410	465	512	566	653
Temporary entry permit	2,048	1,967	1,922	2,141	2,324	2,399	2,741	3,485
Other overseas	71	68	87	81	78	62	17	7
Permanent humanitarian visa	44	60	80	50	56	69	52	75

Source: https://docs.education.gov.au/node/55065

While the ongoing improvement to the number of nursing graduates is very positive for the continued growth of the nursing and midwifery workforce, the ANMF is concerned that not all graduates and early career nurses are finding employment in nursing or midwifery. Governments in some States and Territories have committed to increasing the number of graduate employment opportunities in the public health system. The ANMF is currently monitoring the impact of these changes.

NB: Comparison with figures prior to 2009 is not possible due to the introduction of the “demand driven system” intended to provide access to more university places. Previously figures were based on “eligible applicants” which excluded applicants below an agreed Tertiary Education Rank (TER).

NURSES AWARD 2010

The Nurses Award 2010 commenced on 1 January 2010. It applies to nurses working under the national industrial relations system who aren't already covered by an enterprise agreement. The Award sets minimum wage rates, types of employment, hours of work, overtime and penalty rates, allowances, leave procedures, consultation and dispute resolution and other conditions of employment.

Scope of the Nurses Award 2010

The Nurses Award 2010 applies to registered nurses, (including Division 1 nurses), enrolled nurses (including Division 2 nurses) and nursing assistants. The nursing assistant is someone who reports to a registered or enrolled nurse and whose employment is solely to assist a nurse in the provision of nursing care or nursing services.

The Nurses Award 2010 will cover most private sector nurses working in aged care facilities, private hospitals, and private sector specialist services such as medical practices.

Please note: the Nurses Award 2010 does not cover nurses employed in schools.

A definition of nursing work

The Nurses Award 2010 has a broad interpretation of nursing work. Under the Award, nursing care means:

- giving assistance to a person who, because of disability, is unable to maintain their bodily needs without frequent assistance;
- carrying out tasks that 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.

A full copy of the Nurses Award 2010 is available at:
http://www.fwc.gov.au/documents/modern_awards/award/ma000034/default.htm

NURSES AWARD 2010
CLASSIFICATION STRUCTURE AND MINIMUM WEEKLY WAGES
as at 1 July 2021

Annual Wage Review decision 2020-21 [2021] FWCFB 3500 effective from the first full pay period on or after 1 July 2021

		1 July 2021 Per Week $
14.1	**Nursing Assistant**	
	1st year	843.40
	2nd year	857.20
	3rd year	871.50
	Experienced (the holder of a relevant certificate III qualification)	899.50
14.2	**Enrolled nurses**	
	(a) Student Enrolled Nurse	
	Less than 21 years of age	780.70
	21 years of age and over	821.40
	(b) Enrolled Nurse	
	Pay point 1	916.20
	Pay point 2	928.30
	Pay point 3	940.60
	Pay point 4	954.20
	Pay point 5	963.80
14.3	**Registered Nurses**	
	Minimum entry rate for a:	
	(a) Four year degree is $1023.40 per week	
	(b) Masters degree is $1058.70 per week	
	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	980.10
	Pay point 2	1,000.20
	Pay point 3	1,024.80
	Pay point 4	1,052.00
	Pay point 5	1,084.30
	Pay point 6	1,115.70
	Pay point 7	1,148.00
	Pay point 8 and thereafter	1,177.80
	Registered Nurse - Level 2	
	Pay point 1	1,209.10
	Pay point 2	1,228.30
	Pay point 3	1,249.60
	Pay point 4 and thereafter	1,270.10
	Registered Nurse - Level 3	
	Pay point 1	1,311.00
	Pay point 2	1335.10
	Pay point 3	1358.10
	Pay point 4 and thereafter	1382.50

Registered Nurse - Level 4

Pay point 1	1,496.30
Pay point 2	1,603.50
Pay point 3	1,697.00

Registered Nurse - Level 5

Pay point 1	1,509.90
Pay point 2	1,590.10
Pay point 3	1,697.00
Pay point 4	1,802.90
Pay point 5	1,988.40
Pay point 6	2,175.60

14.4 Nurse Practitioner

1st year	1,508.60
2nd year	1,553.40

14.5 Occupational Health Nurses

Occupational Health Nurse - Level 1

Pay point 1	1,052.00
Pay point 2	1,084.30
Pay point 3	1,115.70
Pay point 4	1,148.00
Pay point 5	1,177.80

Occupational Health Nurse - Level 2

Pay point 1	1,209.10
Pay point 2	1,228.30
Pay point 3	1,249.60
Pay point 4	1,270.10

Senior Occupational Health Clinical Nurse 1,270.10

Occupational Health Nurse - Level 3

Pay point 1	1,331.00
Pay point 2	1,335.10
Pay point 3	1,358.10
Pay point 4 and thereafter	1,382.50

KEY PROVISIONS OF THE NURSES AWARD 2010

As set out in the order they appear in the award

Award flexibility

This clause allows certain terms of the award to be varied by written agreement to suit the individual needs of the employer and individual employee. The employee must not be disadvantaged by the application of this clause.

Consultation and dispute resolution clauses

A clause to manage the consultative and dispute settling processes at the workplace.

Provisions for full-time, part time and casual employment

Full-time employment is based on a 38-hour week. Part-time employment is less than an average of 38 ordinary hours per week, with reasonably predictable hours of work. Before commencing part-time employment, the employer and employee must agree in writing on the guaranteed minimum number of hours to be worked and the rostering arrangements. Casual employees receive a casual loading of 25%.

Wages

The award provides for minimum wage rates for each classification of employee (Registered Nurses, Enrolled Nurses and Assistants in Nursing). These wage rates will be subject to variation through annual national wage reviews conducted by Fair Work Australia.

Allowances

Provides for a range of allowances, some adjusted on an annual basis.

Hours of work

The maximum shift length, or hours of work per day, will be ten hours exclusive of meal breaks. The rest breaks between shifts will be at least 8 hours.

Overtime

Overtime is paid from Monday to Saturday at time and a half for the first two hours and double time thereafter; on Sunday at double time; and on public holidays at double time and a half. All time worked by part-time employees in excess of the rostered daily ordinary full-time hours is overtime. Where TOIL is accrued, it should be taken at overtime rates.

Annual leave

Annual leave is five weeks and six weeks for shift workers. A shift worker is defined as a employee who:

a) is regularly rostered over seven days a week; and
b) regularly works on weekends.

Public holidays

ll work done by an employee during their ordinary shifts on a public holiday including a substituted day is paid at double time of the ordinary rate of pay.

Ceremonial leave

An employee who is legitimately required by Aboriginal tradition to be absent from work for Aboriginal ceremonial purposes is entitled to up to ten working days unpaid leave in any one year, with the approval of the employer.

National Employment Standards

In addition to the award clauses, each award must now operate with the National Employment Standards. There are 10 National Employment Standards including:

- Maximum ordinary hours of work;
- Request for flexible work arrangements;
- Offers and requests to convert from casual to permanent employment;
- Parental leave and related entitlements;
- Annual leave;
- Personal, carers leave, compassionate leave and unpaid family and domestic violence leave;
- Community services leave;
- Long service leave;
- Public holidays;
- Notice of termination and redundancy pay;
- Fair work information statement and Casual Employment Information statement.

A copy of the National Employment Standards is available on:
http://www.fairwork.gov.au/Documents/The-National-Employment-Standards-Part2-2-Fair-Work-Act-2009.pdf

THE APPLICATION OF MODERN AWARDS AND ENTERPRISE AGREEMENTS UNDER THE FAIR WORK ACT

Minimum employee entitlements - Awards, the NES and Enterprise agreements

Nurses in the main, are covered by the national workplace relations system regulated by the Fair Work Act 2009 (FWA) with the major exception being nurses employed in the public sector in New South Wales, South Australia, Western Australia, Tasmania and Queensland. (See the State based public sector agreements on pages 22 and 23 for the respective States).

For nurses covered by the national system, the Nurses Award 2010, together with the National Employment Standard (NES), provides the safety net of wages and conditions of employment, except for those employed in primary and secondary schools who are covered by the Educational Services (Schools) General Staff Award 2010.

However, for the vast majority of nurses and midwives, wages and conditions are determined by enterprise agreements negotiated by the ANMF and nursing employers across all areas of the public and private health and aged care sectors. Under the national workplace relations system, where an approved enterprise agreement is in operation, the wages and conditions under the agreement apply in place of the Award.

Agreement making under the Fair Work Act 2009

The Fair Work Act 2009 sets out the rules and requirements for negotiating enterprise agreements, including rights and obligations of the employer, employees and bargaining representatives and the process that must be followed. A bargaining representative is a person or organisation that each party may appoint to represent them during the negotiations. Where employees are members of a union, the union is automatically a bargaining representative regardless of the number of members at a workplace.

An employer must notify employees of their right to be represented by a bargaining representative during the bargaining process by providing a “Notice of Employee Representational Rights” (NERR). Specific rules apply to when the employer provides the notice and the information provided in the NERR. (This requirement does not apply to Greenfields agreements, that is, where it is a new enterprise before any employees are employed).

The Fair Work Act 2009 sets out good faith bargaining requirements that bargaining representatives are required to meet such as attending and participating in meetings at reasonable times; responding to proposals in a timely manner and giving genuine consideration to proposals. It does not however, require parties to reach agreement on terms to be included in the agreement.

The taking of “protected industrial action” in support of bargaining is subject to specific requirements under the FWA. If industrial action by employees is not “protected” employees and their union may be subject to orders from the Fair Work Commission and subsequent fines if the industrial action is continued.

Voting

Employees who will be covered by an enterprise agreement must have the opportunity to vote for or against the proposed agreement. The FWA sets out the requirements in relation to information and access to the documents before voting commences. A vote is successful if the majority of employees who cast a valid vote endorse the agreement.

If employees vote in favour of the enterprise agreement the agreement is “made” and it can be submitted to the FWC for approval.

Better off overall test

Before the FWC approves an agreement the Commission must be satisfied that it meets a number of requirements under the FWA including the Better Off Overall Test (BOOT). For an agreement to pass the BOOT, the FWC must be satisfied that employees will be better off overall if the agreement applied rather the relevant award.

Generally, an enterprise agreement operates seven days after it is approved by the FWC.

Please note the above information is a brief overview only. For further information please contact your ANMF Branch. (Contact details are at page 43.)

PUBLIC SECTOR NURSES' AWARDS/AGREEMENTS

This part of PAYCHECK provides an overview of the salary increases payable in the public hospital sector in each state and territory. The data also provides information on the tranches of such wage increases.

It should be noted that such agreements often provide a range of additional benefits that may increase a nurse's remuneration.

For further detail on such information, please refer to:

Fair Work Commission:
http://www.fwc.gov.au/

Western Australian Industrial Relations Commission:
http://www.wairc.wa.gov.au/

South Australian Employment Tribunal
https://www.saet.sa.gov.au/

Queensland Industrial Relations Commission
http://www.qirc.qld.gov.au/

New South Wales Industrial Relations Commission
http://www.industrialrelations.nsw.gov.au/Home.html

Tasmanian Industrial Relations Commission
https://www.tic.tas.gov.au/

STATE PUBLIC SECTOR NURSES' AWARDS/AGREEMENTS

State	Award / Agreement	Details of Increase	Expiry Date
NSW	Public Health System Nurses' and Midwives (State) Award 2021 [Reference Pending]	2.04% 01.07.2021	30.06.2022
ACT	ACT Public Service Nursing and Midwifery Enterprise Agreement 2017-2019 [AE503830]	2.25% 01.10.17 0.5% 01.06.18 1.35% 01.12.18 1.35% 01.06.19 1.35% 01.12.19 New agreement pending Interim administrative increases as follows: 1.35% 01.06.2020 1.35% 01.12.2020 And 0.5% increase to super effective 1 July 2020	31.12.2019
QLD	Nurses and Midwives (Queensland Health and Department of Education Certified Agreement (EB10) 2018 [No. CB/2020/44]	2.5% 01.04.2018 2.5% 01.04.2019 2.5% 01.04.2020 2.5%* 01.10.2021 Additional one-off payment of $1,250 to full time nurses and midwives (pro-rata for part time and casual employees). Applies to classifications up to Nurse Grade 8. Paid December 2019. *State government legislated a deferral of 1 April wage increase to 1 October 2021.	31.03.2022
NT	Northern Territory Public Sector Nurses and Midwives' 2018-2022 Enterprise Agreement [AE501953]	2.5% 09.08.2018 2.5% 09.08.2019 2.5% 09.08.2020 2.5% 09.08.2021	20.08.2022

STATE PUBLIC SECTOR NURSES' AWARDS/AGREEMENTS

State	Award / Agreement	Details of Increase	Expiry Date
SA	Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2020 [ET-20-02747]	2% 01.01.2020 2% 01.01.2021 2% 01.01.2022	17.07.2022
TAS	Nurses and Midwives (Tasmanian State Service) Agreement 2019 [T14763 of 2020] Caseload Midwifery Industrial Agreement 2019 [T14762 of 2020]	2.3% 1.12.2019 2.3% 1.12.2020 2.35% 1.12.2021 2.35% 1.12.2022	30.06.2023
WA	WA Health System - Australian Nursing Federation - Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses - Industrial Agreement 2020 [AG 8 of 2021] 2021 WAIRC 00144	$1000 12.10.2020 $1000 12.10.2021	11.10.2022
VIC	Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2016-2020 [AE422722]	There are four annual pay increases in the first four year agreement and three in the second. From the first full pay period commencing on or after: 1 April 2016 - CPD Allowance rolled into rate and an additional 3% 1 April 2017 3% 1 April 2018 3.25% 1 April 2019 Adjustments to rates as per Attachment 2 (4%-26% depending on Classification and experience - see agreement) Subsequent wage certainty 1 Dec 2020 3% 1 Dec 2021 3% 1 Dec 2022 3%	31.03.2020

GLOSSARY OF TERMS

AAIN	Advanced Assistant in Nursing
ADON	Assistant Director of Nursing
ADON/ND	Assistant Director of Nursing/Nursing Director
AIN	Assistant in Nursing
AIN/M	Assistant in Nursing/Midwifery
AN	Assistant Nurse
CN	Clinical Nurse
CN/MC	Clinical Nurse/Midwifery Consultant
CN/ME	Clinical Nurse/Midwifery Educator
CN/MS	Clinical Nurse/MidwiferySpecialist
COM/FCH	Community/Family Child Health Nurse
DDON	Deputy Director of Nursing
DON	Director of Nursing
E/DDN	Executive/District Director of Nursing
EN	Enrolled Nurse (RN Division 2 in Victoria)
EN ME	Enrolled Nurse with Medication Endorsement
EP	Exemplary Practice (NT)
NA	Nursing Assistant / Nursing Attendant
N	Nurse
N/MUM	Nursing/Midwifery Unit Manager
NO	Nursing Officer
NP	Nurse Practitioner
NS	Nurse Specialist
OHC	Occupational Health Clinical
OHS	Occupational Health and Safety
PP	Paypoint
RE	Re-entry
RN	Registered Nurse (RN Division 1 in Victoria)
RN/M	Registered Nurse/Midwife
RUSON	Person currently enrolled at a University to undertake nursing study, who is registered with AHPRA as a student nurse, and who at commencement, has successfully completed not less than twelve months of the Bachelor of Nursing Degree
SN	Student Nurse
SRN	Senior Registered Nurse
TEN	Trainee Enrolled Nurse

PUBLIC SECTOR NURSES' SALARY DATA

This part of Nurses and Midwives' Paycheck provides nurses' wage rates for each state and territory effective from the dates provided in the table that follows. The salary data provides weekly rates of pay for each classification relevant to the public sector in the particular state or territory.

The rates of pay are derived from the most recent public sector nurses' agreements registered by the Fair Work Commission or relevant state industrial authority.

It should be noted that the rates of pay are minimum weekly rates only and that awards and agreements provide for a range of additional benefits including various allowances and penalty rates that may increase a nurse's remuneration.

The commencement date for the rates of pay between the states or territories may differ. Please refer to the table on pages 22 and 23 for details.

Classifications and definitions may also vary across the states and territories. Further information should be obtained from the relevant award or agreement, a copy of which may be obtained from the following websites:

Fair Work Commission:
http://www.fwc.gov.au/

Western Australian Industrial Relations Commission:
http://www.wairc.wa.gov.au/

South Australian Employment Tribunal
https://www.saet.sa.gov.au/

Queensland Industrial Relations Commission
http://www.qirc.qld.gov.au/

New South Wales Industrial Relations Commission
http://www.industrialrelations.nsw.gov.au/Home.html

Tasmanian Industrial Relations Commission
https://www.tic.tas.gov.au/

PUBLIC SECTOR SALARY DATA

	NSW - 1/7/21	ACT - 10/12/20	QLD - 1/4/20	NT - 20/8/2020	SA - 1/1/21	TAS - 1/12/20	WA - 12/10/20	VIC - 1/12/20
AIN	1st year 904.70	Year 1: 1029.82	Gr Band Paypoint	N/A	**Assistant in Nursing and Midwifery**	**Assistant in Nursing**	N/A	N/A
NSW AIN/M	2nd year 933.50	Year 2: 1064.67	1 N/A 1: 1104.85			G1 Y1: 1042.10		
	3rd year 962.80		2: 1127.60		1st increment 1016.35	G1 Y2: 1076.37		
	4th year & thereafter 992.60		3: 1142.50		2nd 1046.45	G1 Y3: 1110.67		
			4: 1168.35			G1 Y4: 1145.04		
			5: 1195.25					
			6: 1209.70					
			Assistant in Nursing Sterilising Services (formerly CSSD)					
								Trainee Year 1: 911.80
			Gr Band Paypoint	**EN in Training**				Tainee Year 2: 986.80
			1 2 1: 1195.55	889.34				
			2: 1212.70					EN 1.1 (EN Y1) 1080.10
			3: 1230.55	**RN in Training**				EN 1.2 (EN Y2) 1102.20
			Undergraduate Students in Nursing and Midwifery	1005.30	**EN (Certificate)**			EN 1.3 (EN Y3) 1124.10
					1st increment 1110.55			EN 1.4 (EN Y4) 1146.40
					2nd 1118.60			EN 1.5 (EN Y5/6) 1190.30
EN	**Without Medication Qualification**		Gr Band Paypoint		3rd 1142.65			EN 1.6 (EN Y7/8) 1227.20
			2 N/A 1: 1127.60		4th 1166.70		**Enrolled Mental Health Nurses**	
	1st year 1110.30		2: 1142.50		5th 1190.75			EN 2.1 (EN Y1/2) 1160.00
	2nd year 1134.70				6th 1214.80	**ENs Grade 2**	PP 1 1140.53	EN 2.2 (EN Y3) 1185.80
	3rd year 1158.80		**ENs**		7th 1238.85	G2 YG: 1144.58	PP 2 1165.77	EN 2.3 (EN Y4) 1211.90
	4th year 1183.50	**ENs Level 1**	Gr Band Paypoint	**ENs**	**EN (with diploma)**	G2 Y1: 1179.33	PP 3 1190.93	EN 2.4 (EN Y1) 1237.80
	5th year & thereafter 1208.40	Year 1: 1214.07	3 N/A 1: 1195.55	N1 Yr 1: 1185.74	1st increment 1142.65	G2 Y2: 1212.48	PP 4 1216.12	EN 2.5 (EN Y6) 1263.60
	Special Grade 1246.10	Year 2: 1234.87	2: 1212.70	N1 Yr 2: 1222.43	2nd 1170.95	G2 Y3: 1247.31	PP 5 1241.31	EN 2.6 (EN Y7/8) 1276.70
		Year 3: 1255.59	3: 1230.55	N1 Yr 3: 1260.40	3rd 1197.65	G2 Y4: 1267.58	PP 6 1266.50	EN 2.7 (EN 5 routes) 1289.60
EN	**EN**	Year 4: 1276.35	4: 1249.00	N1 Yr 4: 1299.45	4th 1220.80	**ENs Grade 2 Specialist**	**Enrolled Nurse**	
	1st year 1134.70	Year 5: 1297.11	5: 1268.90	N1 Yr 5: 1340.36	5th 1250.85	Gr 2S Y1 1323.47	**(Mothercraft**	EN 3.1 (EN Y1-8 SA***) 1354.20
	2nd year 1158.80				6th 1287.00	Gr 2S Y2 1342.14	**Nursing Only)**	EN 3.2 (EN Y1-8) 4 routes 1402.70
	3rd year 1183.50	**EN Level 2**	**EN Advanced Practice**	**Nurse 1 Advanced Practice**		Gr 2S Y3 1360.76	Year 1 1073.41	EN 3.3 (EN Y1-8) 5 routes 1425.40
	4th year 1208.40	1317.93	Gr Band Paypoint		**EN (advanced skills)**	Gr 2S Y4 1379.39	Year 2 1091.94	
	5th year & thereafter 1232.90		4 N/A 1: 1306.45	1374.60	1st increment 1287.00		Year 3 1118.99	Ruson Year 1: 918.10
	Special Grade 1270.70		2: 1386.30		2nd 1311.00		Year 4 1147.21	Ruson Year 2: 979.30
							Year 5 1174.91	Ruson Year 3: 1040.50

NB.: New classification structure in Qld. Band, refers to position in previous structure

NT: EN & RN in Training = employees undertaking supervised practice under a re-entry program

	NSW	ACT	QLD	NT	SA	TAS	WA	VIC
RN	RN/M	RN Level 1	RN/M	Nurse 2	RN Level 1	Grade 3	RN 1	RN Grade 2
	1st year 1259.00	Year 1: 1338.63	Gr Band Paypoint	Year 1: 1340.36	1st increment 1287.00	G3 Y1: 1267.58	Level 1: 1316.88	Year 1 YP2: 1224.10
	2nd year 1327.30	Year 2: 1390.62	5 N/A RE: 1326.85	Year 2: 1412.51	2nd 1327.30	G3 Y2: 1323.47	Level 2: 1367.25	Year 2 YP3: 1293.00
	3rd year 1395.90	Year 3: 1447.88	(NO1) 1: 1388.90	Year 3: 1484.67	3rd 1384.05	G3 Y3: 1379.39	Level 3: 1419.66	Year 3 YP4: 1361.90
	4th year 1469.30	Year 4: 1515.89	2: 1454.20	Year 4: 1556.86	4th 1443.30	G3 Y4: 1435.25	Level 4: 1474.12	Year 4 YP5: 1435.80
	5th year 1542.30	Year 5: 1583.98	3: 1519.60	Year 5: 1640.94	5th 1503.40	G3 Y5: 1491.18	Level 5: 1530.79	Year 5 YP6: 1509.30
	6th year 1614.80	Year 6: 1652.03	4: 1584.85	Year 6: 1704.06	6th 1563.90	G3 Y6: 1547.04	Level 6: 1589.73	Year 6 YP7: 1580.80
	7th year 1697.90	Year 7: 1720.07	5: 1650.40	Year 7: 1773.32	7th 1624.40	G3 Y7: 1603.07	Level 7: 1651.04	Year 7 YP8: 1661.60
	8th year & thereafter 1767.70	Year 8: 1788.17	6: 1716.00		8th 1684.90	G3 Y8: 1621.66	Level 8: 1714.74	Year 8 YP9: 1728.90
	CN/MS		7. 1781.45		9th 1756.05	G3 Y9: 1637.88		Year 9 YP10: 1728.90
	Grade 1 Year 1 1839.60							Year 10 YP11: 1728.90
	Grade 2 Year 1 1976.10							
	Grade 2 Year 2 2041.00				Clinical Nurse/Midwife2) (Level 2)			
	CN/MC				1st increment 1503.40			
	(Appointed prior to 31/12/99)				2nd 1563.90			
	2262.10				3rd 1624.40			
	(Appointed after 31/12/99)				4th 1684.90			
	Grade 1 1st Year 2211.30				5th 1756.05			
	Grade 1 2nd Year 2256.50				6th 1777.55			
	CN/MC Grade 2	RN Level 2	CN/CM	Nurse 3	7th 1818.50	Grade 4	RN 2	
	Grade 2 1st Year 2301.10	Year 1: 1858.97	Gr Band Paypoint	Year 1: 1847.31	8th 1859.45	G4 Y1: 1640.27	Level 1: 1766.86	
	Grade 2 2nd Year 2346.90	Year 2: 1896.10	6 N/A 1: 1811.95	Year 2: 1921.25	9th 1900.40	G4 Y2: 1677.54	Level 2: 1801.71	
	CN/MC Grade 3	Year 3: 1933.15	(NO2) 2: 1854.55	Year 3: 1973.75		G4 Y3: 1714.85	Level 3: 1837.33	
	Grade 3 1st Year 2437.00	Year 4: 1970.25	3: 1897.20			G4 Y4: 1734.71	Level 4: 1873.65	
	Grade 3 2nd Year 2482.30		4: 1940.20					
			Associate/Advanced Practice role		Associate Nurse/Midwife			
	CN/ME				Unit Manager (Level 2)			
	Year 1 1914.00		Gr Band Paypoint		1st increment 1777.55			CNS YS9
	Year 2 & thereafter 1976.10		6-7A N/A 1: 2036.70		2nd 1818.50			1799.10
					3rd 1859.45			
					4th 1900.40			

	NSW	ACT	QLD	NT	SA	TAS	WA	VIC
RN			**Clinical Nurse Consultant** **Nurse Unit Manager** **Nurse Manager** **Nurse Educator** **Nurse Researcher** **Public Health Nurse** **Nurse Practitioner** **Candidate**		**Nurse/Midwife:** **Unit Manager** **Consultant** **Educator** **Manager** **(Level 3)**	**Grade 5**		**RN Grade 3A**
	Nurse/Midwife Educator	**RN Level 3 Gr 1**	**Gr Band Paypoint**	**Nurse 4**	1st increment 2153.00	G5 Y1: 1761.85	**SRN**	1802.50
	Employees on N/ME	Year 1: 2131.23	7 N/A 1: 2224.90	Year 1: 2055.52	2nd 2201.10	G5 Y2: 1789.37	Level 1: 2110.26	
	4th Year as at 1/7/2008 2262.10	Year 2: 2175.09	2: 2325.55	Year 2: 2127.68	3rd 2249.20	G5 Y3: 1826.60	Level 2: 2176.14	
	Gr 1 Y1 2149.90	Year 3: 2218.93	3: 2383.40	Year 3: 2208.56		G5 Y4: 1843.70	Level 3: 2244.16	**RN Grade 3B**
	Gr 1 Y2 & thereafter 2211.30		4: 2415.50		**Nurse/Midwife:** **Advanced Unit Manager** **Advanced Consultant** **Advanced Educator** **Advanced Manager** **Nurse Practitioner** **(Level 4)**	G5 Y5: 1862.16	Level 4: 2314.34	1854.00
	Gr 2 Yr 1 2301.10		**Nurse Practitioner**	**Nurse 5**			Level 5: 2386.80	
	Gr 2 Yr 2 & thereafter 2346.90		**Gr Band Paypoint**	Year 1: 2263.75		**Grade 6**	Level 6: 2534.71	
	Gr 3 Y1 2437.00	**RN Level 3 Gr 2**	8 N/A 1: 2505.10	Year 2: 2358.81		G6 Y1: 1903.36	Level 7: 2692.01	**Associate Charge Nurse/ANUM**
	Gr 3 Y2 & thereafter 2482.30	Year 1: 2409.32	2: 2567.40			G6 Y2: 1947.00	Level 8: 2859.28	Year 1: 1936.60
			3: 2615.35		1st increment 2273.25	G6 Y3: 1990.73	Level 9: 3018.29	Year 2: 2001.70
	Nurse/Midwife Practitioners	**Nurse Practitioner**			2nd 2333.40	G6 Y4: 2003.53	Level 10: 3186.33	
		2580.12	**DON Rural & Remote**		3rd 2369.50	G6 Y5: 2023.59		**RN Grade 4A**
	1st year 2437.00		Gr Band Paypoint					Year 1: 1957.00
	2nd year 2482.30		9 N/A 1: 2558.65		**Nursing/Midwife Director (Level 5)**	**Grade 7**		Year 2: 1957.00
	3rd year 2545.70	**RN Level 4**	2: 2674.40	**Nurse 6**		G7a Y0: 2031.77		
	4th year & thereafter 2609.40	Grade 1: 2409.32	3: 2740.90	Year 1: 2488.55	1st increment 2477.70	G7a Y1: 2078.38		**RN Grade 4B**
		Grade 2: 2580.12		Year 2: 2588.11	2nd 2766.40	G7a Y2: 2124.92		Year 1: 2060.00
		Grade 3: 2750.76	**ADON**		3rd 2910.70	G7a Y3: 2146.18		Year 2: 2060.00
	Nursing/Midwife Unit Manager		Gr Band Paypoint			G7b Y1: 2165.73		
	Level I 2217.70		10 N/A 1: 2615.35		**Director of Nursing/Midwifery**	G7b Y2: 2206.55		**Charge Nurse/NUM**
	Level II 2322.70		2: 2742.10		**(Level 6)**	G7b Y3: 2247.35		Year 1: 2285.30
	Level III 2385.30				1st increment 2477.70	G7b Y4: 2269.81		Year 2: 2285.30
			ND/DON		2nd 2622.05			Year 3: 2285.30
		RN Level 5	Gr Band Paypoint	**Nurse 7**	3rd 2766.40	**Grade 8**		
		Grade 1: 2409.32	11 N/A 2926.65	Year 1: 2795.62	4th 2910.70	* G8 L1: 2288.47		**RN Grade 5**
		Grade 2: 2580.12	12 N/A 3221.95	Year 2: 2895.88	5th 3055.05	G8 L2: 2307.14		13-50 beds 2060.00
		Grade 3: 2750.76			6th 3319.65	G8 L3: 2403.99		51-200 beds 2163.00
		Grade 4: 2945.89		**Nurse 8**	7th 3632.40	G8 L4: 2500.74		201-400 beds 2214.50
		Grade 5: 3287.47		Year 1: 3011.41		G8 L5: 2672.94		401-600 beds 2266.00
		Grade 6: 3629.01		Year 2: 3112.32				601 and over 2266.00

Explanations about particular classifications in SA and Vic are on page 30.

A = Metropolitan (Victoria) B = Country (Victoria)

RN

NSW

Nurse/Midwifery Managers

Grade 1 1st Yr	2211.30
2nd Yr & thereafter	2256.50
Grade 2 1st Yr	2301.10
2nd Yr & thereafter	2346.90
Grade 3 1st Yr	2437.00
2nd Yr & thereafter	2482.30
Grade 4 1st Yr	2572.40
2nd Yr & thereafter	2617.60
Grade 5 1st Yr	2707.20
2nd Yr & thereafter	2753.00
Grade 6 1st Yr	2843.30
2nd Yr & thereafter	2888.80
Grade 7 1st Yr	3068.50
2nd Yr & thereafter	3114.20
Grade 8 1st Yr	3294.80
2nd Yr & thereafter	3339.70
Grade 9 1st Yr	3520.00
2nd Yr & thereafter	3565.50

Registered Mothercraft Nurse

Persons employed after 31 December 1988 are classified as Enrolled Nurses.

As at 30 June 2015 all existing Registered Mothercraft Nurses were classified as Registered Mothercraft Nurse 9th Year

9th Year $1,500.20

Registered Nurse

Pre Registration

1085.50

ACT

Qualifications Allowance

3.5% of RN Level 1 Year 1 for registered nurses:Honours Year, Conversion Degree, Graduate Certificate.
10/12/20: $47.00 p.w.

Diploma 4.5%
Second Degree
10/12/20: $60.43 p.w.

Masters/ Doctorate 5.5%
10/12/20: $73.86 p.w.

3.5% of EN Level 1 Year 1 for enrolled nurses: Course no less than 6 months or no less than 120 hours duration.
10/12/20 $42.63 p.w.

QLD

Nursing Director

DON

Gr	Band	Paypoint
13	1	3449.00

Executive DON

Gr	Band	Paypoint
13	2	4193.30

Qualifications Entitlements

For RN Nurse Gr 5 to 7 and DON Gr 10 Band 1 accelerated advancement by one paypoint.

If at the top paypoint of the classification, after 12 months service at that paypoint: 3.5% of rate of Gr 5 PP7 for Graduate Certificate/ Diploma or equivalent.
= $62.33 per week

For a Masters or PhD degree: if on the top paypoint of that classification, after 12 months service at that paypoint, 5.5% of rate of Gr 5 PP7
= $97.97 per week

NT

Exemplary Practice Allowance

Nurse 1 EP1
6% of
Nurse 1 Yr 4 rate

Nurse 2 EP 1
6% of Nurse 2 Yr 4

Nurse 2 EP 2
13% of Nurse 2 Yr 4

Qualifications Allowance

N1 (EN) -
Course no less than 6 mths or 120 hrs
3.5% of N1 Yr 5
$47.05 p.w.

N2-8 (RN)
Conversion degree or Grad. Certificate
3.5% of top increment N2
$62.27 p.w.

Grad. Diploma
4% of top Increment N2
$71.15 p.w.

Masters/Doctorate
5% of top increment N2
$88.94p.w.

SA

Qualifications Allowance

RNs/Midwives
Levels 1, 2, 3 and 4
Hospital/Graduate Certificate
(3.5% RN/M 1.9)
1.1.21 $3206.25 p.a.

Graduate Diploma
(4.5%)
1.1.21 $4122.32 p.a.

Second Degree/ Masters/PhD
(5.5%)
1.1.21 $5038.39 p.a.

Nurse/Midwife Specialists receive allowance for hospital certificate regardless of qualification held

Enrolled nurses with Diploma qualification or Ädvanced Skills", for post enrolment courses of not less than 6 months
(3.5% EN Dip 6th inc)

1.1.21 $2349.83 p.a.

TAS

*** Existing Level 1 employees as at 24/12/14 will be grandfathered at Level 1 for the life of the agreement**

Grade 9

G9 L1:	2972.48
G9 L2:	3135.53
G9 L3:	3331.60

Qualifications Allowance

RNs

Graduate Certificate 4.0%

Post Graduate Diploma/Degree 6.5%

Masters/Doctorate 7.5%

(of employee's wage rate)

NB:
Nurse Practitioners not entitled to a post-graduate allowance.

ENs

Advanced Diploma 4.0%

Recognised Specialist qualification in a relevant area of Practice 2.0%

WA

Qualifications Allowance

Level 1
(Grad Cert)
3.5% $60.02 p.w.

Level 2
(Grad/Dip/ Second Degree)
4.5% $77.16 p.w.

Level 3
(Masters/PhD)
5.5% $94.31 p.w.

(of base salary for RN Level 1 year 8)

VIC

Nurse Practitioner

Year 1:	2400.30
Year 2:	2445.90

RN Grade 6

51-100 beds	2163.00
101-200 beds	2266.00
201-300 beds	2266.00
301-400 beds	2575.00
401-500 beds	2575.00
501-700 beds	2987.00
701 and over	2987.00

RN Grade 7

Less than 13 beds	2369.00
13-24 beds	2369.00
25-50 beds	2369.00
51-100 beds	2369.00
101-200 beds	2369.00
201-300 beds	2472.00
301-400 beds	2575.00
401-500 beds	2698.00
501-600 beds	2884.00
601-700 beds	3588.10
701 and over	3588.10

Qualifications Allowance

Registered Nurse	
Certificate	$54.50 p.w.
Diploma	$88.50 p.w.
Masters	$102.10 p.w.
Doctorate or PhD	$136.20 p.w.
Enrolled Nurse	
6 month course	$49.10 p.w.
12 month course	$92.00 p.w.

	NSW	ACT	QLD	NT	SA	TAS	WA	
RN								
	Continuing Education Allowance				**Notes:**			
					Level 3 and Level 4 classifications are subject to criteria based on complexity of role and levels of responsibility			
	For RN Yr 1 to 8, NUM or NM Gr 1 and Gr 2, NM Gr 3 and CNS engaged in clinical work >50% of time:							
	Hospital Post Registration Certificate - $41.90 per week							
	Post Graduate Certificate - $41.90 per week							
	Post Graduate Diploma or Degree - $63.00 per week							
	Masters Degree or Doctorate - $75.70 per week							
	For ENs Cert 4 qualification - $30.20 per week							
	Adv. Dip. of Nursing - $37.90 per week							

PUBLIC HOSPITAL AND PRIVATE AGED CARE COMPARATIVE WAGE INFORMATION

This part of Nurses PAYCHECK provides an overview of residential aged care and the employment of nursing staff. It includes data on agreement coverage in the non public residential aged care sector and new average wages data based on an analysis of aged care agreements. It also provides a range of wage information relating to aged care in each state and territory, together with a comparison between public sector rates and aged care collective agreement rates of pay where applicable.

RESIDENTIAL AGED CARE SERVICES AND THE EMPLOYMENT OF NURSING STAFF

Resident characteristics

- 183,989 permanent residents in mainstream residential aged care services at 30 June 2020.
- Average age of residents in permanent care as at 30 June 2020:
  - All 84.9
  - Aboriginal and Torres Strait Islander people 73.9
  - Non-Indigenous 85

Resident dependency levels

In 2019, one third of residents were classified as "high care" in all three domains: Complex health care; Activities of Daily Living and Cognition and Behaviour. About half (52%) had a high care need rating in Complex health care; 54% were rated high care in the Cognition and Behaviour and 60% in the Activities of Daily Living domains respectively. (Gibson D. 2020)

Number of aged care services and providers

As at June 2020 there were 2,722 residential aged care services providing 217,145 resident places (excluding flexible places) delivered by 845 providers.

Number of operational residential aged care places

30 June 1995	134,810
30 June 2005	161,765
30 June 2010	179,749
30 June 2012	187,941
30 June 2013	186,278
30 June 2014	189,283
30 June 2015	192,370
30 June 2016	195,825
30 June 2017	200,689
30 June 2018	207,142
30 June 2019	213,297
30 June 2020	217,145

Ratio of residential aged care places per 1000 persons aged 70 years and over

30 June 2005	86.4
30 June 2009	87.0
30 June 2010	86.8
30 June 2011	85.7
30 June 2012	84.4
30 June 2013	86.0
30 June 2014	82.6
30 June 2015	81.1
30 June 2016	79.7
30 June 2017	77.9
30 June 2018	75.9
30 June 2019	77.5
30 June 2020	74.8

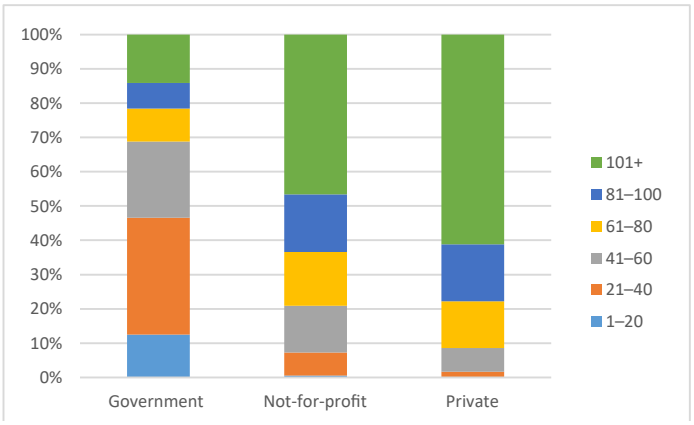
Average number of places per facility

1998	46.4	2015	81.1
2006	60.0	2016	73.4
2010	64.8	2017	75.1
2012	69.0	2018	76.9
2013	68.5	2019	78.5
2014	70.4	2020	79.8

Ownership of residential aged care places

Private for profit providers	41.2%
Private not for profit providers	31.8%
Religious providers	23.2%
State/Territory/local government	3.8%

Places in Residential care, by organisation type and size of service, at 30 June 2020



(Total number of places in residential aged care excludes 77 places of unknown organisation type)

Registered and enrolled nurses in residential aged care

The number of registered and enrolled nurse full-time equivalent positions in residential aged care has dropped by 13% since 2003. Between 2003 and 2015 the number of residential aged care places has increased by 30% and dependency levels of residents have increased from 64.4% assessed as high care in 2003, to 89% in 2015. (See note below)

Wages gap

Full time residential aged care nurses now earn approximately an average of $238 per week less (calculated on the base rate) than their colleagues in other sectors resulting in increasing difficulties attracting and retaining adequate numbers of appropriately trained nursing staff.

Note:

Overall levels of "high" and "low" care are no longer reported by AIHW. The figure for 2015 is derived from the Distribution of care need domain ratings, at June 2015 using the same process to determine the overall high/low distinction in the 2013-14 Report.

The figure of 89% of residents with an overall classification of high care represent people classified as high care if they had an ACFI appraisal of either high in Activities of Daily Living or high in Complex Health Care, or high in Behaviour together with low or medium in at least one of the other two domains, or medium in at least two of the three domains. (http://www.aihw.gov.au/aged-care/residential-and-home-care-2013-2014)

Sources:

AIHW 2000 Residential Aged Care Facilities in Australia 1998-99: A Statistical Overview

AIHW 2011 Residential Aged Care in Australia 2009-2010: A Statistical Overview

AIHW 2016 Residental Aged Care and Home Care 2014-15 Web Report

AIHW 2017 GEN fact sheet 2015-16: People's care needs in aged care. Canberra:

AIHW Nursing Labour Force 1999; 2001; 2002; 2003

AIHW Nursing and Midwifery Labour Force 2005

AIHW 2004 Residential Aged Care Facilities in Australia 2002-03

Department of Health 2016 Report on the operation of the Aged Care Act 1997

Gibson, D. 2020, Who uses residential aged care now, how has it changed and what does it mean for the future? Australian Health Review 2020, 44, 820-828

Martin B and King D, 2008, *Who Cares For Older Australians?* National Institute of Labour Studies, Flinders University, Adelaide, Australia.

Mavromaras K, Knight G, Isherwood L, etal 2017. The Aged Care Workforce 2016. Commonwealth of Australia as represented by the Department of Health Report on Government Services 2015, 2016, 2017, 2018 and 2019

AGED CARE DATA

This section of Paycheck provides information on agreement coverage in the non-public residential aged care sector and an analysis of the wage rates for key nursing classifications based on 718 enterprise agreements operating as at 15 May 2021. The information is updated on a quarterly basis as new agreements are approved by the Fair Work Commission. It includes data at a national level as well as by each State and Territory.

Australia wide, the proportion of facilities covered by awards is 8.7% and the proportion of facilities where the entire nursing workforce is covered by agreements is 91.3%. There has been no change in coverage since the last edition of Paycheck.

Agreements in non-public residential aged care

As at 15 May 2021, we have identified a total of 707 unique agreements operating in the residential aged care sector. The combined total of agreements operating in all States/Territories is 718 - eleven more than the count for Australia as a whole because of seven multistate agreements operating across two states/territories and two agreements operating in three states. The total count of Agreements has not changed since the last edition of Paycheck.

Table 1: Count of current or most recent agreements by State/Territory and nationally

	Count
NSW	223
VIC	214
QLD	77
SA	98
WA	49
TAS	38
NT	4
ACT	15
Australia	718

Agreement coverage and award reliance

Across Australia, 86.2% of all aged care facilities have their entire nursing workforce covered by enterprise agreements (2138 out of 2479 facilities). This coverage rate is calculated by mapping enterprise agreements to the Australian Government Department of Social Services list of Non-Public Sector Residential Aged Care Services (excluding services associated with public hospitals or publicly funded regional area health services). 84% of these fully covered facilities are covered by a single agreement setting out wages and conditions for all classifications of nursing staff (RN, EN and AIN/PCW). In 4.9% of facilities, nursing classifications are partially covered by agreements and partially covered by the Nurses Award.

Only 8.9 % of facilities are totally award reliant. On a State/Territory basis, the percentage share of facilities that are totally reliant on awards is 5.7% in NSW; 2.8% in VIC; 3.2% in SA; 1.5% in TAS; 8.0% in ACT; 22.0% in QLD and 18.3% in WA. In the Northern Territory, all facilities are fully covered by agreements.

Agreement coverage varies markedly across the State and Territories: The Northern Territory and Victoria record the highest rate of complete coverage. All 12 facilities in the Northern Territory are completely covered by agreements and 580 out of 597 facilities in Victoria (97.2%) are completely covered by enterprise agreements. More than 90% of facilities are fully covered by agreements in NSW and Tasmania. In NSW, 94.3% (814 out of 863) of all facilities are covered completely by agreements. In Tasmania, 92.6% (63 out of 68) are fully covered. In Queensland 78.0% (353 out of 454) are fully covered.

In South Australia, roughly half (48.6%) of all facilities are fully covered by enterprise agreements. In 48.2% of South Australian facilities, AINs/PCWs (and presumably support staff) are not covered by enterprise agreements, while RNs and ENs are covered in 96.8% (213 out of 220) of facilities.

Table 2

Percent share of facilities (services) by status of agreement coverage and state

Industrial Instrument Coverage	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
Complete - Single Agreement	91.7%	91.6%	71.4%	14.5%	12.1%	58.8%	91.7%	88.0%	72.4%
Complete - Multiple	2.7%	5.5%	6.4%	34.1%	65.8%	33.8%	8.3%	0.0%	13.8%
Sub Total Complete Coverage	**94.3%**	**97.2%**	**77.8%**	**48.6%**	**77.9%**	**92.6%**	**100.0%**	**88.0%**	**86.2%**
Partial - RNs only	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.1%
Partial - RNs & ENs	0.0%	0.0%	0.0%	48.2%	0.0%	5.9%	0.0%	0.0%	4.4%
Partial - ENs & AINs/PCWs	0.0%	0.0%	0.0%	0.0%	2.5%	0.0%	0.0%	0.0%	0.2%
Partial - AINs only	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	4.0%	0.1%
Sub Total Partial Coverage	**0.0%**	**0.0%**	**0.2%**	**48.2%**	**3.8%**	**5.9%**	**0.0%**	**4.0%**	**4.9%**
Agreement Coverage (Complete or Partial)	**94.3%**	**97.2%**	**78.0%**	**96.8%**	**81.7%**	**98.5%**	**100.0%**	**92.0%**	**91.1%**
Complete Award Reliance	**5.7%**	**2.8%**	**22.0%**	**3.2%**	**18.3%**	**1.5%**	**0.0%**	**8.0%**	**8.9%**
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Residential aged care enterprise agreements average wage rate data – as at May 2021

The average wage rates are based on a comprehensive mapping of 707 agreements to residential aged care facilities covered by non public sector agreements in Australia. The data comes from the complete set of current and most recently expired agreements. Administrative increases, (where known), have been applied to older agreements and agreements which expired before December 2019 were excluded from the sample used to calculate averages.

Table 3

Average wage data – May 2021

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
AIN/PCW entry	21.93	24.49	23.34	22.69	24.12	23.12	23.81	22.26	23.00
AIN/PCW thereafter	23.49	25.14	24.09	23.35	24.61	23.73	24.26	23.93	24.10
AIN/PCW Cert 3 entry	23.71	25.54	24.60	23.79	24.52	24.09	24.44	23.72	24.40
AIN/PCW Cert 3 thereafter	23.80	26.21	25.19	24.71	25.10	24.67	25.38	24.27	24.79
EN min	27.37	27.06	27.45	26.45	27.83	28.18	25.84	28.23	27.24
EN max	29.99	30.86	29.77	30.12	29.35	30.99	30.61	31.41	30.27
RN level1 entry	32.69	31.17	31.21	29.02	33.45	30.28	28.65	33.43	31.68
RN level 1 thereafter	41.02	38.51	37.14	39.18	42.35	39.91	35.64	40.56	39.70

Comparison with public sector rates of pay

The difference between the average rates of pay nationally between the top rate for an RN Level 1 in the public sector and the top rate for an RN Level 1 in the residential aged care sector is currently 16% or $235.60 per week calculated on the base rate.

On a State/Territory basis the difference for an RN Level 1 at the top of the level one classification structure varies from 7% in Western Australia to 26% in Queensland and 31% in Northern Territory.

PUBLIC SECTOR AND PRIVATE RESIDENTIAL AGED CARE WAGES COMPARISON

Classification	NATIONAL		
	Public $	Aged Care $	Diff %
AIN/PCW Entry	26.61	23.00	16%
AIN/PCW Top	27.76	24.10	15%
Cert 3 Entry	26.91	24.40	10%
Cert 3 Top	28.55	24.79	15%
EN min	30.43	27.24	12%
EN max	33.69	30.27	11%
RN Level 1 Entry	34.53	31.68	9%
RN Level 1 Top	45.90	39.70	16%

Classification	NSW		
	Public 1/7/2021 $	Aged Care $	% Diff
AIN/PCW Entry	23.81	21.93	9%
AIN/PCW Top	26.12	23.49	11%
Cert 3 Entry	23.81	23.71	0.4%
Cert 3 Top	26.12	23.80	10%
EN min	29.86	27.37	9%
EN max	32.44	29.99	8%
RN Level 1 Entry	33.13	32.69	1.3%
RN Level 1 Top	46.52	41.02	13%

Classification	VIC		
	Public 1/12/2020 (Re. RN & EN) 1/10/19 re.AIN/PCW	Aged Care $	% Diff
AIN/PCW Entry	25.02	24.49	2%
AIN/PCW Top	25.66	25.14	2%
Cert 3 Entry	26.08	25.54	2%
Cert 3 Top	26.72	26.21	2%
EN min	26.42	27.06	5%
EN max	33.62	30.86	9%
RN Level 1 Entry	34.03	31.17	9%
RN Level 1 Top	45.50	38.51	1%

Classification	QLD		
	Public 1/4/2020 $	Aged Care $	% Diff
AIN/PCW Entry	29.08	23.34	25%
AIN/PCW Top	29.67	24.09	23%
Cert 3 Entry	29.08	24.60	18%
Cert 3 Top	31.83	25.19	26%
EN min	31.46	27.45	15%
EN max	33.39	29.77	12%
RN Level 1 Entry	36.55	31.21	17%
RN Level 1 Top	46.88	37.14	26%

Classification	SA		
	Public 1/1/2021	Aged Care $	% Diff
AIN/PCW Entry		22.69	
AIN Top		23.35	
Cert 3 Entry	26.75	23.79	12%
Cert 3 Top	27.54	24.71	11%
EN min	28.96	26.45	9%
EN max	33.87	30.12	12%
RN Level 1 Entry	33.87	29.02	17%
RN Level 1 Top	46.21	39.18	18%

Classification	ACT		
	Interim Public sector increase 10/12/2020 $	Aged Care $	% Diff
AIN/PCW Entry	27.10	22.26	22%
AIN/PCWTop	28.00	23.93	17%
Cert 3 Entry	27.10	23.72	14%
Cert 3 Top	28.00	24.27	15%
EN min	31.95	28.23	13%
EN max	34.13	31.41	9%
RN Level 1 Entry	35.23	33.43	5%
RN Level 1 Top	47.06	40.56	16%

Classification	NT		
	Public 20/8//2020 $	Aged Care $	% Diff
AIN/PCW Entry		23.81	
AIN/PCW Top		24.26	
Cert 3 Entry		24.44	
Cert 3 Top		25.38	
EN min	31.20	25.84	21%
EN max	35.27	30.61	15%
RN Level 1 Entry	35.27	28.65	23%
RN Level 1 Top	46.67	35.64	31%

Classification	WA		
	Public 12/10/2020 $	Aged Care $	% Diff
AIN/PCW Entry	* 7/10/2020 28.03	23.12	16%
AIN/PCW Top	29.36	24.61	19%
Cert 3 Entry	28.03	24.52	14%
Cert 3 Top	29.36	25.10	17%
EN min	31.34	27.83	13%
EN max	33.33	29.35	14%
RN Level 1 Entry	34.65	33.45	4%
RN Level 1 Top	45.12	42.35	7%

Classification	TAS		
	Public 1/12/2020 $	Aged Care $	% Diff
AIN/PCW Entry		23.12	
AIN/PCW Top		23.73	
Cert 3 Entry	27.53	24.09	14%
Cert 3 Top	30.25	24.67	23%
EN min	30.25	28.18	7%
EN max	33.49	30.99	8%
RN Level 1 Entry	33.49	30.28	11%
RN Level 1 Top	43.27	39.91	8%

* AIN and EN Rates of pay

From WA Health System - United Voice - Enrolled Nurse, Assistants in Nursing, Aboriginal and Ethnic Health Workers Industrial Agreement 2020. (AG7 of 2021)

PRIVATE ACUTE HOSPITALS

This section of Paycheck contains updated information on enterprise agreement data in the Private Acute Hospital sector.

The most recent ABS data reports there are approximately 300 private acute and psychiatric hospitals in Australia providing a total of 31,029 beds. The majority (62%) operate on a 'for profit" basis while a further 28% are religious or charitable 'not for profit" hospitals with the remainder being considered other not for profit hospitals (bush nursing, community and memorial hospitals).[24]

There are a total of 52,923 registered nurses, enrolled nurses and midwives employed in private hospitals across Australia. The vast majority are registered nurses and midwives who comprise 86% of the nursing workforce in this sector.[25]

The NHWDS shows there are 40,305 full time equivalent nurses and midwives based on a 38 hour week.

The following table provides average wages data based on 125 enterprise agreements covering 93% of private hospitals across Australia.

Average Wage Data - June 2021

Classification	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
AIN/PCW min	23.98	25.38	26.99		27.56	23.85		28.56	25.38
AIN/PCW max	26.25	27.48	28.93		28.84	25.51		30.52	27.37
EN min	29.77	28.47	31.02	27.43	30.61	31.41	31.05	32.30	29.56
EN max	33.82	33.36	33.18	32.44	32.83	35.04	35.10	35.20	33.36
RN level1 entry	33.29	33.59	37.64	31.34	34.83	34.56	35.10	35.75	33.80
RN level 1 thereafter	46.82	44.01	44.35	42.94	46.29	45.17	47.33	47.67	45.23

Comparison with public sector rates of pay

Classification	NATIONAL		
	Public $	Private Acute $	% Diff
AIN/PCW min	26.61	25.38	4.85%
AIN/PCW max	28.55	27.37	4.31%
EN min	30.43	29.56	2.94%
EN max	33.69	33.36	0.99%
RN Level 1 Entry	34.53	33.80	2.16%
RN Level 1 Top	45.90	45.23	1.48%

The difference between the average rates of pay nationally between the top rate for an RN Level 1 in the public sector and the top rate for an RN Level 1 in the private acute sector is less than 1.48% or 0.67 cents per hour calculated on the base rate.

24 ABS 4390.0 - Private Hospitals, Australia, 2016-2017. (ABS no longer publish this data)

25 NHWDS 2017

The ANMF

Established in 1924, the Australian Nursing & Midwifery Federation (AMNF) is the only organisation in Australia representing the industrial and professional interests of nurses, midwives and assistants in nursing.

The ANMF has over 285,000 members working across Australia in cities, rural, regional and remote locations and in every area of health, health prevention and aged care. There is a total of 399,364 nurses and midwives in Australia registered to practice [26] who contribute directly to all areas of Australia's health and aged care.

All Australians must have access to safe, quality health and aged care. To achieve this, it is important that Australia continues to have a robust, well-educated and highly experienced nursing and midwifery workforce. Ensuring that every nurse, midwife and assistant in nursing receives pay and conditions reflective of their extensive level of skill and education is a priority for the ANMF.

The ANMF campaigns to raise political awareness, and political action if necessary, among its members and the community in the pursuit of improved public policy on health, aged care, education, employment, industrial relations and all areas of social justice.

Australia's health and aged care systems and its nursing and midwifery workforce face many challenges. The ANMF is working with nurses, midwives and assistants in nursing, governments, community and consumer groups, health and aged care providers and other health care professionals to progress solutions and build a sustainable health workforce for the future good health of Australia.

The ANMF Federal Office

The ANMF Federal Office has locations in Melbourne and Canberra. The Federal Office develops policy and represents ANMF members at a national level in the areas of health, aged care, education, the nursing and midwifery workforce, industrial relations and social justice.

Annie Butler, Federal Secretary of the ANMF and Lori-Anne Sharp, Assistant Federal Secretary, co-ordinate the national activities of the Federation. Branch Secretaries manage the activities of the state and territory branches of the ANMF.

The governing bodies of the Union are the Federal Council and Federal Executive. National committees cover industrial and professional issues, occupational health and safety and aged care.

The ANMF Federal Office publishes two nursing journals:

- The Australian Nursing & Midwifery Journal (ANMJ) published monthly consists of clinical articles, a monthly feature and the latest union, nursing and midwifery news - https://anmf.org.au/anmj-landing
- The Australian Journal of Advanced Nursing (AJAN), published quarterly, is a peer reviewed research journal, available at http://www.ajan.com.au

26 NHWDS Fact Sheet 2019 https://hwd.health.gov.au/publications.html

ANMF MEMBERSHIP

ANMF membership is the most effective way for nurses, midwives and assistants in nursing to ensure that fair working conditions and rates of pay are negotiated for the entire nursing and midwifery workforce. Fair wages and working conditions help to retain nurses, midwives and assistants in nursing in the workforce, thereby improving Australia's health and aged care system. The ANMF provides a range of services to members through its state and territory branches.

Services include:

- information about wages and conditions of employment
- industrial representation
- professional indemnity insurance
- legal representation
- negotiation of awards and agreements
- resolution of workplace disputes
- information and representation on workplace issues such as occupational health and safety
- education services
- library services

Members can become actively involved in ANMF campaigns and activities through their Branch, the ANMF state and federal websites, and the ANMF publications.

Source: Branch Declared Membership 31 December each year.

Joining the ANMF

Nurses, midwives and AINs join the ANMF branch in the state or territory where they work:

ANMF Australian Capital Territory Branch
New South Wales Nurses and Midwives' Association (ANMF NSWNMA Branch)
ANMF Northern Territory Branch
Queensland Nurses and Midwives' Union (ANMF QNMU Branch)
ANMF South Australian Branch
ANMF Tasmanian Branch
ANMF Victorian Branch
ANMF Western Australian Branch

The ANMF's international work

The ANMF represents nurses, midwives and assistants in nursing internationally through membership of other national and international nursing organisations and professional associations. The ANMF is a member of the Commonwealth Nurses Federation, the South Pacific Nurses Forum and the International Council of Nurses (ICN).

The ANMF is affiliated to the Australian Council of Trade Unions (ACTU), International Centre for Trade Union Rights and Union Aid Abroad - APHEDA (Australian People for Health, Education and Development Abroad) which is the overseas aid agency of the trade union movement. Further information about the ANMF is available at: http://www.anmf.org.au

USEFUL LINKS:

Nursing

RCNA	Royal College of Nursing Australia: http://www.rcna.org.au/
NMBA	Nursing and Midwifery Board of Australia: http://www.nursingmidwiferyboard.gov.au/
ANMC	Australian Nursing and Midwifery Council: http://www.anmc.org.au
CNF	Commonwealth Nurses Federation: http://www.commonwealthnurses.org/
ICN	International Council of Nurses: http://www.icn.ch/
GNU	Global Nurses United: via http://www.nationalnursesunited.org/

Industrial

ACTU	Australian Council of Trade Unions (ACTU): http://www.actu.org.au/
FWC	Fair Work Commission: http://www.fwc.gov.au/
FWO	Fair Work Ombudsman: http://www.fairwork.gov.au/

International

ILO	International Labour Organisations: http:/www.ilo.org
ITUC	International Trade Union Confederation: http://www.ituc-csi.org/
PSI	Public Services International: http://www.world-psi.org/
APHEDA	Australian People for Health, Education and Development Abroad: http://www.apheda.org.au/
SPNF	South Pacific Nurses Forum: http://www.spnf.org.au/

Other

AIHW	Australian Institute of Health and Welfare: http://www.aihw.gov.au/
ABS	Australian Bureau of Statistics: http://www.abs.gov.au/
AHPRA	Australian Health Practitioner Regulation Agency: www.ahpra.gov.au

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ANMF BRANCHES

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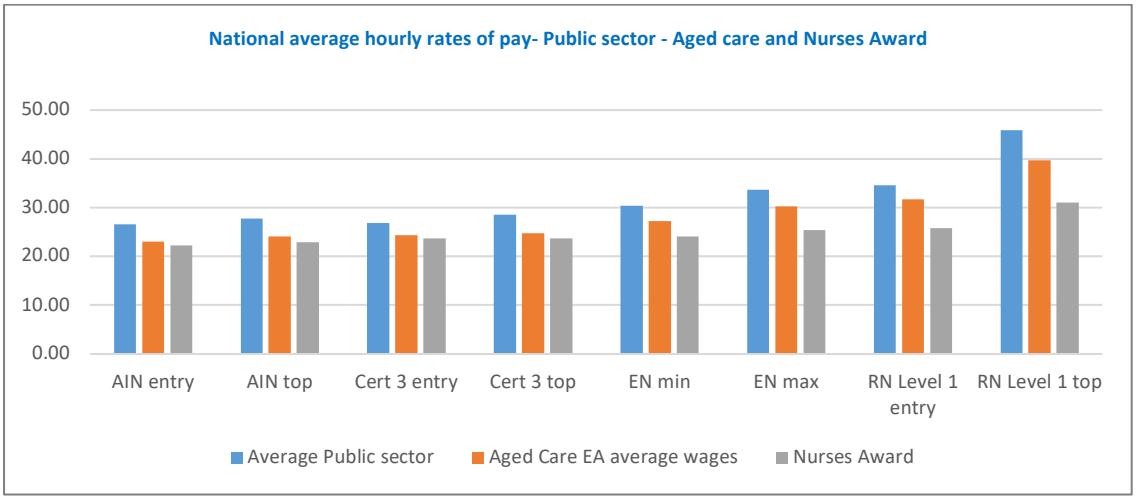
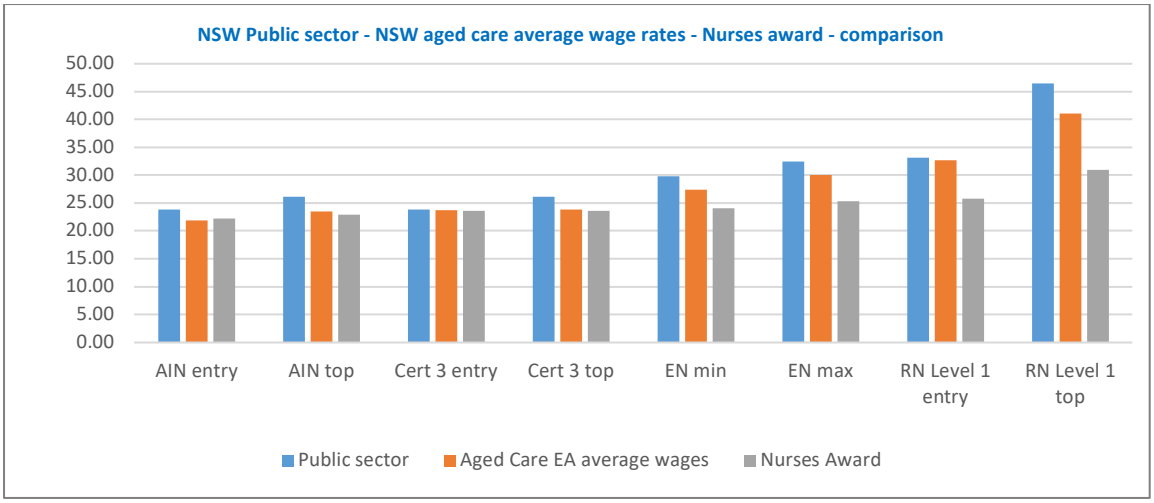
ANNEXURE KW 2(A) – COMPARISON TABLES

Comparison between average wages in aged care and the public sector; average wages in aged care and the Nurses Award and wages in the public sector and the Nurses Award – Nationally and by State and Territory.

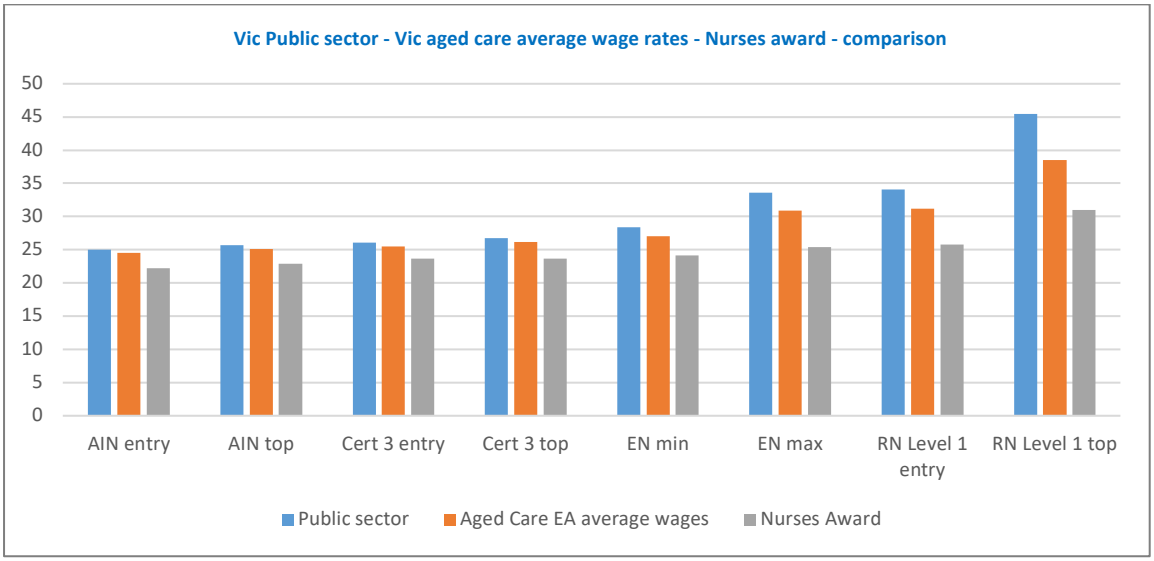
NATIONAL						
Classification	**Average Public sector**	**Aged Care EA average wages at May 21**	**% Diff Public sector and Aged care EA**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**
AIN entry	26.61	23.00	16%	22.19	4%	20%
AIN top	27.76	24.10	15%	22.93	5%	21%
Cert 3 entry	26.91	24.40	10%	23.67	3%	14%
Cert 3 top	28.55	24.79	15%	23.67	5%	21%
EN min	30.43	27.24	12%	24.11	13%	26%
EN max	33.69	30.27	11%	25.36	19%	33%
RN Level 1 entry	34.53	31.68	9%	25.79	23%	34%
RN Level 1 top	45.90	39.70	16%	30.99	28%	48%



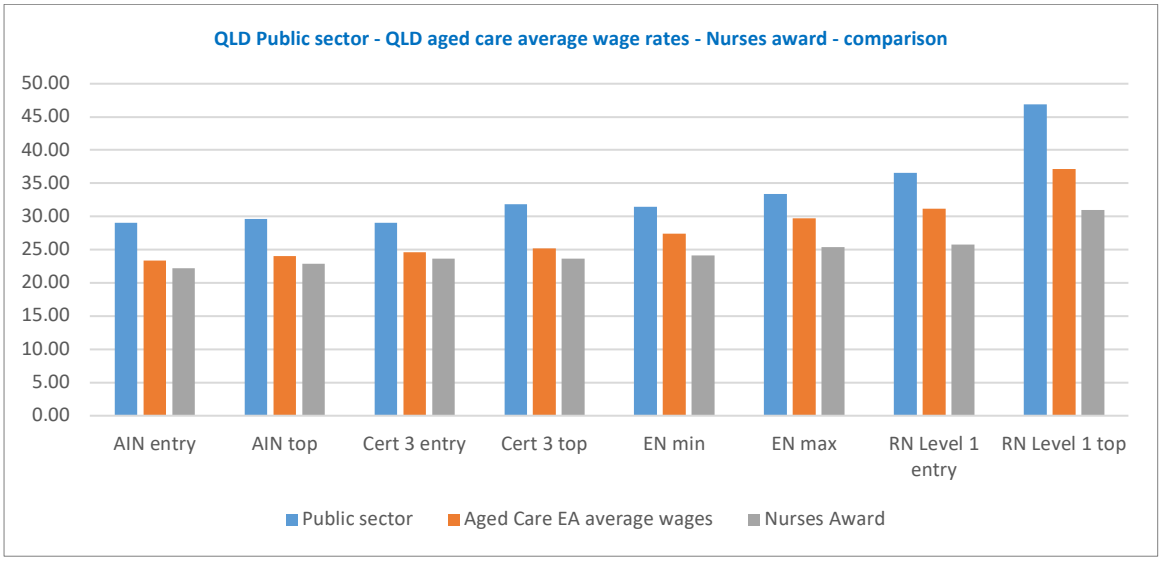
NSW						
Classification	**Public sector 1.07.2021**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**
AIN entry	23.81	21.93	9%	22.19	-1%	7%
AIN top	26.12	23.49	11%	22.93	2%	14%
Cert 3 entry	23.81	23.71	0.4%	23.67	0%	1%
Cert 3 top	26.12	23.80	10%	23.67	1%	10%
EN min	29.86	27.37	9%	24.11	14%	24%
EN max	32.44	29.99	8%	25.36	18%	28%
RN Level 1 entry	33.13	32.69	1.3%	25.79	27%	28%
RN Level 1 top	46.42	41.02	13%	30.99	32%	50%



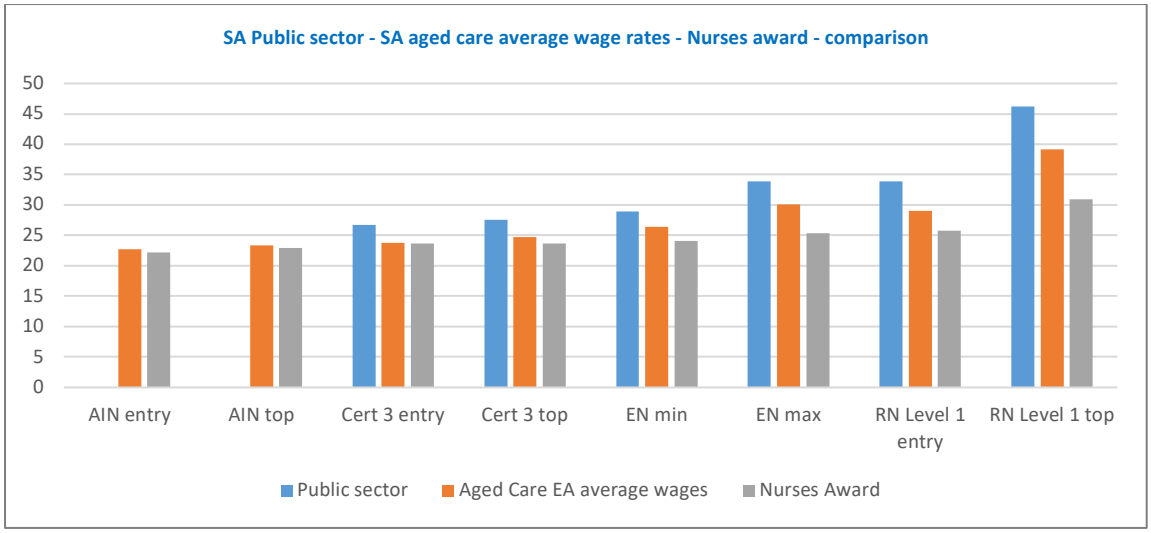
VIC						
Classification	**Public sector 1/12/2020 re RN & EN and 01/10/2019 re AIN/PCW**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**
AIN entry	25.02	24.49	2%	22.19	10%	13%
AIN top	25.66	25.14	2%	22.93	10%	12%
Cert 3 entry	26.08	25.54	2%	23.67	8%	10%
Cert 3 top	26.72	26.21	2%	23.67	11%	13%
EN min	28.42	27.06	5%	24.11	12%	18%
EN max	33.62	30.86	9%	25.36	22%	33%
RN Level 1 entry	34.03	31.17	9%	25.79	21%	32%
RN Level 1 top	45.5	38.51	18%	30.99	24%	47%



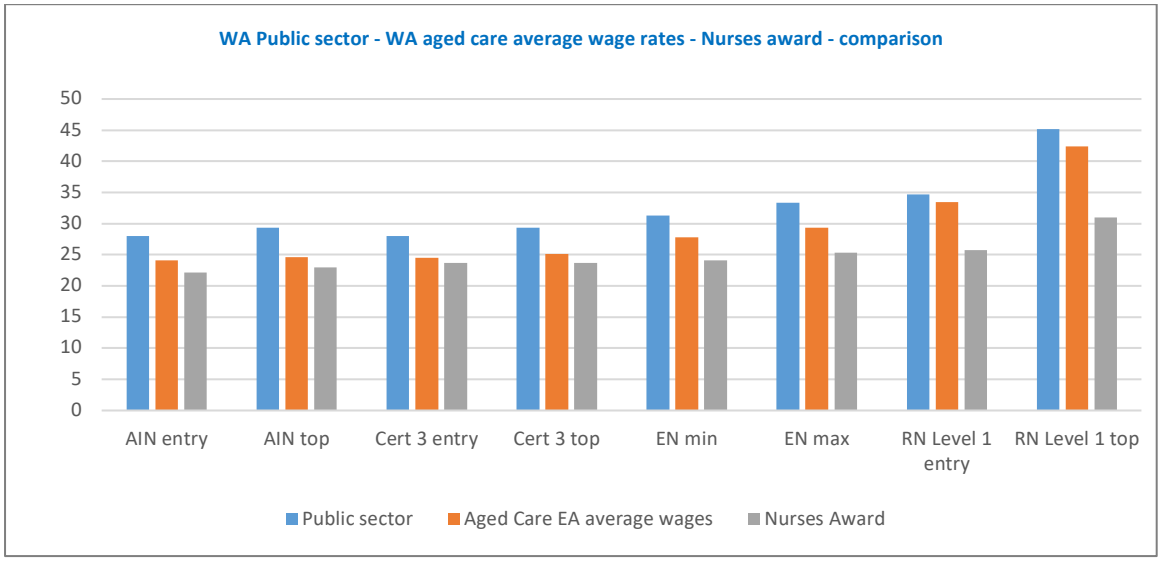
QLD						
Classification	**Public sector 1/04/2020**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**
AIN entry	29.08	23.34	25%	22.19	5%	31%
AIN top	29.67	24.09	23%	22.93	5%	29%
Cert 3 entry	29.08	24.60	18%	23.67	4%	23%
Cert 3 top	31.83	25.19	26%	23.67	6%	34%
EN min	31.46	27.45	15%	24.11	14%	30%
EN max	33.39	29.77	12%	25.36	17%	32%
RN Level 1 entry	36.55	31.21	17%	25.79	21%	42%
RN Level 1 top	46.88	37.14	26%	30.99	20%	51%



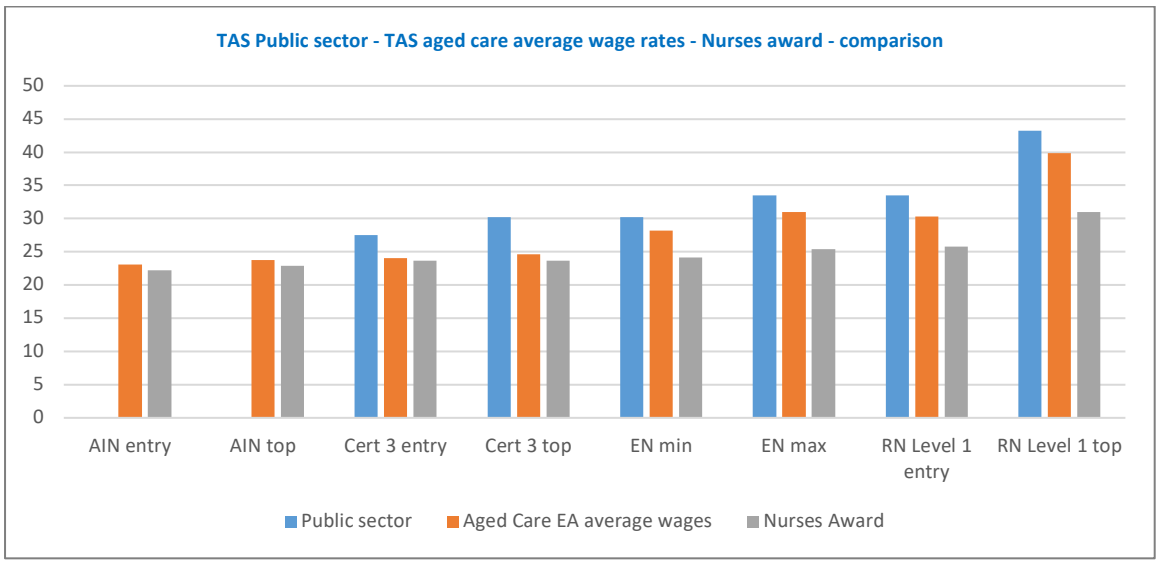
SA						
Classification	**Public sector 1/01/2021**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**
AIN entry		22.69		22.19	2%	
AIN top		23.35		22.93	2%	
Cert 3 entry	26.75	23.79	12%	23.67	1%	13%
Cert 3 top	27.54	24.71	11%	23.67	4%	16%
EN min	28.96	26.45	9%	24.11	10%	20%
EN max	33.87	30.12	12%	25.36	19%	34%
RN Level 1 entry	33.87	29.02	17%	25.79	13%	31%
RN Level 1 top	46.21	39.18	18%	30.99	26%	49%



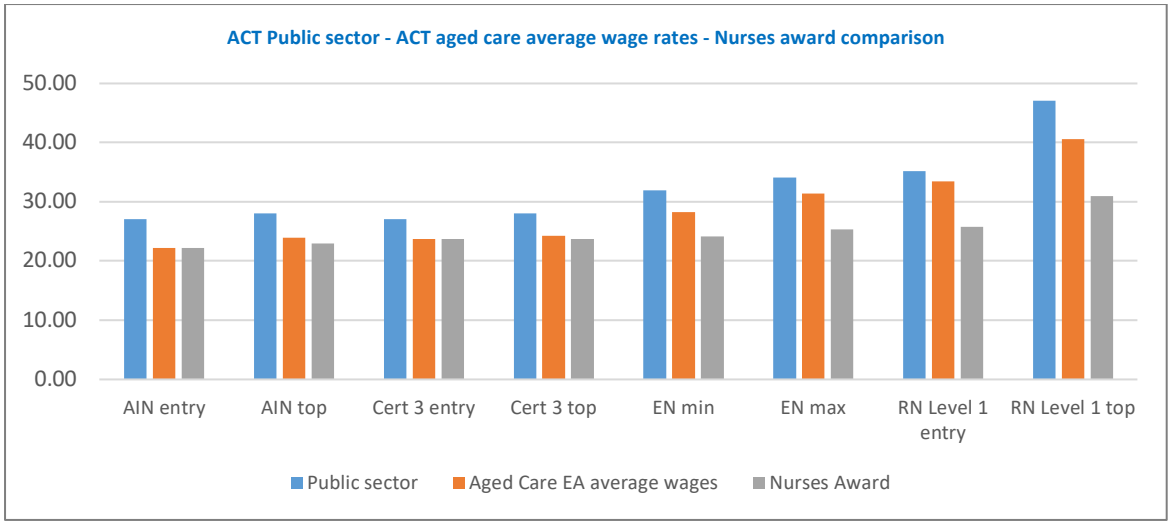
WA						
Classification	**Public sector 12/10/2020 RN 7/10/2020 (AIN/EN)**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**
AIN entry	28.03	24.12	16%	22.19	9%	26%
AIN top	29.36	24.61	19%	22.93	5%	28%
Cert 3 entry	28.03	24.52	14%	23.67	4%	18%
Cert 3 top	29.36	25.10	17%	23.67	4%	24%
EN min	31.34	27.83	13%	24.11	4%	30%
EN max	33.33	29.35	14%	25.36	10%	31%
RN Level 1 entry	34.65	33.45	4%	25.79	14%	34%
RN Level 1 top	45.12	42.35	7%	30.99	8%	46%



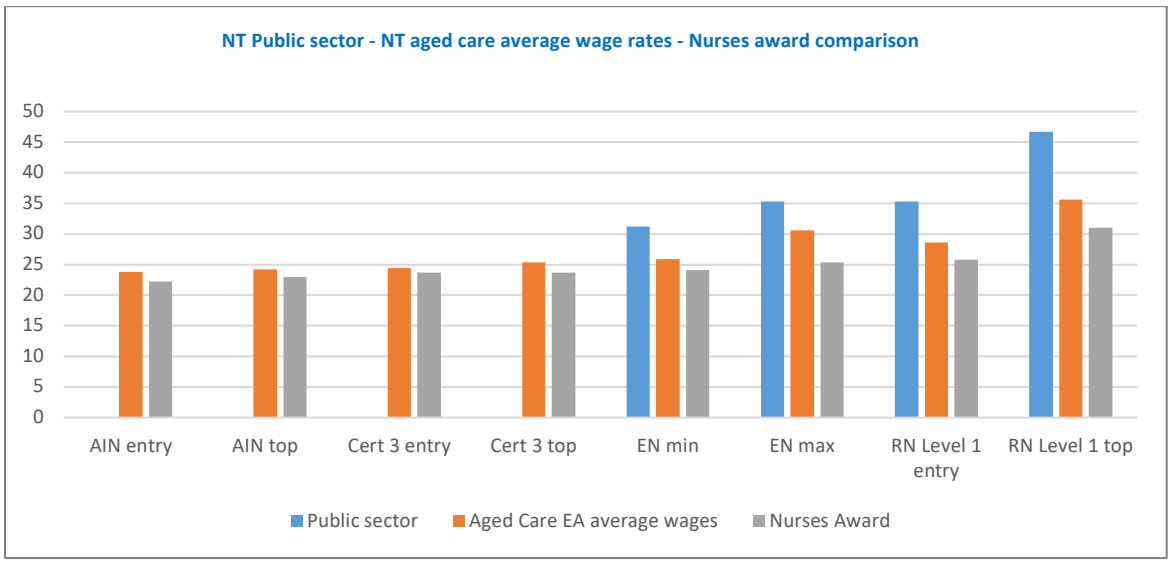
TAS						
Classification	**Public sector 1/12/2020**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**
AIN entry		23.12		22.19	4%	
AIN top		23.73		22.93	3%	
Cert 3 entry	27.53	24.09	14%	23.67	2%	16%
Cert 3 top	30.25	24.67	23%	23.67	4%	28%
EN min	30.25	28.18	7%	24.11	17%	25%
EN max	33.49	30.99	8%	25.36	22%	32%
RN Level 1 entry	33.49	30.28	11%	25.79	17%	30%
RN Level 1 top	43.27	39.91	8%	30.99	29%	40%



ACT						
Classification	**Public sector 10/12/2020**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**
AIN entry	27.10	22.26	22%	22.19	0%	22%
AIN top	28	23.93	17%	22.93	4%	22%
Cert 3 entry	27.10	23.72	14%	23.67	0%	14%
Cert 3 top	28	24.27	15%	23.67	3%	18%
EN min	31.95	28.23	13%	24.11	17%	33%
EN max	34.13	31.41	9%	25.36	24%	35%
RN Level 1 entry	35.23	33.43	5%	25.79	30%	37%
RN Level 1 top	47.06	40.56	16%	30.99	31%	52%



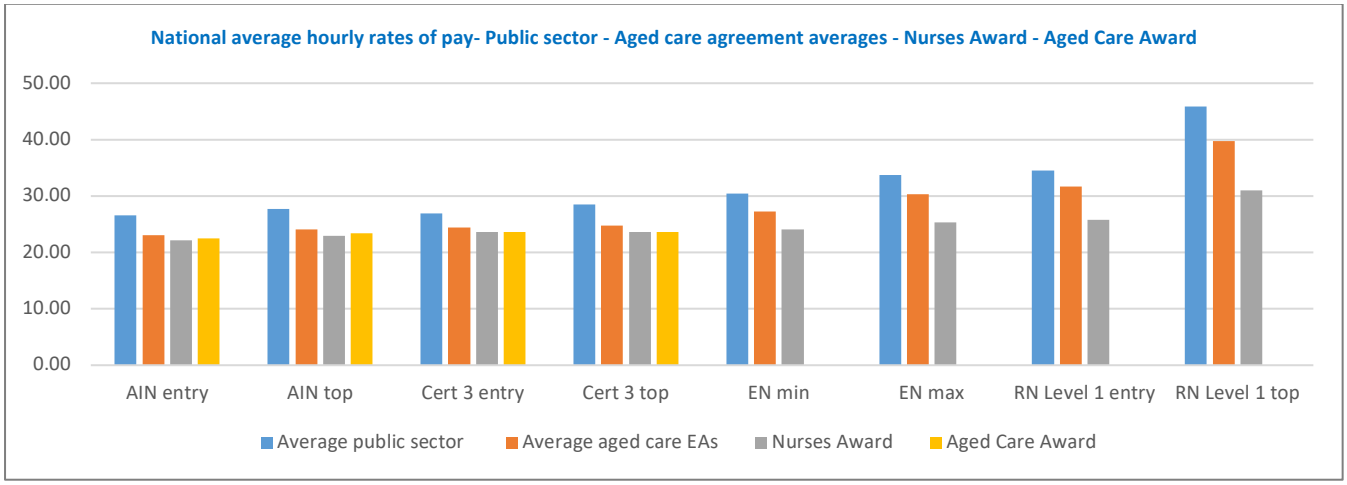
NT						
Classification	**Public sector 20/08/2020**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**
AIN entry		23.81		22.19	7%	
AIN top		24.26		22.93	6%	
Cert 3 entry		24.44		23.67	3%	
Cert 3 top		25.38		23.67	7%	
EN min	31.2	25.84	21%	24.11	7%	29%
EN max	35.27	30.61	15%	25.36	21%	39%
RN Level 1 entry	35.27	28.65	23%	25.79	11%	37%
RN Level 1 top	46.67	35.64	31%	30.99	15%	51%



ANNEXURE KW 2(B) – COMPARISON TABLES

Comparison between average wage rates in aged care and the public sector; average wages in aged care and the Nurses Award; wages in the public sector and the Nurses Award and average wages in aged care and the Aged Care Award – Nationally and by State and Territory.

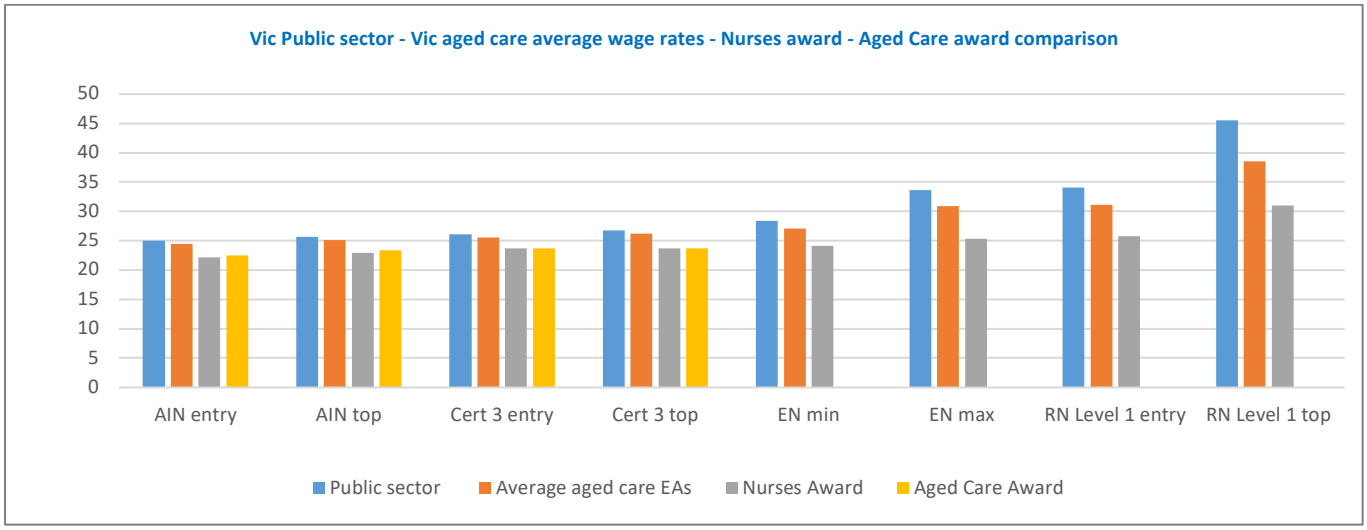
NATIONAL									
Classification	**Average Public sector**	**Aged Care EA average wages**	**% Diff Public sector and Aged care EA**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**	**Aged Care Award 1 July 21**	**% Diff Aged care EA and Aged care Award**	**% Diff Public sector and Aged Care Award**
AIN entry/PCW Gr 1	26.61	23.00	16%	22.19	4%	20%	22.51	2%	18%
AIN top/ PCW Gr 2	27.76	24.10	15%	22.93	5%	21%	23.39	3%	19%
AIN Cert 3 entry/PCW Gr 3	26.91	24.40	10%	23.67	3%	14%	23.67	3%	14%
AIN Cert 3 top/PCW Gr 3	28.55	24.79	15%	23.67	5%	21%	23.67	5%	21%
EN min	30.43	27.24	12%	24.11	13%	26%			
EN max	33.69	30.27	11%	25.36	19%	33%			
RN Level 1 entry	34.53	31.68	9%	25.79	23%	34%			
RN Level 1 top	45.90	39.70	16%	30.99	28%	48%			



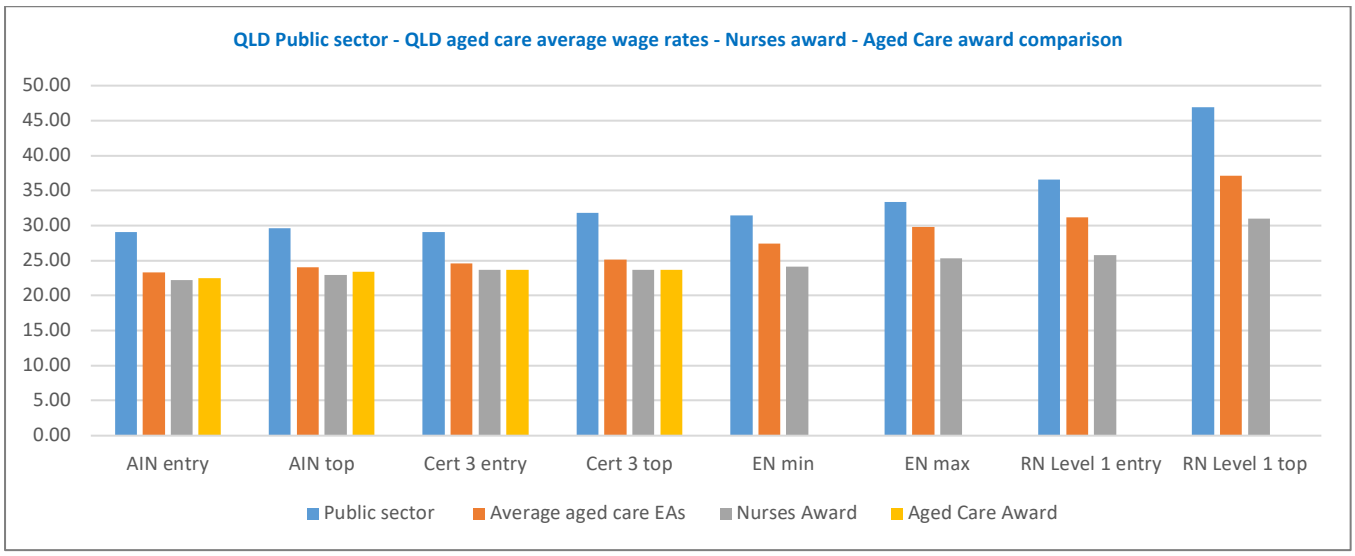
Note: This table does not include NSW agreements in the comparison with the Aged Care Award as average wages in NSW are based on the AIN classification in agreements.

NSW						
Classification	**Public sector 1.07.2021**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**
AIN entry	23.81	21.93	9%	22.19	-1%	7%
AIN top	26.12	23.49	11%	22.93	2%	14%
Cert 3 entry	23.81	23.71	0.4%	23.67	0%	1%
Cert 3 top	26.12	23.80	10%	23.67	1%	10%
EN min	29.86	27.37	9%	24.11	14%	24%
EN max	32.44	29.99	8%	25.36	18%	28%
RN Level 1 entry	33.13	32.69	1.3%	25.79	27%	28%
RN Level 1 top	46.42	41.02	13%	30.99	32%	50%

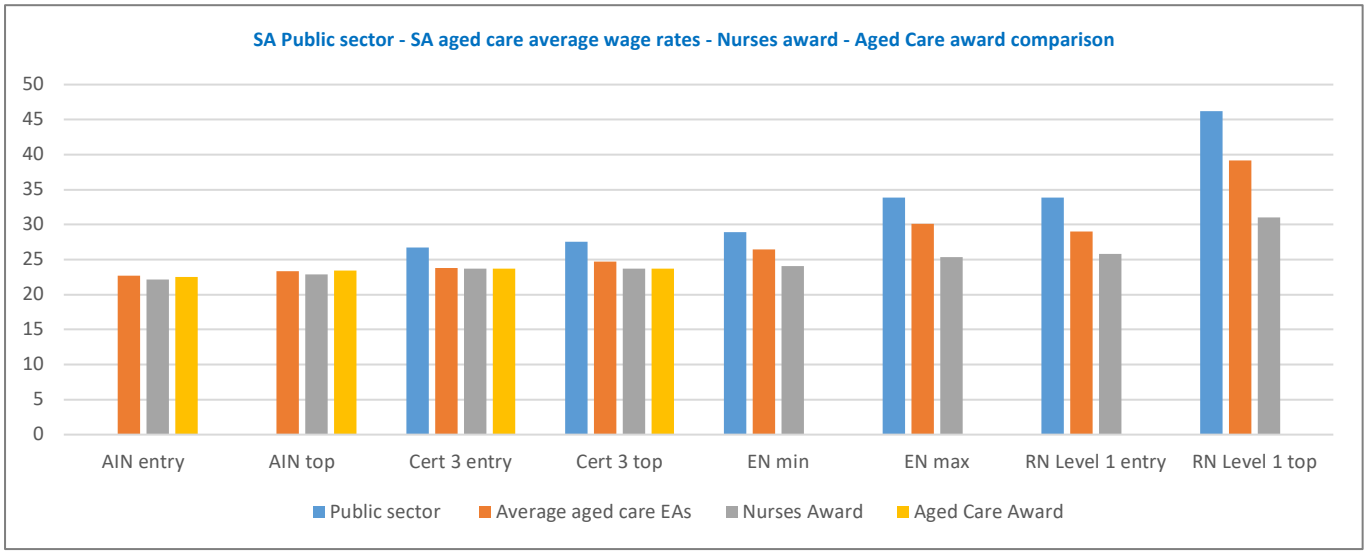
VIC									
Classification	**Public sector 1/12/2020 re RN & EN and 01/10/2019 re AIN/PCW**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**	**Aged Care Award 1 July 21**	**% Diff Aged care EA and Aged care Award**	**% Diff Public sector and Aged Care Award**
AIN entry	25.02	24.49	2%	22.19	10%	13%	22.51	9%	11%
AIN top	25.66	25.14	2%	22.93	10%	12%	23.39	7%	10%
Cert 3 entry	26.08	25.54	2%	23.67	8%	10%	23.67	8%	10%
Cert 3 top	26.72	26.21	2%	23.67	11%	13%	23.67	11%	13%
EN min	28.42	27.06	5%	24.11	12%	18%			
EN max	33.62	30.86	9%	25.36	22%	33%			
RN Level 1 entry	34.03	31.17	9%	25.79	21%	32%			
RN Level 1 top	45.5	38.51	18%	30.99	24%	47%			



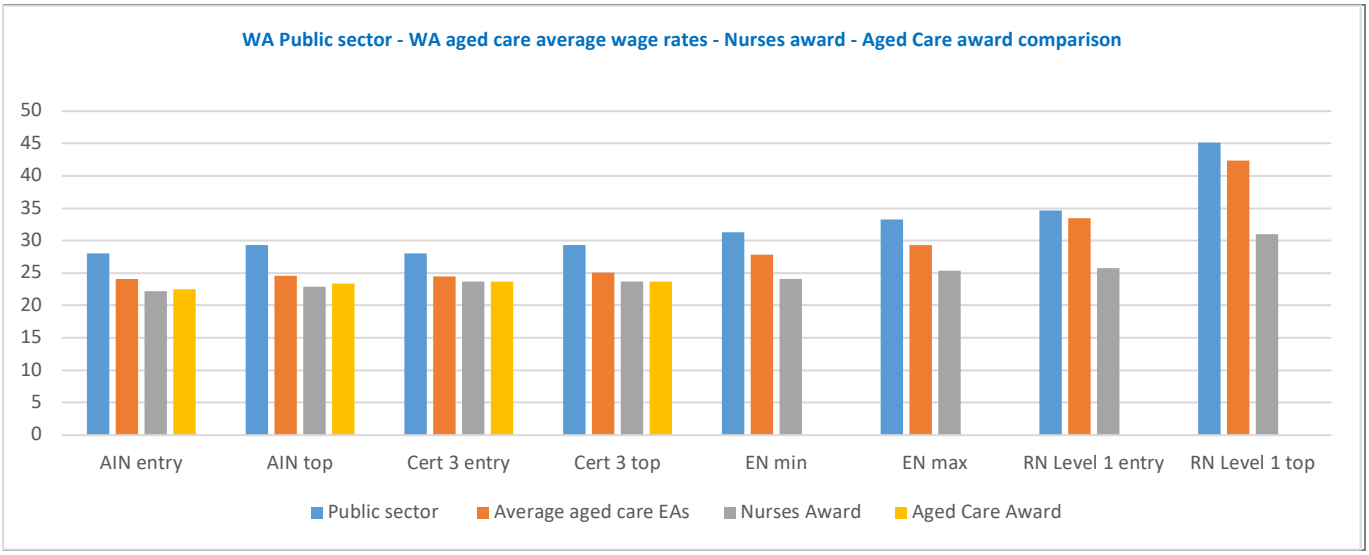
QLD									
Classification	**Public sector 1/04/2020**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**	**Aged Care Award 1 July 21**	**% Diff Aged care EA and Aged care Award**	**% Diff Public sector and Aged Care Award**
AIN entry	29.08	23.34	25%	22.19	5%	31%	22.51	4%	29%
AIN top	29.67	24.09	23%	22.93	5%	29%	23.39	3%	27%
Cert 3 entry	29.08	24.60	18%	23.67	4%	23%	23.67	4%	23%
Cert 3 top	31.83	25.19	26%	23.67	6%	34%	23.67	6%	34%
EN min	31.46	27.45	15%	24.11	14%	30%			
EN max	33.39	29.77	12%	25.36	17%	32%			
RN Level 1 entry	36.55	31.21	17%	25.79	21%	42%			
RN Level 1 top	46.88	37.14	26%	30.99	20%	51%			



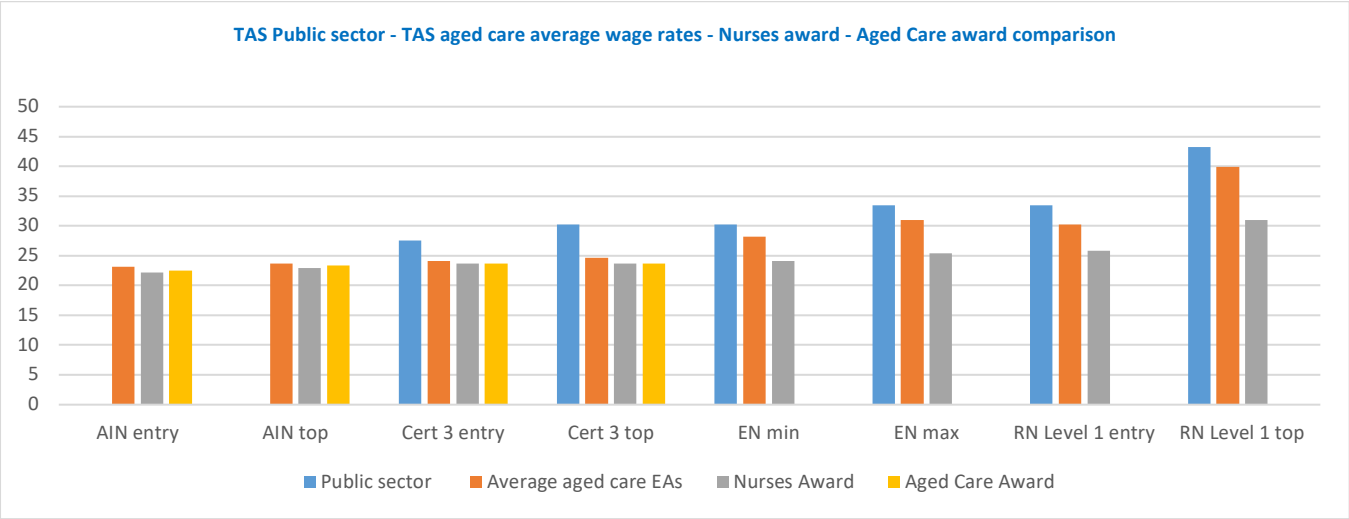
SA									
Classification	**Public sector 1/01/2021**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**	**Aged Care Award 1 July 21**	**% Diff Aged care EA and Aged care Award**	**% Diff Public sector and Aged Care Award**
AIN entry		22.69		22.19	2%		22.51	1%	
AIN top		23.35		22.93	2%		23.39	0%	
Cert 3 entry	26.75	23.79	12%	23.67	1%	13%	23.67	1%	13%
Cert 3 top	27.54	24.71	11%	23.67	4%	16%	23.67	4%	16%
EN min	28.96	26.45	9%	24.11	10%	20%			
EN max	33.87	30.12	12%	25.36	19%	34%			
RN Level 1 entry	33.87	29.02	17%	25.79	13%	31%			
RN Level 1 top	46.21	39.18	18%	30.99	26%	49%			



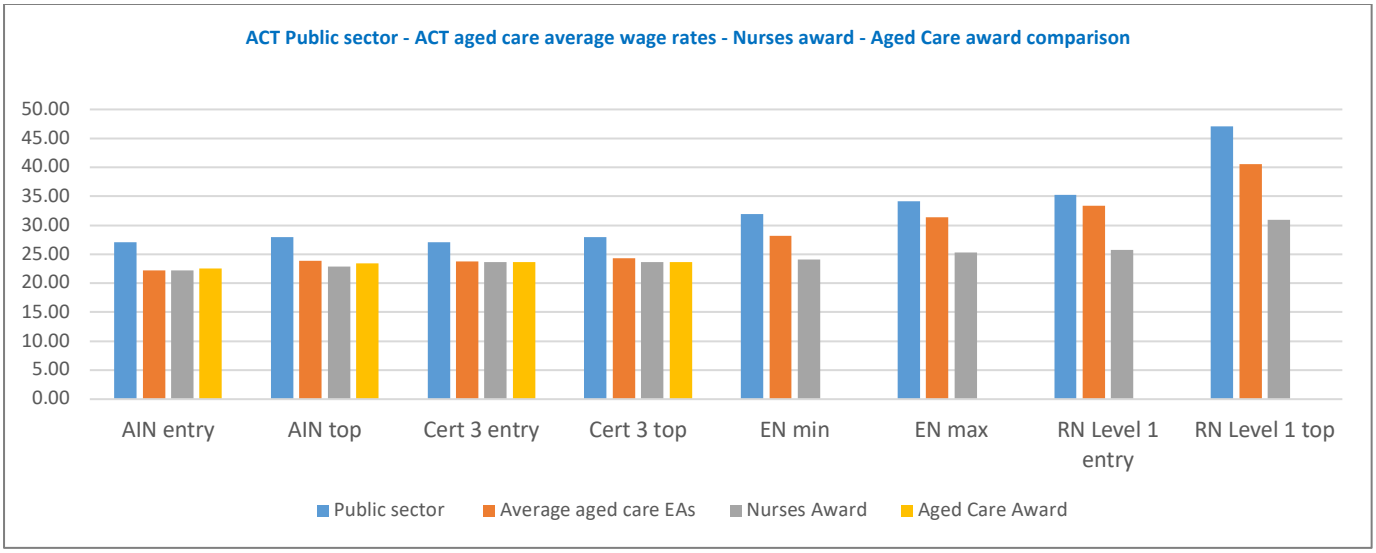
WA									
Classification	**Public sector 12/10/2020 RN 7/10/2020 (AIN/EN)**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**	**Aged Care Award 1 July 21**	**% Diff Aged care EA and Aged care Award**	**% Diff Public sector and Aged Care Award**
AIN entry	28.03	24.12	16%	22.19	9%	26%	22.51	7%	25%
AIN top	29.36	24.61	19%	22.93	5%	28%	23.39	5%	26%
Cert 3 entry	28.03	24.52	14%	23.67	4%	18%	23.67	4%	18%
Cert 3 top	29.36	25.10	17%	23.67	4%	24%	23.67	6%	24%
EN min	31.34	27.83	13%	24.11	4%	30%			
EN max	33.33	29.35	14%	25.36	10%	31%			
RN Level 1 entry	34.65	33.45	4%	25.79	14%	34%			
RN Level 1 top	45.12	42.35	7%	30.99	8%	46%			



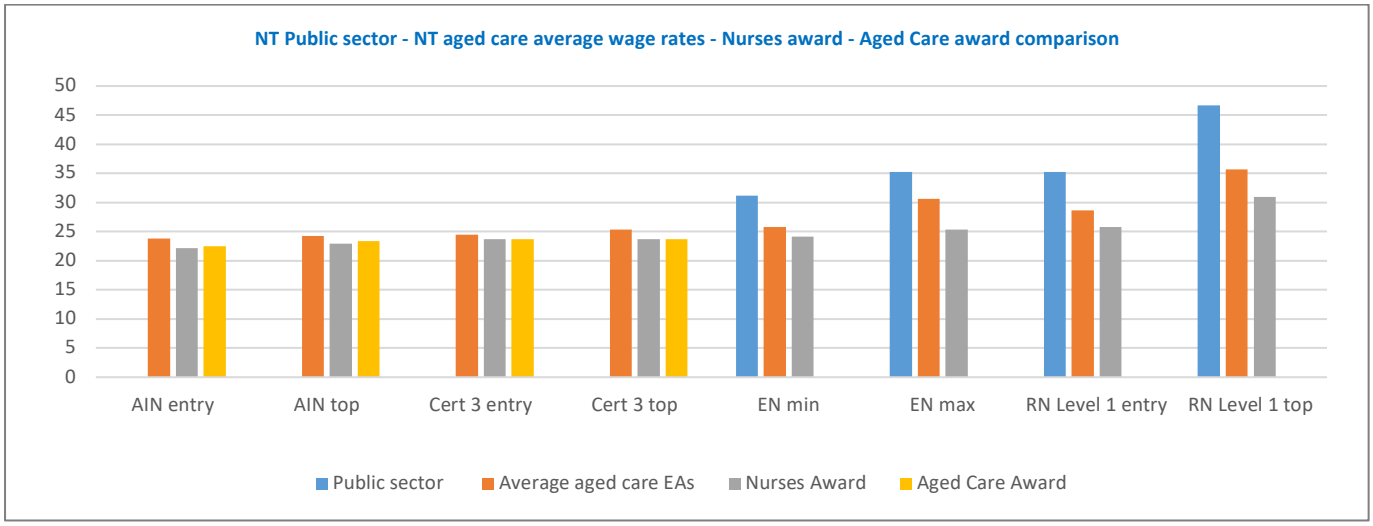
TAS									
Classification	**Public sector 1/12/2020**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**	**Aged Care Award 1 July 21**	**% Diff Aged care EA and Aged care Award**	**% Diff Public sector and Aged Care Award**
AIN entry		23.12		22.19	4%		22.51	3%	
AIN top		23.73		22.93	3%		23.39	1%	
Cert 3 entry	27.53	24.09	14%	23.67	2%	16%	23.67	2%	16%
Cert 3 top	30.25	24.67	23%	23.67	4%	28%	23.67	4%	28%
EN min	30.25	28.18	7%	24.11	17%	25%			
EN max	33.49	30.99	8%	25.36	22%	32%			
RN Level 1 entry	33.49	30.28	11%	25.79	17%	30%			
RN Level 1 top	43.27	39.91	8%	30.99	29%	40%			



ACT									
Classification	**Public sector 10/12/2020**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**	**Aged Care Award 1 July 21**	**% Diff Aged care EA and Aged care Award**	**% Diff Public sector and Aged Care Award**
AIN entry	27.10	22.26	22%	22.19	0%	22%	22.51	-1%	20%
AIN top	28	23.93	17%	22.93	4%	22%	23.39	2%	20%
Cert 3 entry	27.10	23.72	14%	23.67	0%	14%	23.67	0%	14%
Cert 3 top	28	24.27	15%	23.67	3%	18%	23.67	3%	18%
EN min	31.95	28.23	13%	24.11	17%	33%			
EN max	34.13	31.41	9%	25.36	24%	35%			
RN Level 1 entry	35.23	33.43	5%	25.79	30%	37%			
RN Level 1 top	47.06	40.56	16%	30.99	31%	52%			



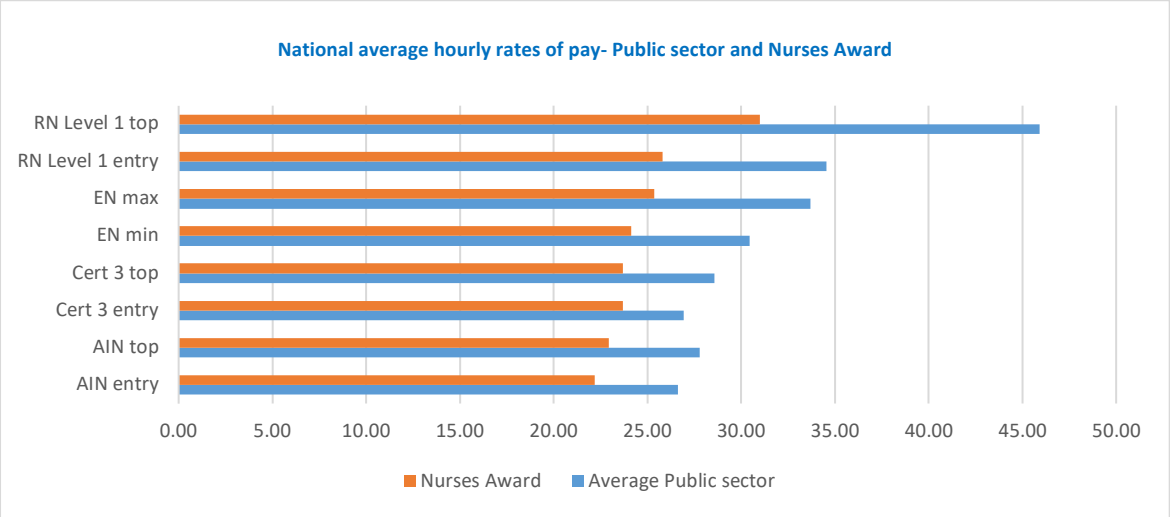
NT									
Classification	**Public sector 20/08/2020**	**Aged Care EA average wages**	**% Diff Public sector and Aged care**	**Nurses Award 1 July 21**	**% Diff Aged care EA and Nurses Award**	**% Diff Public sector and Nurses Award**	**Aged Care Award 1 July 21**	**% Diff Aged care EA and Aged care Award**	**% Diff Public sector and Aged Care Award**
AIN entry		23.81		22.19	7%		22.51	6%	
AIN top		24.26		22.93	6%		23.39	4%	
Cert 3 entry		24.44		23.67	3%		23.67	3%	
Cert 3 top		25.38		23.67	7%		23.67	7%	
EN min	31.2	25.84	21%	24.11	7%	29%			
EN max	35.27	30.61	15%	25.36	21%	39%			
RN Level 1 entry	35.27	28.65	23%	25.79	11%	37%			
RN Level 1 top	46.67	35.64	31%	30.99	15%	51%			



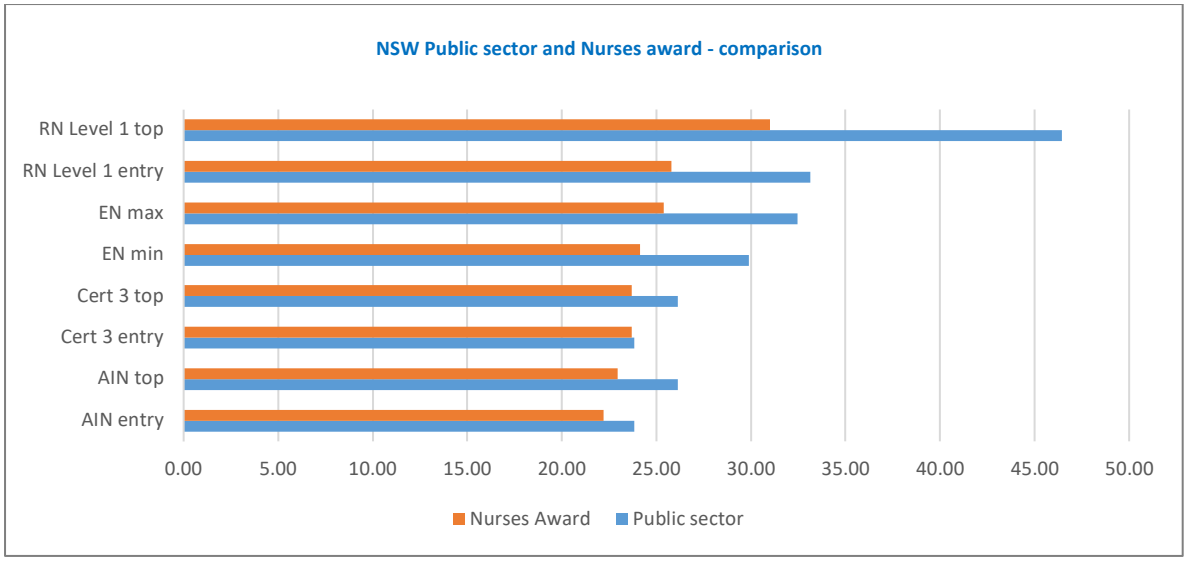
ANNEXURE KW 2(C) – COMPARISON TABLES

Comparison of public sector rates of pay with the Nurses Award – nationally and by State/Territory

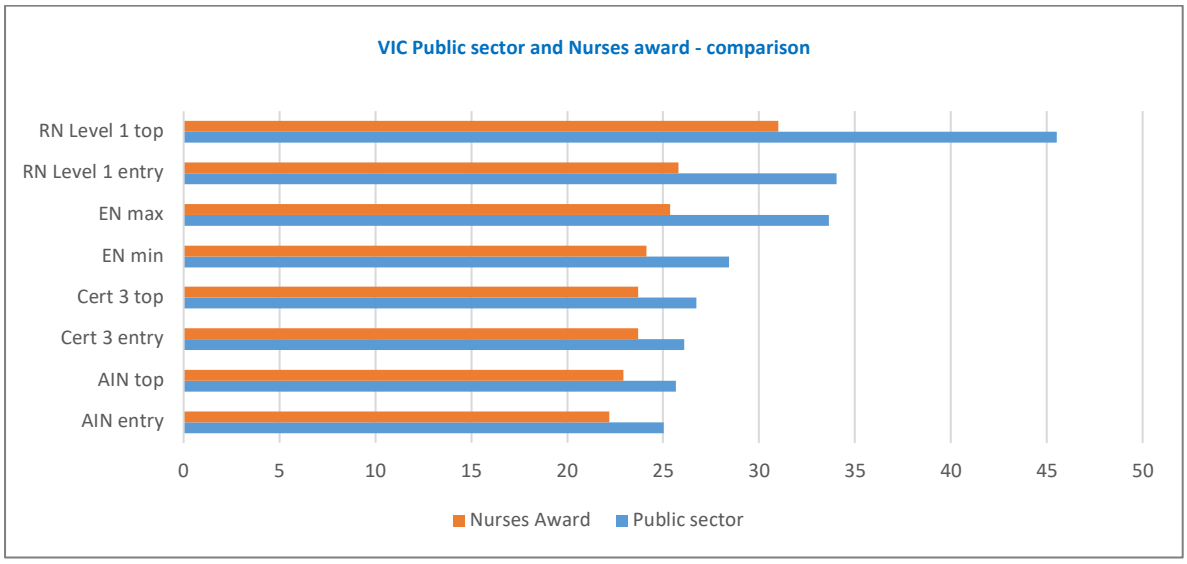
NATIONAL			
Classification	**Average Public sector**	**Nurses Award 1 July 21**	**% Diff Public sector and Nurses Award**
AIN entry	26.61	22.19	20%
AIN top	27.76	22.93	21%
Cert 3 entry	26.91	23.67	14%
Cert 3 top	28.55	23.67	21%
EN min	30.43	24.11	26%
EN max	33.69	25.36	33%
RN Level 1 entry	34.53	25.79	34%
RN Level 1 top	45.90	30.99	48%



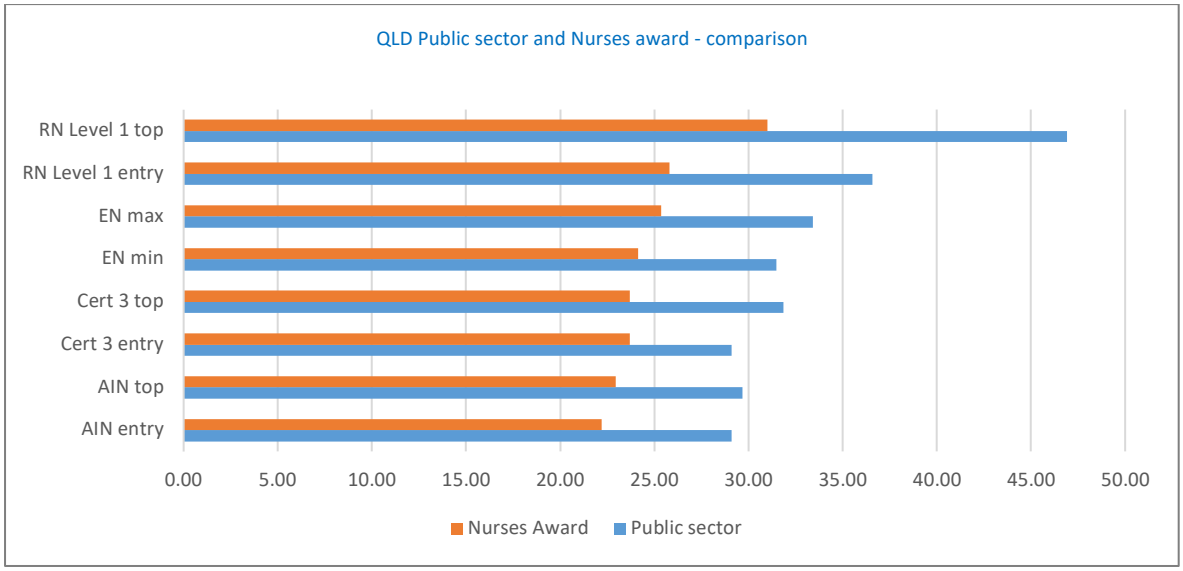
NSW			
Classification	**Public sector 1.07.21**	**Nurses Award 1 July 21**	**% Diff Public sector and Nurses Award**
AIN entry	23.81	22.19	7%
AIN top	26.12	22.93	14%
Cert 3 entry	23.81	23.67	1%
Cert 3 top	26.12	23.67	10%
EN min	29.86	24.11	24%
EN max	32.44	25.36	28%
RN Level 1 entry	33.13	25.79	28%
RN Level 1 top	46.42	30.99	50%



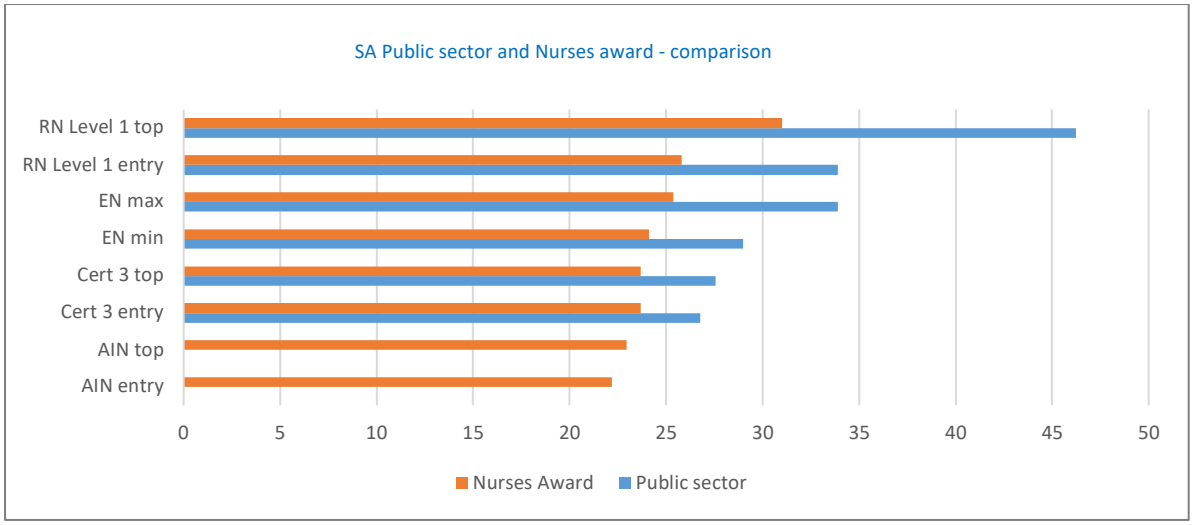
VIC			
Classification	**Public sector 1/12/2020 re RN & EN and 01/10/2019 re AIN/PCW**	**Nurses Award 1 July 21**	**% Diff Public sector and Nurses Award**
AIN entry	25.02	22.19	13%
AIN top	25.66	22.93	12%
Cert 3 entry	26.08	23.67	10%
Cert 3 top	26.72	23.67	13%
EN min	28.42	24.11	18%
EN max	33.62	25.36	33%
RN Level 1 entry	34.03	25.79	32%
RN Level 1 top	45.5	30.99	47%



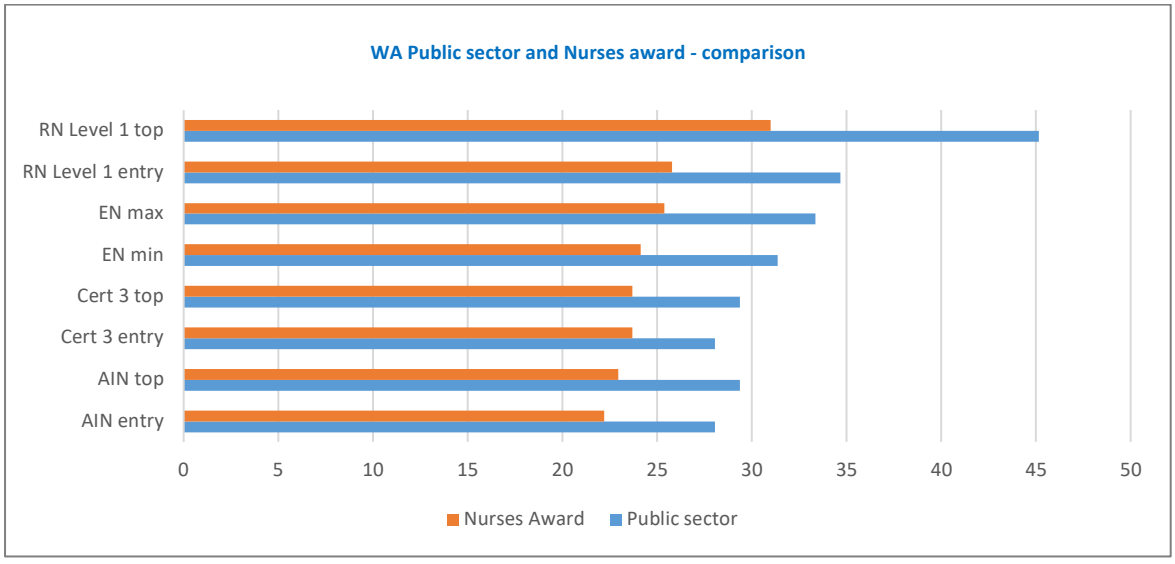
QLD			
Classification	**Public sector 1/04/2020**	**Nurses Award 1 July 21**	**% Diff Public sector and Nurses Award**
AIN entry	29.08	22.19	31%
AIN top	29.67	22.93	29%
Cert 3 entry	29.08	23.67	23%
Cert 3 top	31.83	23.67	34%
EN min	31.46	24.11	30%
EN max	33.39	25.36	32%
RN Level 1 entry	36.55	25.79	42%
RN Level 1 top	46.88	30.99	51%



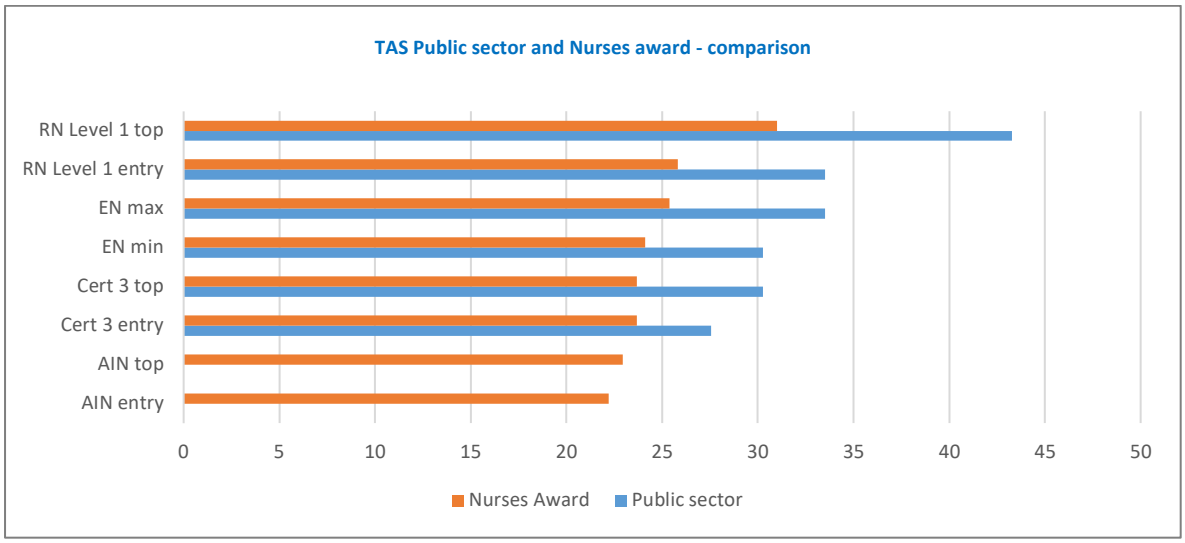
SA			
Classification	**Public sector 1/01/2021**	**Nurses Award 1 July 21**	**% Diff Public sector and Nurses Award**
AIN entry		22.19	
AIN top		22.93	
Cert 3 entry	26.75	23.67	13%
Cert 3 top	27.54	23.67	16%
EN min	28.96	24.11	20%
EN max	33.87	25.36	34%
RN Level 1 entry	33.87	25.79	31%
RN Level 1 top	46.21	30.99	49%



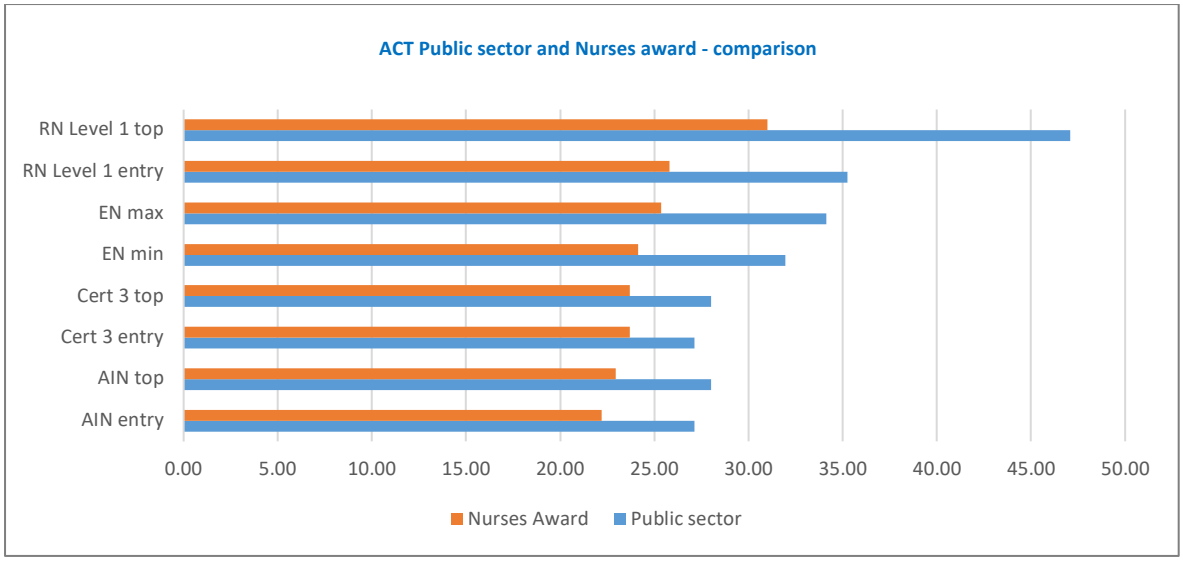
WA			
Classification	**Public sector 12/10/2020 RN 7/10/2020 (AIN/EN)**	**Nurses Award 1 July 21**	**% Diff Public sector and Nurses Award**
AIN entry	28.03	22.19	26%
AIN top	29.36	22.93	28%
Cert 3 entry	28.03	23.67	18%
Cert 3 top	29.36	23.67	24%
EN min	31.34	24.11	30%
EN max	33.33	25.36	31%
RN Level 1 entry	34.65	25.79	34%
RN Level 1 top	45.12	30.99	46%



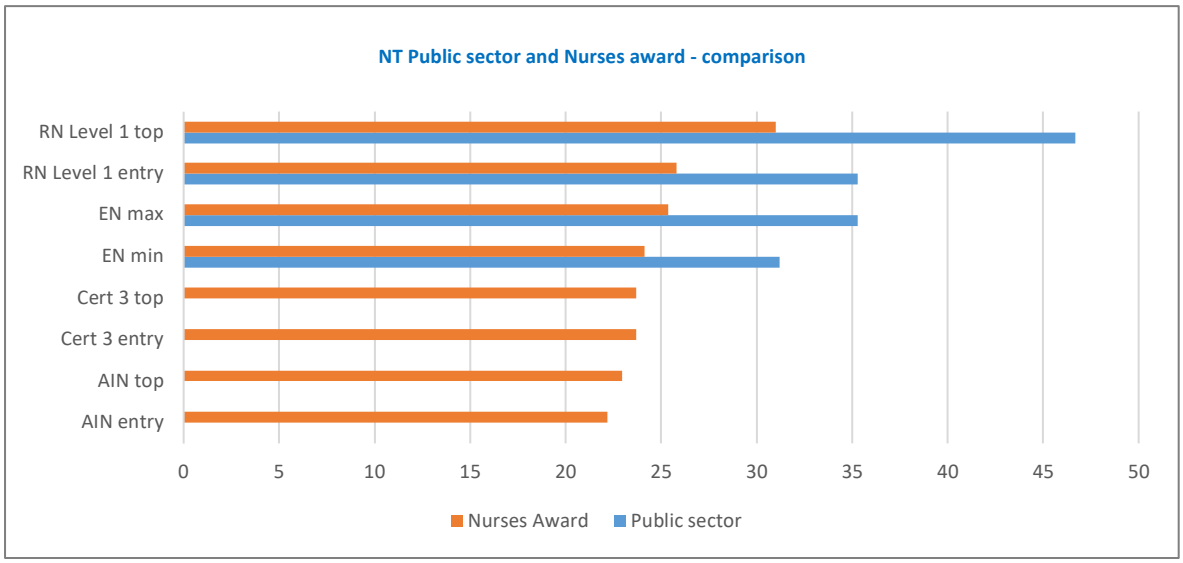
TAS			
Classification	**Public sector 1/12/2020**	**Nurses Award 1 July 21**	**% Diff Public sector and Nurses Award**
AIN entry		22.19	
AIN top		22.93	
Cert 3 entry	27.53	23.67	16%
Cert 3 top	30.25	23.67	28%
EN min	30.25	24.11	25%
EN max	33.49	25.36	32%
RN Level 1 entry	33.49	25.79	30%
RN Level 1 top	43.27	30.99	40%



ACT			
Classification	**Public sector 10/12/2020**	**Nurses Award 1 July 21**	**% Diff Public sector and Nurses Award**
AIN entry	27.10	22.19	22%
AIN top	28	22.93	22%
Cert 3 entry	27.10	23.67	14%
Cert 3 top	28	23.67	18%
EN min	31.95	24.11	33%
EN max	34.13	25.36	35%
RN Level 1 entry	35.23	25.79	37%
RN Level 1 top	47.06	30.99	52%



NT			
Classification	**Public sector 20/08/2020**	**Nurses Award 1 July 21**	**% Diff Public sector and Nurses Award**
AIN entry		22.19	
AIN top		22.93	
Cert 3 entry		23.67	
Cert 3 top		23.67	
EN min	31.2	24.11	29%
EN max	35.27	25.36	39%
RN Level 1 entry	35.27	25.79	37%
RN Level 1 top	46.67	30.99	51%



Annexure KW 3 – C10 Comparison Table
Manufacturing and Associated Industries Award
Nurses Award and Aged Care Award

Classification level **Manufacturing and Associated Industries Award 2020**	**Minimum weekly rate** **(full-time employee)**	**Minimum hourly rate**	**Nurses Award comparison**	**Minimum hourly rate** **Nurses Award**	**Aged Care Award**
	$	**$**			
C14 / V1	772.60	20.33			
C13 / V2	794.80	20.92			
C12 / V3	825.20	21.72			
C11 / V4	853.60	22.46			
C10 / V5 100% Certificate III	899.50	23.67	100% Certificate III AIN and PCW $899.50		100% Certificate III Level 4 PCW $899.50
C9 / V6	927.70	24.41			
C8 / V7	955.90	25.16			
C7 Certificate IV 115% of C10	981.50 109% of C10	25.83			Level 6 Associate Diploma/Advanced Certificate $980.10 Level 7 Associate Diploma/Advanced Certificate 997.70 111% of C10

Classification level Manufacturing and Associated Industries Award 2020	Minimum weekly rate (full-time employee)	Minimum hourly rate	Nurses Award comparison	Minimum hourly rate Nurses Award	Aged Care Award
	$	$			
V8	984.10	25.90			
C6 / V9	1031.30	27.14			
C5 / V10 130% Diploma	1052.40 117% of C10	27.69	Diploma EN PP1 $916.20 + < 2% EN PP5 $963.80 + 7%		
C4 / V11	1080.60	28.44			
C3 / V12	1137.20	29.93			
C2(a) / V13	1165.60	30.67			

Notes:

1. The percentage wage relativities to C10 in the table in clause A.3.1 reflect the percentages prescribed in 1990 in *Re Metal Industry Award 1984—Part I* (M039 Print J2043). The minimum rates in this award do not reflect these relativities because some wage increases since 1990 have been expressed in dollar amounts rather than percentages and as a result have reduced the relativities.

Level C1 is not included in the Manufacturing and Associated Industries Award. It refers this level to the Professional Employees Award.

IN THE FAIR WORK COMMISSION

Matter No.: **AM2020/99, AM2021/63 & AM2021/65**

Re Applications by: **Australian Nursing and Midwifery Federation and others**

AMENDED STATEMENT OF PATRICIA MCLEAN

I, Patricia McLean, Enrolled Nurse (**EN**), of [redacted] in the State of Queensland say:

1. I am a member of the Australian Nursing and Midwifery Federation (ANMF).
2. Where I refer to a conversation in this statement and cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. My date of birth is [redacted].
4. I live alone in a serviced apartment within [redacted]. I moved to [redacted] in 2020. I previously owned my own townhouse which was mortgaged. With my reducing work I was not able to continue to pay my mortgage, so I sold my townhouse and moved to [redacted].
5. I have relied on my income from aged care work to pay my mortgage and living expenses. After selling my townhouse I relied on this income to pay my [redacted] apartment fees, groceries, fuel, coffee, overnight stays at Caloundra, a little bit of medicine, hydrotherapy, saving for retirement through super and other savings via salary sacrifice.
6. I was employed full-time by the Uniting Church in Australia Property Trust (Q.) trading as Blue Care (Blue Care) from 2009 until 2017. Between 2017 and about 2019 I worked 8 shifts a fortnight for Blue Care. Between about 2019 until about 2020, I worked six shifts a fortnight. Then from 2020 until 26 July 2021, I worked 4 shifts a fortnight for Blue Care. I resigned my employment with Blue Care effective on 26 July 2021.

Lodged by:	Telephone:	03 9603 3035
The ANMF		
Address for Service:	Fax:	03 9603 3050
Level 22, 181 William St	Email:	nwhite@gordonlegal.com.au
Melbourne VIC 3000		

7. My income working in aged care did not meet my living expenses. Just before my retirement I was paid a base wage of $30.42 / hour by Blue Care, which is the rate for an EN Level 2.3 under the Blue Care / Wesley Mission Brisbane Nursing Employees Enterprise Agreement 2013.
8. Between about 2020 and July 2021, I received from Blue Care about $350 net wages each fortnight plus $400 deposited into my salary sacrifice account. At this time, I also received around $300 from Centrelink.
9. At that rate I could not afford private health insurance, life insurance or go to the dentist. Previously, to increase the likelihood that I could pay my electricity bill, I would use less electricity by avoiding running the heater in my house in winter and having shorter showers.
10. Since June 2021 I have been working one day a week for the Queensland Nurses and Midwives' Union.
11. I am [redacted] years old and I would like to retire now, but the amount I have been able to save from my wages, salary sacrifice amounts and my superannuation from 43 years of work in aged care are not enough to retire on, so I will have to continue to work to make ends meet.

Work history and qualifications

12. Before working for Blue Care I was employed by Baptist Care (now re-named as Carinity) in aged care from 1972 to 2009 (during which I had about 6 years of maternity leave for 3 children). I first worked as a Domestic Assistant (now called an environmental worker) for 2 weeks, and then as an Assistant in Nursing (AIN) at Brookfield Village in Brookfield, a western suburb of Brisbane. Brookfield Village is a large, aged care complex accommodating around 250 residents comprising:
    a. William Carey Nursing Home – renamed Haven Lodge;
    b. Poinsettia Place, a high-care Hostel;
    c. Miller Terraces, which were a series of bed sitters (like serviced apartments);
    d. Bougainvillea Hostel;
    e. Camellia Court (a secure low care dementia unit); and
    f. Three sets of independent living units, Carey Court, Frankston Court and McAllister Court.
13. I lived in at Brookfield Village in 1972 -73.
14. From about 1986 – 2007 I was a manual handling facilitator for Baptist Care / Carinity.
15. Between about 1987 – 2007, I was classed by Baptist Care as a Senior AIN. In that role, I:
    a. Mentored new staff and was buddied up with them;

b. Worked closely with the physiotherapist; and
c. Was also the "Link Nurse" i.e. the nurse who liaised with the nursing home's continence product provider, Hartmann's.

16. I became registered by Australian Health Practitioners Regulation Agency (APHRA) as an Enrolled Nurse on 14 September 2007 and my employment classification with Baptist Care changed to Endorsed Enrolled Nurse (**EEN**) around the same time, and I remained employed in that capacity until 2009. "Endorsed" in my job title referred to the fact that I was endorsed by APHRA to administer medicine.

17. While employed as an EEN by Baptist Care, I also performed the specialist roles of Workplace Health & Safety Officer, Fire Safety Advisor & Infection Control Co-ordinator.

18. On. 6 October 2009 I commenced full-time employment as an EEN with Blue Care Community Service. My work in that employment has always been principally providing nursing care in elderly client's homes on the northside of Brisbane. My employment with Blue Care was based at the following locations (in chronological order):
    a. Blue Care Northside Community Care office at Milton;
    b. Blue Care Northside Community Care office at Everton Hills (that office having moved from Milton);
    c. Blue Care Community Care office at Sandgate at 50 Ibis Avenue, Deagon; and
    d. Rangeview Respite Centre – a day respite centre at Rangeview Place, Ashgrove.

19. My employment with Blue Care was converted to part time in 2017, working 4 days / week. I then reduced to 2 days / week.

20. I resigned my employment with Blue Care, effective 26 July 2021.

21. My Certificate of Service given to me by Blue Care is **Annexure PM 1**.

22. My position description, entitled "Critical Job Demands Analysis" is **Annexure PM 2**.

Qualifications and training

23. I have a Certificate IV in Aged Care which I obtained on 20 January 2004 through Bremer Institute of TAFE.

24. I undertook a Diploma of Nursing through TAFE Toowoomba and completed that in 2007.

25. I completed a certificate IV in Workplace Health and Safety through Future Skills on 27 July 2011.

26. I have done a number of Blue Care courses including continence and safety coaching. Some of that has been through a Blue Care online training program called SABA.

27. I have done a lot of courses. In dementia and I specialised in providing dementia care to many clients.

28. I have done driver safety training including fatigue avoidance, being a 30-minute course on-line every 12 months since about 2011.

Description of role and work

Residential care at Brookfield Village

29. When I worked in the William Carey Nursing Home. (Haven Lodge) from 1979 until 2008,, there were 52 residents living in that nursing home. I worked in Poinsettia Place in 2008-2009, during which time about 30 residents lived there. Between 1983 and 1986 I worked night shift across both facilities as an AIN..
30. William Carey Nursing Home has a 12-bed Dementia unit and three wings, with 14 beds in each of Wings A & C.. B-wing and the Dementia ward each comprised twelve single-bed rooms.

Community Care with Blue Care

31. My work as a Community EN for Blue Care has always been principally in elderly client's homes on the Northside of Brisbane. I typically saw 7-10 clients each day but I saw up to 14 clients some days when most of those clients were scheduled for shorter visits, such as for insulin injections.
32. I have mostly worked day shifts in community aged care. I worked on weekends from 2009-2017. Since 2017, I have worked only Monday-Friday each week. Prior to about 2016, I would generally see clients between 7am and 1pm and work from the office from 1 to 4pm each day, doing paperwork associated with the clients I had seen that day. After about 2016, I was directed by my manager at Blue Care to do paperwork in the client's home rather than doing this from the office. From that time, I started doing my paperwork during my client visits.
33. Also in 2016, Blue Care directed me to complete training in a module entitled "Lone Worker" or similar. I completed that module each year after that time. After 2016 I generally worked as a "lone worker".
34. Being a "lone worker" meant I went straight from my home to my first client's home and spent my day working through a list of clients. After I reduced my work to 3 days per week in 2019, I was told by Blue Care that I couldn't garage the Blue Care car at home and so I'd have to attend the Blue Care office to pick up a car at the start of each day and drop it off at the end of the day.
35. Since 2016, my typical shift would involve me driving to my first client around 7am, usually in the Clayfield / Albion area. From 2009-2019 I home garaged the Blue Care car and travelled in

unpaid time from my home to my first client and from my last client back to my home. Sometimes, such as when my first or last client was at Sandgate, that unpaid travel was one hour each way. Sometimes up to two hours on the return trip in peak hour traffic.

36. Since 2019 I would also attend the Blue Care office at their Ashgrove Respite Centre at 7am to collect a Blue Care car. Often the time allocated to get from the Ashgrove Respite Centre to the first client would not be sufficient. I would usually see 4-5 clients until 12.30pm at which time I usually, but not always, had lunch and morning tea combined. After lunch I would go to the next client and continue with my list. I would usually see around 2-3 clients after lunch.

37. After about 2016 I completed paperwork throughout the day. This made time management harder and meant that I had to be doing paperwork whilst providing care to clients. I would have lunch on the road and at the end of the day, I went home. I had almost no direct face-to-face interaction with other nurses.

38. At Blue Care, I reported to my manager, the Clinical Care Co-ordinator.

Nature of work

Complexity of my work

39. The work I have performed in aged care has become more complex and challenging since 1998, both when I was working in residential care at Brookfield Village prior to. 2009 and in community care with Blue Care since that time.

40. For example, in my *work* at Blue Care:

    a. I have observed that older people are remaining in their homes longer before being admitted to an aged care facility. As a result, the complexity of clinical issues and the needs of clients have increased. My clients had greater and/or increased levels of co-morbidities and acuity in 2021 than in earlier years. By 2021, many of my clients has deteriorated and chose to spend more time sitting or lying in bed. Clients spending more time in bed can itself cause problems such as “pressure” injuries.

    b. For clients with wounds, I clean wounds with boiled (not boiling) water or a product called Prontosan Irrigation Solution (depending on what the client could afford) and apply wound dressings. I deal with complex wounds and have treated many acute wounds including venous ulcers, large wounds, wounds caused by pressure on the skin from sitting / lying. One one occasion a client’s muscle was exposed because of a 250 x 25 millimetre tear in the skin on his leg. I have been nauseated from the smell and sight of wounds on many occasions.

c. My knowledge of wound dressing products has increased significantly since I first started with Blue Care. Also, wound dressing products have changed significantly during the time I've been working in aged care. Blue Care has significantly reduced the amount of stock dressings provided to me since 2009. Blue Care has a contract with CH2 and we could not get products that CH2 did not supply. Clients were required to pay for all dressings that I applied, so I needed to have knowledge of various products and their prices and be able to recommend the best products to clients that they can afford. For example, I used to use Betadine solution, which was effective for about 24 hour in resisting infection, but later changed to using Inadine gauze because it was effective in resisting infection for 2-3 days when multiple layers are applied to a wound.
d. I conduct skin integrity checks including inspection for bruises and skin tears, including under clothing. I advise clients about skin care.
e. I assess the mobility of clients whenever they are moving in my presence. If I assess that a client may benefit from a physiotherapist or equipment from an Occupational Therapist, I would refer the client to the Allied Health staff. I would also record observations in the clients notes. If the mobility off the client had recently changed, I would do an assessment and also record this in the notes.
f. I have been encouraged in recent years, much more than in 2009, to check the weight of our clients more regularly, and to educate clients more about the importance of remaining hydrated.
g. I talk to all of my incontinent clients about incontinence pads and other strategies to deal with their concerns about toileting with the objective of them maintaining good hygiene: bowel care was also discussed.
h. I have noticed an increased prevalence of clients who want to talk beyond the end of my scheduled visit. This coincided with a reduction of social support in recent yers, especially for Commonwealth Home Support Programme clients and the reduction of the duration of Blue Care client appointments. To deal with this, I developed extra social skills to be able to leave their home without offending them; and
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.

41. In my work at Brookfield Village towards the end of my time working in the late 2000s, there was a significant reduction in the use of chemical and physical restraints. Bed rails stopped being used because they restricted the client's freedom to move. This led to more challenges providing care to prevent falls. I discuss the changes to medication use further below.

42. Attitudes towards dementia clients have changed and training has increased. Previously, dementia clients were all treated the same way. We used chemical and physical restraints upon residents and clients who posed a risk to their own safety or the safety of others. Now, we do not restrain residents or clients generally, but instead distract them and occupy their attention to prevent them from engaging in dangerous behaviour. It is now recognised that even though people with dementia have similar symptoms, each must be treated as an individual. 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. This is a significant change that I have observed over my career. As a result of training and encouragement from Blue Care, all nurses at Blue Care treat elders with dementia more as individuals in 2021 than in 2009. I support the changed attitudes and increased training, but it means more time is needed to spend with clients and more skill is required.

Care plans

43. Since about mid 2020 the initial care plan would be prepared by an RN. Prior to that time I would prepare the care plan. For my new Blue Care clients care plans would be signed off by the client then entered into Blue Care systems.

44. Every new client of Blue Care goes through an admission process involving the creation of a care plan. Care plans record details of the client, including what they wanted to improve and the agreed action to be taken. Until about 12 months ago I was regularly involved in the admission processes. I have admitted more than 100 clients to nursing care in their home by Blue Care. The admission of those clients to nursing care involved me developing the care plan for each of those clients. I did so in consultation with the client.

45. Often a care plan would require me to make additional assessments and judgements of what treatment I need to provide. I would make assessments of the health of every client on every occasion when I have contact with them. My work as an EN at Blue Care involved keeping care plans up to date by making changes as appropriate. Often a care plan would require updating because things would change. For example, a wound may improve so visits to the client may reduce from 3 to 2 times per week. It was important that care plans were kept up

to date so any Blue Care nurse providing care to the client would have accurate information about them.

Other documentation and reporting

46. A large part of my job at Blue Care was filling in progress notes as a part of reporting. For each client visit I would record in the progress notes my clinical observations, sometimes attaching photographs taken and uploaded to file. Sometimes my notes would include recommendations, such as a referral to an RN or a doctor. I may also record levels of anxiety, concerns or stresses of the client. If the care plan needed to be changed or varied, I would do that and then also record this in the progress notes.
47. At Blue Care I was also required to take other actions to assure that all documentation was up to date. For example, clients require referrals from their GP for a catheter change. Where the referral for the client catheter change is out-of-date, I would need to contact the doctor and get a written referral or verbal permission from the doctor to change the catheter. If the doctor wouldn't provide such verbal referral during our telephone conversation, I would need to schedule another visit to that client for a later day.
48. Sometimes I had substantial involvement with GPS, especially for more complex clients. From time to time I would take photos of wounds and send them to a client's doctor for them to review.

Physical demands of work

49. Working for Blue Care, visiting clients in their home was physically demanding. Some clients did not have hospital beds or slide sheets. This meant that attending to these clients in bed and moving these clients can be difficult.
50. I would also carry two work bags in my car, one with personal items such as water / tissues etc. I would carry a bag which weighed about 5 kilograms in and out of each client's residence. It held the tablet, phone, gloves, sanitiser, pen and paper etc.
51. In about 2014 I understand that Blue Care arranged for a Critical Job Demands Analysis to be prepared for the job I was doing (see **Annexure PM 2**). That document included a "Task Analysis", detailing the physical, psychological and cognitive demands that was completed in respect of the job entitled. I have reviewed this part of the document. It provides an accurate description of the demands of my tasks as at 2014. Although there were some changes to the nature of my work after 2014, I confirm that it accurately describes the nature of the work I would perform.

Emotional demands of work

52. My aged care work is emotionally demanding and stressful. In both residential care and community care I have had clients who died while in my care which is very distressing. I developed long-term professional relationships with most of my clients. Some of my clients get better and no longer need nursing. Some unfortunately die. On one occasion a client fell and hit his head when letting me into his house. I administered first aid, called an ambulance, contacted his family and Blue Care office. I was with him until the ambulance arrived and took him to hospital. That client died a few days later.
53. Anytime a client of mine dies I feel sad knowing I won't see them anymore.
54. I remember a night in the mid 1990's working at Brookfield Village when a female resident was dying and the locum GP was lost trying to find the facility. The RN and I took turns sitting with the resident to comfort her. We would leave the room to cry, then return once settled for a bit. The woman was in pain and thrashing around. It was very hard watching her dying in pain.

Scheduling of my work

55. At Blue Care, I would do my work each day according to a schedule provided to me by Blue Care, identifying which clients I was to see at specific times. Until around 2016, Blue Care employed an RN who would make up my schedule. The RN had a clinical background and set a schedule of appointments which I found to be realistic. That is, the schedule allowed me sufficient time to deal with clients. In about 2016, Blue Care implemented changes to this system and began employing a team of "schedulers" to prepare schedules of nurses providing community care. I understand that those people did not have nursing experience or qualifications. Around this time, I was also given a smart phone and tablet to use for work. From 2016 my schedule was provided to me through the "Procura Mobile" app on my Blue Care smartphone. My schedule would often, but not always, include a lunch break. Sometimes I would be scheduled to see two or even three clients at the same time in different locations. Occasionally my schedule would include gaps or "admin time" when there were no clients to see. I would use that time to make sure my paperwork was up to date, review client files or complete online learning.
56.
57. In or about early 2021, my manager told me that those gaps in my schedule had reduced my productivity and asked me to call the schedulers to get those gaps filled. After that discussion, I would call the schedulers and ask them to fill the gaps in my schedule. Schedulers were not always able to fill gaps if no further client visits were required that day.

58. When I received training on the use of the new technology introduced by Blue Care I was told by my manager that I would need to go into the tablet and download my client list on the "CDV" program (Clinical Day View) in my own time before work. The CDV program contained a copy of my daily client schedule, client's care plans, wound care plans, referrals, client details (next of kin etc). Because glitches sometimes occurred it was necessary to download all documents before I started work.
59. I was required to log on and off the Procura Mobile app for each client appointment.
60. My schedule was subject to change at any time of the day or night. Sometimes my schedule on the Procura Mobile app on my Blue Care smartphone would change and become different to my schedule in the CDV program.
61. Over my time with Blue Care, the times allocated to me for client appointments decreased. For example, in 2009 I was generally scheduled for appointments which averaged about 40 minutes. In 2021, I was generally scheduled for appointments of about 20-30 minutes. The main change to the length of appointments occurred in around 2016.
62. In addition to the shortened scheduled appointments, I was also required to fill in paperwork during the appointments after 2016.

General changes

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.
64. During my time in residential care I also noticed a change in that things became more task orientated than supportive and I had less time to provide care. This coincided with an increase in verbal and physical aggression towards me from residents.

Diverse backgrounds of my clients

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. Previously, the majority of residents I nursed were of Anglo-Saxon- Celtic descent. In 2021, I nursed more Italian clients than those of any other cultural group.

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.

69. Blue Care required me to undertake cultural diversity training of about 90 minutes online, through SABA.

Additional client care

70. In my providing community care I had to do some additional duties to be able to provide the care. I did some cleaning for infection control. For example, sometimes I needed to clean a client's dining table to make it sterile for clinical use.

71. I provided social support to my clients, most of whom would live alone in their own home. Since the mid to late 2010s, Blue Care has been more orientated to the performance of pre-determined nursing tasks for which Blue Care was funded. At the same time, I was also required by Blue Care to apply the Blue Care Tailor Made Service Model, including Blue. Care's "Person. Centred Care Philosophy and the Well-being Approach". The Blue Care Tailor Made Service Model was described as focused on the person "who comes first and is at the centre of all we do". A copy of the Blue Care Tailor Made Service Model is **Annexure PM 3**.

72. I have always delivered care in a person-centred way. Occasionally I would put the kettle on for a client or fetch things from another room in their residence at the request of a client with limited mobility. I have made sandwiches for diabetic clients with low blood sugar levels, collected Webster packs from a chemist and helped plan meals for clients whose nutrition is inadequate. I have also advised upon, and arranged, recreational activities for residents and clients. Also, as discussed further below, I worked with other health professionals for the well-being of clients.

Skills and responsibility

Clinical work

73. My work with Blue Care involved changing catheters, providing wound care (including drains), treating ulcers, assessing clients as to whether they needed to go to their GP / hospital, applying cream (medicated and non-medicated) to client's skin, administering

medicine, assisting clients with medication, and monitoring client's health to ensure they are doing okay at home. In doing this work I exercise the skills that I have developed working in aged care over around 45 years and the skills I learnt through my training.

74. The skills I use and responsibilities I had in caring for residents and clients includes communication, assessing needs, supporting residents and clients emotionally, socially and physically, making written records of clinical assessments, administering treatments and making assessments of any other issues or concerns I have, or which are expressed to me about the client's health.

75. At Blue Care, I knew the allergies of most of my regular clients without having to look them up. I knew what wound care products worked best for individual clients. I knew how to approach a client about future care planning, such as them moving to residential aged care or palliative care.

Time management and IT

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. Despite my improved time management skills, I would still need to work at home after rostered shifts simply because I was not scheduled enough time during my rostered shifts to do all the necessary recording of clinical information.

77. I have gained IT skills, especially skills in problem-solving IT malfunctions. When I first started using some of the software that Blue Care required me to use, I didn't understand how that software worked, but became very competent in using that software. I had to learn where to find particular documents in the software (apps) For example, clinical documents more than 3 months old are archived in a different system called Core Procura. I learned how to get out of CDV and open up the Core Procura app and then find the document I needed. The tablets that Blue Care gave me and other nurses regularly malfunctioned. I learnt how to trouble shoot some of those malfunctions.

Working with other staff and skill mix

78. In residential care I supervised AINs and support workers (now called environmental staff e.g. kitchen staff and cleaners.)

79. In community care I have supervised Personal Support Assistants (**PSAs**), especially in their prompting of clients to take their medicine and to ensure that services required by a nursing care plan or a personal care plan were provided by the PSA to each client.

80. I had more responsibility in every aspect of my job in 2021 than I did in 2007 when I started working as an EEN. In 2021 there was less RN support than when I started working in community nursing in 2009 and I needed to shoulder more responsibility to ensure that clients received the care they needed.

81. Since about 2016 at Blue Care there has been a reduction in registered nurse numbers as team leaders. The consequences of that has been reduced access for me to support by an RN. Prior to 2016 I used to organise 'double visits', that is a visit to a client attended by me and my Team Leader where I was particularly concerned about a client's health. After 2016, whenever I tried to schedule a double visit, I would be advised that this was not possible. Until about 2016 I also used to have a 'support day' about every 3 months or upon request. 'Support days' were shifts during which my Team Leader accompanied me on all client visits for the entire shift. In about 2016 the Team Leader positions were made redundant and so support days simply stopped happening.

82. Until 2011, Blue Care would almost always engage an agency nurse to replace any Blue Care nurse that was absent from a rostered shift. From 2011 however, Blue Care stopped engaging nurses to replaced any Blue Carew nurse in Northside Community Care that was absent from a rostered shift.

Additional skills and training

83. Between 2009 and 2017, I annually assessed the competency of RNs in hand washing and manual handling (e.g. the use of hoists and slide sheets) and recorded these assessments.

84. Since about 2016, I perform basic maintenance of CPAP (continuous positive airway pressure) machines used for sleep apnoea. This included cleaning the machine, checking the hoses and refilling with fresh water. Instructions were included in the care plan and any action would be included in the progress notes.

Interaction with other health professionals

85. Working at Blue Care I would often interact with my client's General Medical Practitioner (GPs) about my client's various health issues. I email photos of their wounds to their GPs. Sometimes I make urgent appointments with GPs for my clients who did not succeed in convincing a GP practice receptionist that their condition required urgent attention by their GP. My interactions with GPs have increased in frequency since 2009. Many of my clients are

also clients of the Lutwyche Family Practice and so I have built up a good rapport with both doctors in that practice.

86. I would also interact with Blue Care RNs and hospital-based nurses including Hospital-in-the-Home nurses who were also treating my clients. I interacted with other health professionals (some of whom are employed by Blue Care and others who are not), such as GPS, hospital discharge planners, allied health professionals including physiotherapists, dieticians, social workers, podiatrists, Occupational Therapists. If I observed that a client had lost weight or had poor nutrition, I would refer them to a dietician.

Medication and pain management

87. As noted above, as an EEN. I am "endorsed" to administer medicine under the guidance of an RN, I administer medication, ensuring clients are taking the right medication in the right dose at the right time.

88. Part of my community care work included applying Morphine patches. I have observed that doctors have generally reduced prescriptions of Morphine and other opioids since about 2016. As a result, clients suffer more pain. So, since 2016, I have increased my knowledge of alternative pain management (e.g. physiotherapy, hydrotherapy and TENS machines)) and arranged more of these for clients. With less use of drugs like Morphine, more skill is required. It is more time consuming and you need to explain to clients what is happening and to gain their trust. I am even more gentle when I need to touch the skin of client's in pain than I was before 2016.

89. Medicine is always changing. There are always new brand names of drugs to learn. I do my own research for new products or medications.

90. Blue Care clients would regularly receive their medications in Webster packs. Webster packs are useful but I would still need to check what was being dispensed against the medical summary from the doctor. Sometimes the pharmacy would make changes in consultation with a client's GP but this change isn't recorded in the medication summary provided for the client. Sometimes the pharmacy can make errors. Whenever I saw a difference between the Webster pack and the medication summary I would call the pharmacy and ask them about it. If they said that there had been a change from the GP I would then call the GP and ask for an updated medication summary.

91. Sometimes medication is called by different names. Sometimes brand names change, sometimes a medication summary will list the brand name and sometimes the drug / generic name. Sometimes a client would tell me that they usually had a pink tablet and ask why today they have a white one. I would talk clients through their medication and make sure

that what the client was getting is the one contained on their medication summary. I would also educate clients about what medial condition is to be treated by the medicine, and about what medicines they should take themselves.

92. From 2009 I would dial up the dose to be delivered by an insulin pen and the client would then inject themselves with that pen. Since about 2011 Blue Care required me to inject insulin clients with a syringe containing insulin if the client was unable to inject themselves.

Client behavioural management

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.

94. When working at Blue Care in community care, I advocated for the interests of clients, particularly to my supervisor regarding client concerns about having visits from different nurses (which is known in aged care as lack of continuity of care) and arranging timely access to the client's doctor.

95. At Brookfield Village, I would ensure that activities to entertain and engage residents and improve their cognitive abilities such as jigsaws, trivia games were provided by other staff.

Additional steps re client welfare

96. At Blue Care I found myself pulled in different directions concerning the duration of my client visits. Blue Care gave me set times for each visit. But clients and their family members wanted me to listen to the client's life history. I found that families didn't always understand that it wasn't a 24 hour emergency service and management didn't appreciate the needs and expectations of clients.

97. Working at Blue Care I would sometimes seek the client's permission to communicate with their family members about the health of their loved one who is my client, and, if permission is given, I would communicate these issues.

98. If a client didn't answer the door when I knocked on it or rang their doorbell, I would phone the client's next of kin and ask about the client's whereabouts and well-being.

99. On 19 April 2021 I knocked on a client's door. The client did not answer the door. I could hear her yelling so I decided to walk around the outside of her house to the back door, but both side gates were locked and I couldn't get to the back door. I phoned her daughter in

the hope that she had a key to unlock the gates or could tell me where such a key was. The daughter did not answer my call. I phoned my manager and then the client's other daughter. The client's sister who lived next door then came over with a key to the front door and she let me in. When I was able to enter the house the client told me she had slipped and fallen. She had managed to get herself up off the floor but had sustained a skin tear on each arm. I attended to those wounds. We then discussed the cause of the slip and I advised her how she could avoid slipping again and the obtaining / use of a wearable emergency alarm. This all took more time than I had been allocated. So I was required to contact the scheduler to negotiate how I was going to manage the rest of my day without forfeiting any other clients.

Work conditions

Client homes

100. When I would enter a client's home for the first time and the client locked the door behind me, I often found this daunting.

101. Some clients are hoarders. A lot of the material they hoard is paper, cardboard and other flammable material. Hoarded material is often stacked up between furniture in client's residences so that it would restrict my movement through the house and often prevent entry to their toilet.

102. Some clients wouldn't like you using their toilets and some are so dirty or broken that I wouldn't use them. I would try to avoid using any client's toilet. I would use MacDonald's toilets instead. Every day I would need to plan my toilet use because my access is infrequent. I had a toilet location app on my phone until I learnt where most of the public or customer toilets are that I could use in my work patch.

103. There have been hundreds of occasions when I have not been able to go to the toilet when I have felt the urge.

Occupational Violence and Aggression

104. My work at Brookfield Village would often involve occupational violence. The care needs of residents increased significantly between 1997 and 2009. There was also a massive increase in aggression and bad behaviours towards me from residents over that period.

105. I was assaulted about 150 times while working in residential aged care in periods from 1972 – 2009. The worst kind of assaults I suffered were those I didn't see coming. I was whacked the back by one resident. Most attacks on me occurred while I attempted to shower the resident. I suffered broken skin (split or torn) in around 20 of those assaults. One resident

gave me a 'Chinese burn'. I suffered bruising from about 100 of those assaults. My spectacles were broken in one assault around 2004.

106. At Brookfield Village until around 2006 being bashed by residents was generally regarded as inevitable in Dementia Care.

107. Working at Blue Care I also dealt with difficult clients. For example, in or about 2015, I saw a client Monday to Friday to provide her daily medications. Her medications were locked away in her home. Most days she told me that she was angry about the medications being locked up and sometimes would threaten to hit me.

Exposure to infections and infection control

108. Since the commencement of the COVID – 19 pandemic in early 2020, I have worn a mask during outbreaks. When seeing clients at the Sandpiper Hostel in Albion (a supported residential service in which some of my clients lived), I wore a mask, plastic apron, saw clients only in a treatment room (not the clients bedroom) and rubbed hand-sanitiser on my hands before and after seeing every client.

109. During the COVID – 19 pandemic outbreaks I was directed by Blue Care to wear disposable masks while seeing clients and dispose of them in paper bags provided to us and to put these into a bin in the office.

110. Since 1998 I have been involved in three Norovirus outbreaks. During those outbreaks at Brookfield Village, I and my co-workers were supplied masks, googles, aprons. We doffed all that PPE and donned unworn items between contact with each resident.

Injuries and illness from work

111. Whilst working at Brookfield Village in around 2000 I strained a muscle moving a resident in their bed without a slide sheet and had a 3-day back injury.

112. I became infected three times with Norovirus during each of the three outbreaks ((2 were at Brookfield Village and the third was while I was doing 2 weeks prac at Redcliffe Peninsula Hospital as part of my EN diploma.

113. Before I began receiving flu vaccination around the mid-1990s I often suffered sever upper respiratory tract infections in flu season. In each case, my illness followed having been nursing a resident with the same illness within several days before I developed symptoms. On each occasion I was not aware of having had any contact with each anyone outside the nursing home with symptoms of that disease.

114. Coronavirus has been a major hazard to me in my work at Blue Care since March 2020.

Interactions with persons other than clients and residents

115. In Brookfield Village I had typically about 1-10 interactions with visitors each day, mostly those who were visiting a resident, but also tradespeople including electricians and plumbers, GPs, Aged Care Assessment Team (ACAT) members (all nurses), pharmacists, police and paramedics.

116. At Blue Care, I would interact extensively with the families of clients, especially with family members who live in the same residence as a client.

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.

118. In my work at Brookfield Village, I interacted with volunteers occasionally, especially those who were willing to assist in the feeding of residents and I would monitor and supervise them feeding residents to ensure it was a being done safely and correctly.

119. At Brookfield Village I also interacted with animals. Some family members would bring in the pet dog to visit their family member. At other times a petting zoo was temporarily established at the facility.

120. In my community care work, Blue Care had a policy that clients must lock their dogs away during my visit but often dogs were not locked away. When this happened, I would quietly suggest that the client put their dog away in a spare room or back garden, but often this still would not happen. Cats were not required to be locked away. Dogs sometimes barked at me or licked me. Dogs and cats got under my feet and created a tripping hazard. Cats jumped up on my lap and the client's lap while I was engaged in hands-on treatment of the client, which could be disruptive and dangerous. I learned the nature of particular animals and how to deal with them to minimise disruptions and hazards.

Travel and transport

121. My community nursing work at Blue Care also required me to get into and out of a car about 10 times per day. Often it was not possible to get a park close to the client's residence or one that is in the shade. Also, the distance between client's was sometimes a short drive. As a result, I found that my car would get very hot and would not have the opportunity to cool down between appointments.

122. Blue Care used to give the nurses ice-blocks on a hot day when we returned to the office, but this stopped about 2016.

123. When it rained, I walked in the rain to the client's door and back. I would drive in the rain, which required me to concentrate harder and often resulted in reduced visibility and me feeling stressed.

124. I am a non-smoker and the Blue Care car which I would collect from work from 2019 often stank of cigarette smoke.

Additional comments

125. I was an enterprise bargaining rep for the ANMF/ QNMU's Blue Care members. I found Enterprise Bargaining outcomes to be disappointing, especially with regard to wage increases. Real wages and employment conditions have not really improved in aged care in the 43 years of my working in aged care.

126. Residents at Brookfield Village and clients at Blue Care told me that they valued the work I did. I have always felt valued by residents and clients but often did not feel valued by management. I felt that my remuneration did not properly value the work I was doing.

127. I consider that an increase in minimum rates would change and improve the likelihood of people remaining or re-entering aged care.

PATRICIA MCLEAN

9 May 2022

PM 1

17 August, 2021

Patricia MCLEAN
[redacted]

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CERTIFICATE OF SERVICE.

This certificate, without alteration or erasure, is granted on the above date.

NAME:	**Patricia MCLEAN**
COMMENCEMENT DATE:	**06-OCT-2009**
RESIGNATION DATE:	**26-JUL-2021**
POSITION HELD:	**Enrolled Nurse Level 2**
EMPLOYMENT TYPE:	**Part-time**
HOURS OF SERVICE:	**21,309.02 hrs**
CLASSIFICATION:	**QEEN3 QNU Enrolled Nurse**

SERVICE HISTORY:

10-APR-2018 TO 26-JUL-2021	**Enrolled Nurse Level 2**	**QEEN3**	**Part-time**
17-FEB-2015 TO 09-APR-2018	**Enrolled Nurse Level 2**	**QEEN3**	**Full-time**
29-JUL-2014 TO 16-FEB-2015	**Enrolled Nurse Level 2**	**QEEN3**	**Full-time**
06-OCT-2009 TO 28-JUL-2014	**Endorsed Enrolled Nurse**	**QEEN3**	**Full-time**

[redacted]
Payroll Officer

BlueCare™

Critical Job Demands Analysis

A Critical Job Demands Analysis is a detailed analysis of how a role or task is completed and includes detailed descriptions of the physical, psychosocial and cognitive requirements of activities, task frequency/duration, environmental factors and the equipment required to complete a role. This document is to assist Blue Care Services in determining suitability of tasks in the management and prevention of injuries within the workplace for Endorsed Enrolled Nurses in the community.

Job Title:

- ✓ Endorsed Enrolled Nurse (Community)

Position Description:

- ✓ To provide nursing care, and support and guide other unlicensed care staff in the provision of quality care based on assessed clients' needs that promotes quality of life and enhances the ability of individuals to maintain their independence and remain within their home in the community, ensuring that care is consistent with the mission of Blue Care and current best practice (as per Blue Care's Position Description).

POSITION DESCRIPTION	
Hours/Roster	Full Time Employees ❖ Standard day shifts – including an early shift and a late shift ❖ Standard meal breaks
Environment	❖ Staff are required to work within the community, with up to approximately 15 jobs scheduled per shift. ❖ Staff can travel up to 45 minutes each way to visit clients in their homes. ❖ Staff drive company owned vehicles of varying models. ❖ Staff usually report back to base following a shift to complete necessary documentation and follow up. ❖ Staff are often unaware of the clients immediate environment until the first initial visit has taken place (i.e. whether the client has a clean and tidy environment, whether they have pets, whether the home has uneven ground). ❖ Staff are scheduled with jobs throughout the day, so working within work deadlines is important.
Equipment/Tools	❖ Staff may be required to utilise a range of equipment within clients' homes including, but not limited to: - Transfer equipment (hoist, slide sheet) - Charts/files - Wound care equipment - Mobility equipment (wheelchair, wheeled walkers, sling hoists, standing hoists) - Cleaning equipment
Personal Protective Equipment	❖ Closed in shoes ❖ Uniform ❖ Apron ❖ Gloves
General Duties	❖ Assisting clients with all activities of daily living including: - Hygiene assistance (showering and toileting)

	- Dressing - Grooming - Eating/drinking ❖ Assisting clients with mobility and transfers ❖ Operating vehicle to travel to and from clients homes ❖ Completing administrative functions ❖ Liaising with clients, clients' families, health professionals etc. regarding any issues or concerns ❖ Administering medication ❖ Wound treatment

Task Analysis

The following table provides detailed information on the tasks performed by Endorsed Enrolled Nurses in the community and the physical demands required of each task. It is considered that the physical demands outlined should be utilised for a general guide only, as depending on the circumstances and situations encountered by staff, the physical demands of the tasks may vary.

TASK	PHYSICAL DEMANDS
1. Assisting clients with activities of daily living: - **Hygiene assistance** - **Dressing** - **Grooming** - **Eating/drinking**	❖ Sustained standing with intermittent short distance walking (up to 20 meters) to obtain necessary items. ❖ Unilateral/bilateral lifting and carrying of items weighing up to 10kg (i.e. cosmetics, food etc.). ❖ Frequent bilateral gripping and grasping patterns to hold items. ❖ Intermittent squatting and spinal flexion to access lower levels to dress, wash, dry and groom lower limbs. ❖ Frequent bilateral forward reaching, with elbow extension and flexion. ❖ Occasional above shoulder height reaching to access cupboards and to dress clients. ❖ Working from floor level to overhead height. ❖ Occasional neck flexion, extension and lateral rotation. ❖ Verbal prompting. ❖ Repetitive arm movements to complete tasks. ❖ Moderate to heavy bilateral pulling and sudden/jerky movements to don/doff clients clothing (i.e. compression stockings). ❖ Frequent wrist and digit movements. ❖ Ability to exaggerate walking gait to mobilise over uneven and wet flooring surfaces.
2. Assisting clients with mobility and transfers	❖ Sustained standing with intermittent short distance walking (up to 20 meters). ❖ Occasional moderate to heavy pushing and pulling to assist client to sitting and standing, pushing wheelchairs (i.e. pushing up to 100kg clients). ❖ Bilateral lifting and carrying up to 25kg (i.e. wheelchairs, mobility aids and limbs). ❖ Moderate bilateral gripping. ❖ Frequent forward bending through the hips. ❖ Frequent squatting and spinal flexion. ❖ Frequent forward reaching, with flexion and extension of the elbows, and flexion, extension and abduction of the shoulders. ❖ Bilateral moderate to heavy grasping and gripping.
3. Operating vehicle to travel to and from clients homes	❖ Bilateral cylindrical gripping to hold steering wheel. ❖ Unilateral gripping with the left hand to operate gears. ❖ Sustained sitting (up to 30 minutes at a time).

	❖ Short to medium distance walking to mobilise from vehicle to clients home (up to 100 meters) ❖ Sustained hand-eye coordination. ❖ Frequent knee and ankle flexion and extension to operate foot pedals.
4. Completing administrative functions	❖ Unilateral/bilateral forward reaching. ❖ Unilateral fine motor skills to write/document. ❖ Sustained standing and occasional walking and sitting to obtain charts etc. in office. ❖ Requirement to flex through the spine to document notes in charts on lap or on surfaces not ideal in height at clients home. ❖ Ability to take notes efficiently and succinctly. ❖ Ability to prioritise clients' needs.
5. Liaising with clients, clients families and health professionals	❖ Intermittent sitting and standing depending on location. ❖ Providing verbal information. ❖ Unilateral lifting and holding of phone to ear when making phone calls. ❖ Sustained eye coordination. ❖ Unilateral phone motor tasks to complete relevant communication and administrative based functions including documenting in charts, documenting notes if charts and dialling numbers. ❖ Mobilising over uneven ground to attend meetings, whether this be in a public facility or in a client's home.
6. Administering medication	❖ Bilateral fine motor tasks to distribute and administer medication. ❖ Neck flexion to view medications. ❖ Can be completed either sitting or standing.
7. Wound treatment	❖ Frequent and repetitive bending, kneeling, squatting and stooping, often in awkward positions within the client's home. ❖ Lifting and manoeuvring of clients limbs (weighing up to 25kg). ❖ Pushing/pulling of client and equipment/furniture to set up appropriate area for treating wounds (i.e. up to 100kg + clients). ❖ Lifting/carrying of wound care box (weighing approximately 5-10kg) from vehicle into client's home (up to 50-100 meters). ❖ Bilateral fine motor gripping to hold items (i.e. gauze, pads) to complete wound management.

Overall Physical Demand Level of the Role

KEY	
R = RARE (1-15%)	**O = OCCASIONALLY** (15-33%)
F = FREQUENT (34-66%)	**C = CONSTANT** (67-100%)

PHYSICAL WORK DEMANDS					
Task	**R**	**O**	**F**	**C**	**Comments**
Standing			•		❖ Sustained dynamic and static standing required negotiate home and complete tasks.
Sitting	•				❖ Sitting to complete basic personal grooming, to complete administrative based tasks or to take breaks.
Walking				•	❖ Frequent short distance walking within the home and to and from vehicle (up to 50

					meters). ❖ Walking outside of home with clients and within the community (up to 500 meters). ❖ Walking whilst pushing trolleys and wheelchairs.
Squatting/Kneeling			•		❖ Repetitive squatting, lunging or kneeling required to assist with transfers, personal care tasks and domestic tasks. ❖ Also required to access cupboards and pick up items from the floor.
Forward Bending/Stooping			•		❖ Repetitive and/or prolonged forward bending to assist with positioning of clients, transfers, grooming, showering, toileting, and dressing. ❖ Forward bending also utilised while completing domestic duties such as wiping down surfaces, mopping, sweeping etc.
Neck Postures			•		❖ Neck mobility required for attending to transfers and personal hygiene care of residents. Frequent flexion, extension and lateral rotation required in many aspects of the position including performing ADL and domestic tasks with clients.
Reaching			•		❖ Repetitive and/or prolonged forward reaching to assist with positioning of clients, and attending to personal care and grooming. ❖ Routine forward and occasional overhead reaching to access items from cupboards.
Hand Function (Bilateral)				•	❖ Fine motor skills required when writing in charts, dressing residents, shaving and nail care. ❖ Bilateral hand grip required for using transfer equipment, pushing chairs, lifting and carrying items.
Lifting/Carrying			•		❖ Assisted lifting when using transfer equipment (hoist, slide sheets). ❖ Lifting of personal items, cleaning equipment, mobility aids (e.g., weights ranging from a few grams up to approximately 25kg +). ❖ Lifting of clients limbs while assisting with dressing and transfers.
Pushing pulling		•			❖ Pushing/pulling wheelchairs, shower chairs, hoists and grocery trolleys. ❖ Pushing/pulling to assist with client transfers. ❖ Pushing/pulling of bariatric residents in wheelchairs/over toilet frames (with maximum resident weight approximated at 100kg+).
Vision				•	❖ To complete and assist with all procedures in a safe and appropriate way. ❖ To drive work vehicle in varying weather and traffic conditions. ❖ To supervise and monitor client safety. ❖ To view written paperwork and computer screen. ❖ To complete all documentation and chart

					notes.
Hearing				•	❖ To communicate effectively with the client, their family and other staff.

Overall Psychological Demand Level of the Role

PSYCHOSOCIAL AND CONGITIVE DEMANDS					
Task	**R**	**O**	**F**	**C**	**Comments**
Liaising with staff and residents				•	❖ High level of verbal communication to liaise with clients, their family and staff.
Follow Instruction				•	❖ Having the ability to work under the supervision and instruction of the RN.
Conflict resolution and negotiation			•		❖ High level of conflict resolution and negotiation required when working with clients who can display aggressive behaviours, maintaining a professional manner throughout.
Teamwork			•		❖ To work within a multi-disciplinary team when required, and to liaise with other health professionals for the clients care.
Follow safety policies				•	❖ To work within recommended safety policies and procedures.
Time management skills				•	❖ Working within time constraints and meeting daily tasks within timeframes.
Learn and retain new information			•		❖ Being up to date with mandatory training. ❖ Participate in ongoing professional development. ❖ Ability to utilise short and long term memory to document events accurately.
Respond to emergencies	•				❖ To respond appropriately to emergencies in a timely manner and apply basic life support if needed.
Maintain confidentiality				•	❖ To maintain client confidentiality at all times.

Note: This report has been prepared based on observation and report from the community home visit assessment conducted on 17 December 2014.

BlueCare™

TailorMade

Blue Care *Tailor Made*

Wellbeing Approach

Wellbeing

The Blue Care *Tailor Made* Wellbeing Approach has been developed as part of Blue Care's *Tailor Made* Service Model. This model includes the Person Centred Care Philosophy and the Wellbeing Approach. Together these approaches guide our practice.

The Wellbeing Approach focuses on supporting a person to maintain and strengthen their capacity and skills to manage their daily life; maximising a person's independence and autonomy as well as enhancing their connections with their social networks and community. It is a powerful way to support a person to improve their function, independence and quality of life as the Wellbeing Approach focuses on the person and their strengths, capabilities and aspirations. It is about working with the person to achieve their goals and supporting them to live as independently as possible. The Wellbeing Approach is based on our Blue Care values; compassion, working together, respect, justice and leading through learning.

A successful implementation of the wellbeing approach will:

- support a person to be as independent as they can
- increase a person's quality of life, capacity and autonomy
- improve access and availability of services through a less restrictive approach maximising resources across all service settings

Blue Care's *Tailor Made* Wellbeing approach is one that every employee at Blue Care will apply in their daily work. Wellbeing is:

- 'doing with' a person rather than 'doing for'
- supporting a person to do as much as they can for themselves
- person centred, encouraging a person to be in control of their life
- engaging a person to participate actively in decision making, goal setting and achieving these
- supporting a person's relationships, social connections and participation
- increasing a person's confidence, capacity, independence and autonomy to manage their life

Principles which inform the Wellbeing Approach

- Everyone, regardless of their age, gender, health issues or disabilities, has capacity to increase their independence and confidence to cope with their life
- A person and their family know their individual goals, capabilities and aspirations best; what wellbeing and a quality of life mean to them and what kind of support will help them to achieve their goals
- A person is in control over their support and decisions about this
- Only ‘just enough’ support is provided to help a person to achieve outcomes relevant to their situation and to live as independently as possible
- Staff are adequately trained, supported and supervised to reach their own full potential to deliver support based on the wellbeing approach
- Each person will have an individualised solution for them, delivered in a person centred way; not a one-size-fits-all approach

Key concepts of wellbeing

- Promotion of healthy and active ageing, wellbeing, social participation, independence and autonomy
- Engagement of a person in their goal setting, support planning and journey to reach their goals
- Timely, goal focused support built on the person’s strengths and capabilities
- Relevant information, advice and equipment is available to the person
- Understanding what motivates a person to regain skills and confidence to optimise their independence
- Sustainable support and future planning
- Interdisciplinary team work
- Appropriate training and supervision for staff

Services that exercise the Wellbeing Approach

- Use language that reflects the Wellbeing Approach
- Develop and maintain a culture of ‘doing with’ instead of ‘doing for’
- Establish and maintain an equal partnership with a person, their family and friends
- Involve a person in decision making, goal setting and the journey to achieve desired outcomes
- Support a person as little as necessary and step back when support and help is not needed
- Have information and resources on wellbeing and how it works available for a person, their family, friends and the wider community
- Have high level awareness of available community resources that can meet a person’s needs and aspirations
- Provide training and support to staff to understand the wellbeing approach and to apply it to their daily work
- Have staff who enjoy working with a person to enhance their health and active ageing, social participation, independence and autonomy

Blue Care *Tailor Made* Approach	Living Blue Care *Tailor Made* Wellbeing
The Blue Care *Tailor Made* approach focuses on the person who comes first and is at the centre of all we do. Each individual's uniqueness is appreciated. It is an equal partnership. The role of family and friends is also recognised and is an important part of partnership.	• A person is the centre of our support which is built on the person's unique capabilities, strengths and resources • A person is in control over all support that is tailored to help the person achieve their goals and aspirations • We establish and maintain a partnership with a person, their family, friends and other important networks as they are seen as integral resources
When we utilise active listening, we hear the needs and wants of the individual. We recognise and focus on their skills and capabilities. This guides the design and delivery of service and accommodation solutions that are individually 'tailor made'. Services are then delivered in such a way that the person is in control rather than controlled.	• We promote an equal partnership and facilitate open discussion with a person to find out how they can achieve their goals and the best possible outcomes and be all they can be • By actively listening we find out what motivates a person to achieve their goals and desired outcomes • We offer individualised and 'just enough' support to help a person to achieve their short and long term goals

Blue Care *Tailor Made* characteristics	Living Blue Care *Tailor Made* Wellbeing
Doing *with* not doing *for* The person has the choice and say in what, when and how they wish to receive services.	• We remember a person makes decisions and has control over support we offer • We provide up-to-date information so that a person can make well informed decisions • Together with the person we find out what motivates them to work towards their goals • We use language that reflects a 'doing with' approach, that is easy to understand, emphasises an equal partnership with a person and puts them in control
Building from strengths Working with the individual's strengths and capabilities we aim to help them be all they can be, to live independently for as long as they wish and to have a daily life that is fulfilling.	• We built our support on a person's strenghts, skills and resources • We support a person to regain skills and confidence to manage their daily life and effectively use their capabilities, strengths and resources • We encourage a person to do for themselves as much as they can • We motivate and encourage a person to reach their goals and to live the life they want to • We enable, mentor and coach them to be all they can be and be as independent as possible

Flexible and proactive It's what suits the individual that's important for where and how we provide services. Accessing services has to be easy.	• We are always open to feedback and discussion with a person and their family around the support we provide • Together with a person we evaluate how well the support we provide helps them to achieve their goals and desired outcomes • We acknowledge and accept that a person's future plans and goals might change as their life circumstances might change • We respond flexibly to a person's life circumstances, when their goals have changed • We support a person to achieve their goals within a mutually agreed time frame • We help a person access the information and support they need and / or want to get
Seamless and inclusive Transition and continuity across the full wellbeing and health continuum needs to be seamless. Supporting the person to age in place and continue to be connected with their community will be achieved by integrated and inclusive services provided across a range of sites.	• We encourage and support a person to review their future plans and goals whenever they have achieved their goals or their life situation changes • We seamlessly reduce or withdraw support when a person no longer needs it • We help a person access information, resources, activities and support that better responds to their changed life circumstances • We support a person to move smoothly to another level of services when required

	• We establish and maintain equal partnerships with a person, their family, friends and networks, wider communities, service providers and other stakeholders and work collaborately with them to together achieve best possible outcomes that benefit everyone • We continuously seek opportunities to develop new partnerships that support a person to live the life they want to • We invite a person's family, friends and networks to support the person during their journey to reach their goals
	• We desire to get to know a person and their life journey as well as possible • We respect a person's values, culture, traditions and spiritual preferences and use them as resources to achieve their goals • We keep our own views and our own values separate • We interact and do with a person in a way that fits with their values, culture, traditions and spirituality

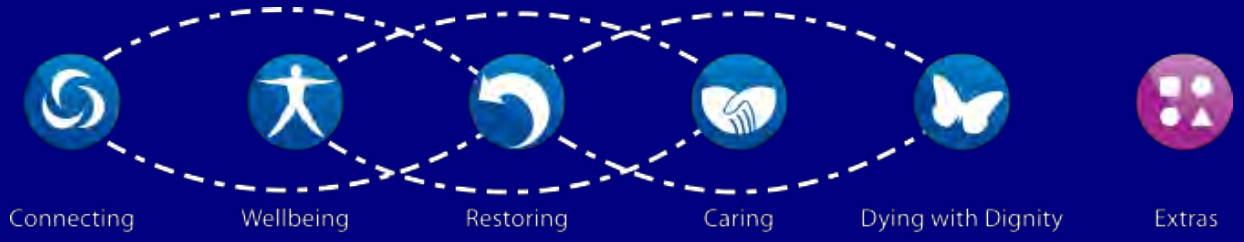
Being sustainable As well as supporting people's immediate needs, we take a long-term view to service delivery. Our aim is to ensure support is viable for all. Sustainability also involves a respect for the environment and we are mindful of reducing our footprint and minimising our impact.	• We ensure support is viable by encouraging and supporting a person to plan their future • We explore future options with a person and encourage them to develop proper future plans that support them to stay independent • We promote a person's independence and aim to reduce a person's need for further support or early residential care • We support people to limit the impact on the environment by using resources efficiently and effectively and to support them to minimise risks, use equipment and assistive technology when appropriate
Local solutions We aim to work with communities to help develop and deliver 'tailor made' local solutions. Just as each person is different, so too are communities and we will plan together how the service model is best applied and implemented.	• We build and maintain relationships with local networks, communities and opportunities and we work collaborately with them so that we can together provide the best possible support to people • We work with a person to find out what local solutions, opportunities and networks suit them and they are keen on • We support a person to (re)connect with their local networks and communities • We provide support which utilises local resources and opportunities for the benefit of the person

Blue Care *Tailor Made* Approach Enablers	
Workforce – people, capabilities and development	• Ensure Blue Care has skilled staff to deliver support based on the wellbeing approach • Provide training, supervision and resources to help our staff to reach their full potential to support people and to work with them • Through evaluation and continuous improvement we ensure the wellbeing approach is implemented in our support delivery
Community engagement and collaboration	• Develop and maintain awareness and partnerships with local communities, networks, social, sports and other clubs, associations, churches, faith-based groups, formal and informal groups and other stakeholders to be able to link and connect people with them • Link people with local networks, groups and communities they are interested in • Utilise community resources and networks where possible rather than duplicating them • Reach the best possible outcomes for the person and the community through collaboration and an equal partnership • Enhance volunteering opportunities at Blue Care and resourcing our volunteers to adopt the wellbeing approach in their work and activities • Utilise client engagement strategies to expand partnerships and collaboration

Evidence based research and practice	• Development of our support is based on validated evidence and best practice • Continuously review our practices in light of the most recent evidence based practice and research • Evaluate and improve our current support delivery continuously aligning with the best practices • Utilise the most recent research results and findings to innovate new methods and practices to deliver support
Government policies and compliance	• Legislation, government policies, guidelines and manuals direct the development and provision of support and advocacy • We reflect the Government guidelines in our support delivery • We advocate on behalf of our clients, their families and carers to the Government and other peak bodies
Communication and information	• Provide information on the wellbeing approach and its benefits to a person and the wider community • Provide information on topics relevant to a person, their carers and families to help them to make good choices for healthy ageing and healthy lifestyle • Communicate information to people, their carers, family members, friends and the wider community in a way that is easy to understand and embraces their abilities • Help a person to improve their health literacy skills
Central support	• Support and resources for staff to understand and strengthen their knowledge about the wellbeing approach and to implement it in their work practices

	• Ensure the wellbeing approach is implemented and reflected across the whole organisation, including Central Support
Care technology	• Support the access to care technology and assistive technology and assist people in using it whenever appropriate • Encourage people to use information technology to enhance wellbeing and independence; and have access to information to maintain and increase their connection with their networks and communities

Wellbeing *Tailor Made* components – Personal stories



Wellbeing – Connect

Keeping you connected to your community.

Blue Care knows the importance of strong connections with your family, friends and community life. Blue Care will work with local communities to understand and

Mrs Smith, 79, contacted the My Aged Care Gateway as she found it hard to get to the shops, visit her friends and participate in local activities. She is able to walk down her street to visit neighbours and to the local park, and does not use any aids. Mrs Smith has never held a driver's licence as her husband did all the driving before he died five years ago. Since then her neighbour has provided transport for shopping and their attendance at a local bowls club where they played together with other friends. Mrs Smith has recently moved to a Blue Care retirement village which is located across the river from her neighbour and they are no longer able to do these trips together.

The Blue Care Retirement Living Officer advised Mrs Smith to contact My Aged Care Gateway and the Regional Assessment Service. Mrs Smith nominated Blue Care as her provider for support with accessing transport for weekly shopping for a period of twelve weeks. Mrs Smith's goal was to be able to shop independently.

At the first visit Mary, a Personal Support Assistant, introduced her to the wellbeing approach which underpins Blue Care's services and how the time limited services and staff would be focused on supporting her to achieve her goals and remain in control of her life. Mary encouraged her to be as independent as possible and was always happy to discuss any suggestions, ideas, questions or concerns around the support she provided. Mrs Smith discussed her goals with Mary and together they broke these down into achievable steps. The first of these was to:

1. I will travel to the local shopping centre and shop independently.

Mary drove Mrs Smith to the nearest shopping centre, encouraged her to use a trolley instead of carrying heavy shopping bags and then dropped her back at home.

strengthen the ability to respond to local needs.	2. I will reconnect with my friends at the bowls club. Together Mrs Smith and Mary found out about a bus route which Mrs Smith could take. However, she didn't feel confident as she had never used public transport. Mary suggested they could do a bus trip together to make sure it worked for Mrs Smith. After the first two trips Mrs Smith and Mary agreed to progress to the next step. 3. I will purchase a pre-paid travel card and travel independently by public transport. Mary supported Mrs Smith to buy a pre-paid travel card and they travelled together a number of times by bus until Mrs Smith was confident on her own. Mrs Smith expressed that she found it easy to catch the bus to the bowls club and found those trips very entertaining as during the bus trip she always met new people and had a chat with them. Mrs Smith was happier being able to play bowls again and to meet with her friends as well as new people. She also enjoyed a sense of independence as she was able to make her own decision when to go and how long to stay. After several weeks Mrs Smith was shopping independently as well as participating in recreational and social activities and had reconnected with her friends as well as establishing new relationships. After eight weeks of support, Mrs Smith completed her program having achieved her goals earlier than planned.
 **Wellbeing – Wellbeing** *Sustaining body, mind and spirit.*	Mr Wilson had been recently widowed and was struggling to manage his daily life. He described how his wife had cared for him, preparing wonderful meals for them both, looking after the house and managing his diabetes. Now Mr Wilson wanted to learn how to look after himself, especially how to manage his diabetes. His two adult children live in other cities, but keep in regular contact and talk regularly on the phone. They contacted My Aged Care asking if there was any support available to Mr Wilson. My Aged Care Regional Assessment Service referred Mr Wilson to Blue Care's Revitalise program with a timeframe of 8 weeks. At the first home visit, Mr Wilson worked with Sue, a Personal Support Assistant, and identified how he would achieve his goals.

Blue Care will help you define personal goals, achieve your potential and participate in life in a fulfilling way.	1. I will be able to prepare and cook meals for myself. 2. I will be able to do household tasks. 3. I will be able to test my own blood glucose level. During the eight weeks, Sue partnered with Mr Wilson to clean, do laundry, shop for healthy eating options, prepare meals and manage his diabetes including regaining skills to take his own blood glucose levels. At the end of the program Mr Wilson managed his everyday life independently. The next time his children visited, he described how proud he was to have gained skills to live alone, care for himself and look after his diabetes.
Wellbeing – Restore *Helping you achieve health and independence.* Blue Care will help you rebuild abilities so you can be as independent as you can be.	Mr Evans recently had a few falls due to dizziness. He visited his GP after the latest fall in his bathroom as he had a large bruise on his right knee and a continuous headache. The doctor was working with Mr Evans regarding his health and had referred him to My Aged Care Gateway for community support. The Regional Assessment Service (RAS) assessor referred him to Blue Care to improve his strength and balance as well as an Occupational Therapy assessment for any aids or home modifications (Restore). RAS also referred Mr Evans for domestic assistance (Wellness) to help him with cleaning while he improves his balance through the exercise program and regains his confidence. When he first met with June, a Blue Care Physiotherapist, they talked about his goals and how he was going to achieve them. Mr Evans agreed to: • learn how to exercise at home using the Blue Care Exercise program • continue exercising independently, at least 5 times a week • identify local community exercise groups such as Thai Chi • participate in helping with the cleaning provided as part of domestic assistance with his Personal Support Assistant • the installation of recommended home modifications and aids

	Mr Evans participated in a time limited group exercise program that focused on increasing mobility, strength and balance. Mr Evans was also provided with instructions and a DVD so that he was able to exercise independently. The installation of hand rails for his bathroom was arranged, as well as other home modifications as recommended by the OT assessment. He was also provided information on local exercise options. June also advised Mr Evans that he would be encouraged to do as much cleaning as he could with Jill, a Personal Support Assistant. Together they would investigate easier ways to do tasks or use equipment. At first Mr Evans was reluctant to work alongside Jill as he would rather work in the shed while the Personal Support Assistant cleaned his home. Jill always discussed with Mr Evans his preferences and how they would work together. Mr Evans suggested that he could wipe and dust whilst Jill vacuums. Whilst cleaning together Mr Evans and Jill got to know each other and Jill encouraged Mr Evans to follow his exercise program. Jill advised Mr Evans of an aid that would allow him to be able to reach high places. She advised him of various dust cleaners with long handles available from a cleaning product shop. When doing his weekly shopping Mr Evans bought new cleaning gadgets specifically suited for older people. Now Mr Evans was able to do even more than he had done before. Jill wrote notes in Mr Evans' record to describe the cleaning and to record Mr Evans' progress towards his goals. After four months Mr Evans reported that he felt better both physically and emotionally since receiving the support. He feels he has been able to slowly increase his activities and has less fear of falling. He was confident to take a shower by himself as he had hand rails in his bathroom and he felt safer at home after the modifications had been completed. He also valued the Blue Care Exercise program as he was able to exercise at home when it suited him. He was also attending a community Tai Chi group where he had already made new friends. His mobility, strength and balance improved. Mr Evans achieved his goals within the agreed timeframe and is now managing independently. His progress and achievement were reported back to RAS.

Wellbeing – Caring

Caring for your health needs.

Blue Care will partner to provide access to specialised care when, where and how you choose it.

Mrs Joy Hardy is receiving support through a Home Care Package level 4 due to her deteriorating chronic Parkinson's disease. She is supported by her husband, Ron, to stay at home as long as possible and she is determined to be as independent as she can. Joy and Ron planned her care together with her Home Care Package Coordinator, Liz. The care was focussed on:

- assistance with daily activities including personal care
- providing specialised allied health and nursing advice
- supporting Ron in his role as carer including respite

As part of her package, Joy received assistance with showering and dressing. Personal Support Assistant, Karen, always encouraged Joy to continue to do whatever she could for herself such as buttoning a shirt or putting tooth paste on her tooth brush. Sometimes it took longer, but Joy felt proud of her efforts.

As Mrs Hardy's condition deteriorated Liz recommended contacting Parkinson's Queensland for specialised support, advice and resources for living with Parkinson's. The family requested that Liz organise a meeting with Joy, Ron, Liz and a representative from Parkinson's Queensland. At this meeting Ron learnt about a local Parkinson's support group for carers where he would have access to practical tips and advice, social outings and education sessions. Ron was keen to participate in the group, but worried about leaving his wife alone. Together with Joy, Ron and Liz planned to arrange a regular in-home respite. Joy requested Karen to stay with her as she would be with someone she knew. Ron joined the support group and told Liz how much he valued the information, companionship and break from his carer role.

Liz identified that her team would benefit from more information on caring for people with Parkinson's. She arranged a training session for her team members.

Wellbeing – Dying with Dignity *Supporting you and your family and friends.* Blue Care will support you and your family and friends throughout the process of planning and making care choices when living with a life limiting illness.	Mrs Wong lives at a Blue Care residential facility. She is a very proud lady and has always maintained strong ties with her Chinese culture and community. Two years ago Mrs Wong was diagnosed with cancer and is now collaborating with the staff to support her palliative care needs. She is often visited by her supportive and caring family. Due to her cancer Mrs Wong experienced pain. Blue Care staff talked with Mrs Wong about a range of strategies to manage her pain, however Mrs Wong and her family were hesitant to use many of them. They told the staff they would prefer traditional pain management treatments such as herbal remedies. The nurse supported them with their decision, reinforcing with Mrs Wong how important it was for her to feel able to make decisions that suited her at this time of her life. This included what pain management she used The nurse worked with Mrs Wong's daughter in contacting a local Chinese herbalist and suggested the GP also be involved to ensure any medication he has prescribed did not interact with the prescribed herbal medication. Together they arranged for Mrs Wong to use her desired pain management methods. As Mrs Wong's mobility had deteriorated, she was no longer able to visit her friends and community. She missed the symbols and rituals of her religion and the connection with her spiritual leader. The staff at her residential facility encouraged the family to bring meaningful mementos including religious items from her previous home. They also brought in long remembered and familiar music to be played in her room. The staff contacted the spiritual leader (300 km away) seeking advice and information on community and spiritual activities he arranged. An electronic tablet was made available and set up so that Mrs Wong could participate in virtual religious and community activities. The spiritual leader suggested that he could have a one-to-one conversation with Mrs Wong via Skype. Mrs Wong was comforted to talk with him. A few days later Mrs Wong passed away peacefully surrounded by her family and her precious items.
	Ms Jones is a self-funded retiree who has always been active and healthy. Her health has recently declined and she has noticed her balance is not as good. She has limited her social activities due to her health issues and now she has found she is lonely. She wanted to get her lifestyle back and called Blue Care's Customer Service Centre to find out what Blue Care has to offer. She was told that she can register at My Aged Care for a referral to services funded by the Commonwealth Government or she could purchase services on a user pays basis if she preferred

Wellbeing – Extras *Purchasing extra services.* Blue Care will provide the option for you to access extra or different services through a fee for service.	not to go through a screening and assessment process. She decided to participate in Blue Care's Falls Prevention Program and purchase ongoing domestic assistance support on a fee for service basis. Ms Jones progressed through the eight week Falls Prevention program very well and her balance improved. She also was able to perform some cleaning tasks independently as she worked together with her Personal Support Assistant on how to do cleaning in an energy saving way. Ms Jones identified she had regained her ability to go out more and socialise, but she now admitted she limited her social participation due to incontinence problems. She used to go to various shopping centres with her friends just for fun, but recently she had refused invitations as she was worried about not finding public toilets in a shopping centre she didn't know very well. Ms Jones thought Blue Care might have another program that could help her to manage this concern so she decided to ask Blue Care if they had any continence programs available. She was told about the content of the program and was very happy to hear she would get a map of public toilets. She learned that she may, after an assessment, be able to participate in an exercise program which would assist in managing the concern and have access to appropriate continence aids in the interim. She attended the 8 week program as a private client and at the end of it she was confident enough to regularly go out with friends. She was provided with an ongoing self-management guide, how to exercise at home, how to maintain the level she reached during the program and even continue to improve. She described how happy she was to be able to accept her friend's invitations to join shopping tours to shopping centres they had never visited before. Ms Jones thought the services and outcome she received were good value for money.

IN THE FAIR WORK COMMISSION

Matter No.: **AM2020/99, AM2021/63 & AM2021/65**

Re Applications by: **Australian Nursing and Midwifery Federation and others**

AMENDED STATEMENT OF ROSE NASEMENA

I, Rose Nasemena, of [redacted] in the State of Victoria say:

1. I am a member of the Australian Nursing and Midwifery Federation.

Personal Details

2. My date of birth is [redacted]. I am currently [redacted] years old.
3. I live in a unit which I lease monthly.

Work history and qualifications

4. I am employed as a Personal Care Assistant (PCA) by BUPA at Bupa Bonbeach. I have worked in aged care for about 13 years. I started work in September 2009 with Bupa Edithvale which has now closed. I moved across to Bupa Bonbeach in 2011. I also worked casually with Japara in 2019 but I went to PNG for six weeks in March 2020. When I came back on 28 April I recommenced at Bupa Bonbeach as my single site employer because of COVID restrictions.

   I resigned from my position with effect from 7 May 2022 to take time out.
5. I have Certificate IV in Aged Care which I gained in November 2015. Before that I had gained a Certificate III in Aged Care in 2009. In this statement I refer to PCAs as both PCAs and carers. I work as a senior carer at the facility because of my qualifications and experience and knowledge of the residents.
6. I worked full-time from 2009-2011. I then went to permanent part-time at 30.5 hours a fortnight because I was doing an admin job as well at Lowelippman an Chartered Accounting Firm 3 days a week. I left the admin job in November 2018 to go home Papua New Guinea to [redacted]. I am now doing the 41 hours a fortnight and I occasionally I pick up additional shifts. I find working the 41 hours exhausting work. I do

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Melbourne, Victoria 3000		

seven regular PM shifts a fortnight. In week one I work Tuesday, Wednesday, Thursday, Saturday and Sunday. In week two I only work Saturday and Sunday but pick up occasional extra shifts during the week.

7. I always do PM shifts and have done so since 2011. I like PM shift because I'm not a morning person and the pace is slightly less frantic than on the AM shift. I feel I get more opportunity to talk to the residents.
8. Bupa Bonbeach is a 100 bed facility but with about 90 residents currently. There are three sections: Parklane 33 beds; Mayfair 13 beds and Lodge 47 beds. I mainly work in the Parklane Unit of 33 beds but I do some shifts in the dementia unit, Mayfair, of 13 beds which is attached to Parklane. They are medium to high care residents. Residents come into aged care later and later from their own homes and are more frail and unwell than when I began work at Bonbeach. Our residents range from some mobile residents to residents who need significant levels of care throughout each day.
9. Prior to working in aged care I had worked in administration 2 ½ years at Ernst and Young and Lowelippman 7 ½ years as permanent part time. I had done a Cert II, Cert IV and a Diploma in Office Administration at RMIT as at 2011 to November 2018 I was doing two jobs.
10. I did the Certificate IV in Aged Care to help learn more about aged care especially the documentation and ACFI. Bupa was helpful and encouraged us to do the Certificate IV. I have also undertaken Courses: "Assist Clients with Medication" and "Recognising healthy body systems in a health care context".
11. I have also continued to do e-learning. For example, I've done two modules on dementia. It has provided me with medical information about dementia. Dementia is a major part of my work in aged care now. While the work isn't often as heavy it is mentally challenging as you need to understand the personalities and quirks of the individuals and be in tune with how they react to things. Every person with dementia is unique.
12. Caring is very specialised work and different carers like different aspects of the work. For example, some carers love dementia work. Others like relating those who want to talk and engage more. Others love leading activities. So caring work has many aspects.
13. I think gaining my Certificate IV resulted in me earning a tiny amount more, but I don't feel it has been really recognised.
14. At Bupa I am paid under the Enterprise Agreement as a Work Skill Group (WSG 8) Year 3 at $1019.54 per week or $26.83 per hour. When Bupa extended the Agreement last year

they agreed to pay carers 3.5% for the one year extension (and nurses 5% and other support staff 3%).

15. I rely on penalty rates to earn enough to pay bills and my rent. I would not be able to manage and support myself if I wasn't working afternoon shifts and on weekends. As it I work weekends and PM shift to earn extra penalty rates (150% on Saturday and Sunday), plus shift loadings of around $24.11 per shift which bring in an extra so about $300-500 gross per fortnight depending on how many hours I work. I usually earn about $1400 - $1550 net a fortnight. I think I work very hard to get that. A copy of my payslip is **Annexure RN 1**.
16. Even at age [redacted] the intensity of the work has an effect on my well-being and energy. I find that after finishing on a Tuesday evening it takes me a couple of days to recover. I start to feel normal again by Thursday morning.

Description of your role and work

17. My typical PM shift as a PCA starts with clocking on handover is between the RNs.
18. I do a handover check with the AM carer staff who we are replacing to see what needs to be done. I will also check the progress notes which are paper based to see what has happened in the day and what needs to be done. If there is a new carer or casual or agency carer staff I will need to work with them to ensure they know the systems and particular resident care needs. I will also need to check in with the RN if there are any issues for the shift.
19. For 44 beds on my PM shift we have one RN overall, two PCAs in Team A (Parklane, 20 beds), two PCAs in Team C (Parklane, 12 beds) and one carer in dementia unit (Mayfair, 12 beds). It fluctuates in dementia during the weekdays. On weekends there is only one PCA, but on weekdays there is sometimes an activity staff member until 5pm. Then there would be a short shift PCA from 5-9. On the AM shift there are more staff. At night there is one RN for the whole facility and only 2 carers for Parklane (all 30 beds) and 2 carers for Lodge, the other 56 beds. I'm not sure how night duty staff cope as there is so much to do.
20. There are about 11 residents across the 44 beds – 9 in Parklane and 2 in the dementia unit who require lifting and standing machines. To take them from bed for toilet or shower it requires two people to transfer. If they are bed-bound we also need two people to change pads and re-position or make them comfortable. This has increased over the years and

safe lifting and transfer often slows the work and makes it more stressful, as you know you need to be somewhere else but can't be.

21. I do a round to check on the residents as soon as I start. Unless someone is on leave they try and roster people consistently in the same areas in the facility. However, it is too hard to do all of your shifts in dementia as the intensity is too high. So most people rotate around the three areas across the 44 beds.
22. If we are short staffed on PM they usually replace people who call in sick. A few years ago they wouldn't have done that but it has improved.
23. I have to plan my work carefully – I make mental maps of when I have to do things and what the shortest path to complete the work is. We have a residents list but from memory I know who has to be put to bed first and who needs to go to dinner when. I then communicate with the other carer and we work as a team. All the time you know that if someone isn't ready to go to bed or get changed or they are uncooperative, then you have to be agile enough to change the routine. We know the residents very well, so that usually isn't an issue but you have to keep track of them.
24. I do documentation on personal hygiene and care throughout my shift by entering it in the progress notes. Anything clinical we write it down and pass it on to the RN. If we have a complex issue then we will page the RN.
25. I started assisting residents with administering their medications in July 2013 after doing the Assist Clients with Medication course. That was a one-day course was an introduction and I started assisting with administration of meds after that. I was the first and other PCA's we had a training on the same time to undertake this work at the facility. However, there is more theory in the Certificate IV which I did in 2014. In the Certificate IV we learnt things like the five rights, use of blister and webster packs, distribution of the drug, ability to eliminate the drug, what medications should be crushed and not crushed, legal and legislative requirements in assisting self-medication and good practice in the administration of medications. We also learned about RN responsibility for dangerous drugs and dangerous drugs counts. I felt much more confident having done the Cert IV course.
26. The prospect of making a medication error is always hanging over us and adds to stress. One error I made was that I provided the right medication but entered the wrong number into the computer which was identified.
27. It is quite dangerous because while assisting with the meds we are still having to watch out for residents and can be called to do other tasks by the RN. After any error the RN

comes and does the round with the carer and do an assessment and the RN will check that we are doing everything properly. This re-assessment also happens annually, regardless of any error. Assisting residents with meds is done under the supervision of the RN.

28. Occupational violence and aggression has increased over the last few years. Dementia has increased as a proportion of residents and behaviours are varied and sometimes more volatile. The increasing age, frailty and acuity of residents over the years has changed the demands of my work.
29. We have one 83 year old resident who is a [redacted] and is still in very good shape. He is very strong and lashes out. His wife couldn't cope with him at home. He likes female company. We keep him busy pushing the tea trolley around, helping us in the kitchen. If we don't keep him busy and calm he can become aggressive. So that takes time and energy.
30. On 11 July this year I was working with a couple of agency staff in the dementia section (Mayfair). One of the male agency staff came into the unit with PPE items for preparation in room 64. Our [redacted] became very aggressive. I was sitting with our [redacted] at about 9pm and the agency fellow walked towards us. The resident tried to follow him out and charged out the door to attack the agency staff member. I ran after him. He tried to punch the agency staff member and the staff member had to push him away he lost balance with force the resident fell on the floor and hit his chin and elbow on the wooden chair. I think the resident didn't like the body language of the agency worker and also the tone of his voice.
31. The next day I had to write a statement. I was quite distressed still and I went to the Director of Nursing that I needed a mental health break. She said that I should take annual leave so I had to go back to work. I got one session of counselling through Bupa Care Services EAP.
32. We have another resident where we need three people to get him up, including a male carer (otherwise it is four women). He is obese. He gets aggressive and won't cooperate when we try and move him. The care required to assist this resident is an example of the various skills required as it involves manual handling, co-ordination and co-operation as well as good communication with resident and staff as well as empathy and caring skills. So, it needs a combination of technical skills as well as empathy and using an appropriate tone of voice and physical approach.
33. During meal-time we also have to be very conscious of choking risks. We have about 3 residents in Team A (20 beds) and others in the other two sections where they require

pureed food and need to be helped one on one. They can hardly swallow and it is very slow. We use different techniques like holding their hand. We stop if we see they are struggling. It makes it hard because we can't hurry them and we are conscious of what else we need to do in tight timeframes. I've had someone choke on me and it is very scary. You have to put them in an upright position and rub their back. Then you have to check on them regularly afterwards.

34. There is quite a lot of verbal abuse, which includes racist remarks like "black bitch". We report it to the RN but she says, "Don't take it too personal, they are sick". So it is part of the culture and you try and separate yourself from it mentally. However, that is partly why I can't do 76 hours in a fortnight. With some residents this abuse happens every day. We have one resident who is in pain but with every turn in bed or transfer she swears at us.

My skills and responsibility

35. In my role, I help less experienced and less trained staff to learn what is needed in the role. This is always the way with new casual or agency staff. Some new staff do not seem to have received very good quality training or it isn't in-depth enough about dementia and pain and diabetes and so on. We are working with the most vulnerable people, but when people come out their courses, they have not done enough practical training. Much of what is learned is learned on the job.
36. When I'm partnered with someone who is inexperienced, I teach them routines. For example all the steps needed to change a person's soiled pad hygienically and safely. It is very important to observe good hygiene care for the resident and to make sure you care for the skin of the resident and report any skin tear, bruise or pressure sores to the RN in charge. If you don't clean well and moisturise, residents can get urinary tract infections, or skin rashes.
37. If I have a resident in pain, I go to the RN in charge and report what is going on. We will try offering a heat pack, drink or reposition the resident, before resorting to PRN medication.
38. The direct care staff, RNs and carers have to work as team. I do discuss with the RN developments in resident condition such as an increased risk of falls, a change in medication that needs to be dealt with by the RN. I will report to the RN matters such as pressure sores, compromised skin integrity, a change in swallowing, and an increase in agitated behaviour or changes in diet. The RNs rely especially on the PCAs to convey information about residents. In the case of the carers we also need to communicate with

each other about things that need to be done following handover, as numerous aspects of the role need more than one carer to assist.

39. We have some residents who go to bed early and others who sit up very late or get up after a few hours' sleep. I sit and talk to them when I can. I make them a cup of coffee or do an activity with them in order to calm them and get them back to bed. It is really draining. We recently had a resident with Parkinson's and we used music on an iPad to calm him. I talked to him about South Africa, his homeland. He was at high risk of falling and we needed to occupy him to stop him getting around and falling. He recently had a fall and was admitted to hospital. He passed away not long after returning from hospital. He could not be restrained so we needed to use all of our wits to avoid risks.
40. Some residents are often agitated and will tell me about their life, the things that annoy them or what they want. I have to make decisions about what to pass to the RN. We need to assist them with their mental health as well as physical needs.
41. Often the residents simply want human company and comfort. A lot of them live in their rooms so they are craving contact and the only contact they have is the carer that comes in to do something for them. Often, they push their buzzers and really don't need anything. We have to answer those calls within a few minutes each time. Rather than get cranky with them I have to remind myself they are simply seeking human contact and want to speak to someone.
42. Many are very depressed – they haven't seen their families regularly during COVID. They often cry although they are getting more used to very few visitors. They talk on the computer at an allocated time. Everyone in the team have had to deal with a lot more of the emotional side of residents and psychological ups and downs over the last 18 months of COVID in particular.
43. We do a lot of the eye care, mouth wash, oral care. I also monitor stomas (we have one resident) and assist with changing them. With have several residents with catheters which I change and empty the catheter bags, make sure the strap is clean, log the output, and monitor redness on catheter sites.
44. We often have to look after clothing needs for residents when families don't bring things in. This means searching in the store room where left over clothes are kept from previous residents.
45. We keep an eye on skin integrity and feet to make sure nothing like pressure sores or fungal infections are developing. Often the RN will tell us to apply anti-biotic ointments for a number of days in accordance with the prescription.

46. With palliative care we do repositioning and hourly eye and mouth care. In COVID times residents being provided with palliative care are usually allowed some close family members and we have to work around the family members, being both upbeat and positive but also respectful of the emotions they are going through with their loved one. We need to make sure the surrounding area is calm and quiet.
47. It can be extremely draining when a resident passes away – you really bond with many residents and it is emotional. However, you have to try and put it in the back of your mind and be there for the other residents. Over time the stress has moderated for me and I mostly manage to treat it as part of the job. But some carers can't handle this side of the job.
48. We do mandatory e-learning courses annually – infection control, communication skills, fire safety, manual handling, dealing with dementia are mandatory. We get an email to say we need to complete by December in each year.
49. COVID-19 has made the work harder because everyone is so tired. Everyone has their own issues and health problems to deal with as well. We need to wear a mask and shield always from the start to the finish of the shift. That is quite wearing. If someone has an infection and is a suspected COVID, or comes back from the hospital, we need to don and doff properly in the right order. We have never had a COVID case yet which hopefully indicates we have been doing things correctly.
50. After dinner when the residents go to bed and after the paperwork each shift has to do additional cleaning. On PM shift we do handrails, chairs, couches and dining area. The night staff do more of the equipment such as the hoists, walking frames and tubs. While we did some cleaning before COVID, but since April last year we are much more focused on disinfecting and cleaning. I do it often before I open the bathroom door for example even though I'm wearing gloves in a resident's room. This all adds to the workload.
51. Over the last ten years there have been a number of changes in the work as a result of such matters as:

    a. The increased number and nature of residents with dementia. This has required greater skill and attention by staff as result of increased occupational violence and aggression, the removal of the use of restraints and the need for skills in deflecting risky behaviour or dealing with a resident or residents in what we call their "romance world";

b. The responsibility placed on PCA to assist residents with the administration of medication and the increased number and complexity of the medications needed by residents;

c. An increase in the proportion of bed bound residents with complex needs and an increase in the frailty of residents demanding greater attention to the every aspect of their physical, social and mental well-being;

d. The introduction of computers, where medication administration is already computerised, and we are moving to computers for all other care such as bowel charts, fluid charts and progress notes;

e. The increased number of high care residents with fall risks that require constant monitoring;

f. Changes in staffing with fewer RN hours and more responsibility for the PCAs; and

g. The consequences of COVID and the range of infection control requirements the pandemic has required.

52. Because of single site working as result of COVID we have lost a number of our staff (who now work at their primary place of employment) and there are quite a lot of new staff who don't know the ropes as well. There are many more calls to pick up extra shifts to help out. Because we don't use agency as much there is more pressure on the existing workforce.

Perception of aged care

53. I love caring for older people, but it is not well paid.
54. I think there are too many people working in aged care who say to themselves 'why exhaust myself for the hourly rate I'm getting'. This needs to change.
55. I think if we want to offer better quality care, people working in aged care need to be better paid and better trained. The carer role needs to made more professional and provide for a career. The standard of training needs to be better and include more issues relevant to aged care – such as dementia and diabetes.
56. The work we do is undervalued and people don't realise the amount or complexity of the work and the range of skills involved by all of us in the nursing team. We are taking care of the most vulnerable people in our society and I don't think people in the community understand what that involves.

57. The work is more rewarding in many ways than my administrative accounting work and the residents become like a family. However, I think all carers, especially those assisting with medications, should be given more recognition given the emotional and physical challenges and the range of formal and informal skills required day to day.

ROSE NASEMENA

6 May 2022

[redacted]

LOCN: Bupa Bonbeach
Facility : Bupa Bonbeach

RN 1

Rose Nasemena

PAY NO: 2896 PAY DATE: 22 Sep 2021 BANK
PAY PERIOD 06 Sep 2021 TO 19 Sep 2021

Salary Class: 3CG8Y3
Title: AIN / PCA
Award: Carer_Wage Skill Group 8 Yr 3 Status: PART-TIME EMPLOYEE

COMPONENT	THIS PAY	YTD	HOURS	RATE
Ordinary	1247.60	6354.94	46.50	26.83
50% Shift	335.38	1826.50	25.00	13.42
AftS Alw-P	192.88	982.77	8.00	24.11
Laundry	2.64	13.53	8.00	.33
NauseousWk	5.00	29.84	2.00	2.50
Uniform	10.32	55.47	8.00	1.29
GROSS	1793.82	9834.47		
TAXABLE	1793.82	9834.47		
TAX	252.00	1268.00		
NETT	1541.82	8566.47		
BTBG	179.38	961.18		

LEAVE ENTITLEMENTS:-
Annual Lve Total: 120.32 H

IN THE FAIR WORK COMMISSION

Matter No.: **AM2020/99, AM2021/63 & AM2021/65**

Re Applications by: **Australian Nursing and Midwifery Federation and others**

AMENDED STATEMENT OF STEPHEN ANDREW VOOGT

I, Stephen Andrew Voogt of [redacted] in the State of Victoria say:

1. I am a member of the Australian Nursing and Midwifery Federation.
2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details, work history and qualifications

3. My date of birth is [redacted].
4. I live in [redacted] but work consistently in Wangaratta and across the north-east of Victoria in a range of aged care facilities looking after certain residents. I also provide consultancy services across the public and aged care sector around Victoria.
5. I am a Nurse Practitioner (**NP**) in Gerontology (since 2010). Much of my work involves mental health and dementia/psycho-geriatric behaviours. I have worked in private aged care since 2013.
6. I currently work as a consultant Nurse Practitioner. For example, on 6 September 2021, I commenced an eight week contract to review the care and systems in several aged care facilities for a major Melbourne public health provider. This involves:
    a. performing comprehensive geriatric assessments on most of the residents which includes investigations. This has involved a lot of prescribing and deprescribing.
    b. Advising on the current model of practice.
    c. Advising on how care is delivered.
    d. Advising on the new standards and how this affects care at the bed side.
    e. My colleague is advising on compliance and quality etc.
7. However, a large part of my on-going work is with a group of about 10 GPs in Wangaratta. I look after their residents in several private aged care facilities in Wangaratta – St Catherines

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The ANMF		
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(72 beds) where I look after about 40 residents and Rangeview (about 60 beds)where I look after about 20 residents.

8. I have a Collaborative Agreement (CA) arrangement with each of the participating GPs which is a condition for me prescribing medications, ordering diagnostics and charging consultations against the MBS items available to Nurse Practitioners.
9. I did my Registered Nurse training at Mercy Private in East Melbourne from 1986 to 1988. After I finished my training, I moved around Victoria and Australia undertaking nursing work. I worked at St Vincent's public hospital and then worked in the Northern Territory at Tennant Creek hospital in around 1990. I was there six to eight months and then moved back to Victoria to Warrnambool Base Hospital for six to 12 months. I then moved back to Melbourne to worked at the Epworth Hospital for about a year.
10. From about 1992 to 1997, I worked at the Austin Hospital. I was Nurse Unit Manager in the Surgical Ward at the end of my time there. In that role I managed about 30 staff and was responsible for the staffing of the busy ward, relationships with surgeons and visiting medical officers and ensuring that the ward complied with policies and standards.
11. In late 1997, I moved to South Eastern Private Hospital. In about 2000, I moved to Knox Private Hospital for 18 months where I did my Post Graduate certificate in Critical Care.
12. In about 2001 I moved to Canada and worked in a major hospital in Edmonton for one year doing critical care nursing and developed specialty skills in neuro-trauma in an ICU environment.
13. I returned to Australia in April 2002 and was employed at Northeast Health Wangaratta (**NHW**) in critical care. In the years that followed I performed a number of different roles with NHW as discussed below.
14. I had an interest in mental health issues so started working at the Kerferd Psychiatric Unit at NHW where I completed my Graduate Certificate in Mental health Nursing from RMIT.
15. In 2007, I commenced my Nurse Practitioner candidacy in gerontology. I completed all of the practical and theoretical components over the next three years. This involved advanced work during placements in aged care as well as completion of a Masters Degree. This included Pharmacology component for the Masters as well as Advanced Clinical Decision Making. I was endorsed as a Nurse practitioner in 2010 by the Nurses Board of Victoria. I'm proud to say that I was the first aged care Nurse Practitioner endorsed in Victoria. A copy of all of the qualifications mentioned are in **Annexure SAV 1.**
16. From 2010 until about 2012 I worked as a NP at Illoura, public health aged care facility in Wangaratta as an employee of NHW. My work as an NP at Illoura and in public health aged

care facilities is essentially the same as the work I do now as a NP consultant discussed below. Illoura is a residential aged care facility that is part of public hospital system. Around this time and as part of my employment with NHW, I also worked:

a. on the Geriatric Evaluation and Management (**GEM**) Unit in Wangaratta;
b. at the Kerford Acute Psychiatric Unit; and
c. with the Older Persons Community Mental Health (**OPMH**) which involved providing psycho-geriatric services to older people in the community. These services were provided to older people who had chronic mental health issues or who developed acute mental health issues such as depression/anxiety. Patients became involved with OPMH based on a referral from a GP. The work of OPHM involved a team including a psychiatrist, mental health nurses and allied health professionals such as occupational therapists and social workers. In this work I provided direct care to older people in their homes, in aged care facility and in the acute hospital setting. Much of this work involved working in residential aged care facilities assisting in the management of behavioural/psychological symptoms of dementia (**BPSD**) and general psychiatry including depression/anxiety. OPMH also use to be deliver the Dementia Behaviour Management Advisory Service (**DBMAS**), a service run out of St Vincent's Hospital. Part of my work was with this service.

17. In about 2015 or 2016, OPMH was taken over by Albury Wodonga Health, another public sector health provider. I continued to work in the OPMH program after it transferred to Albury Wodonga Health for a short period.
18. The DBMAS program was dismantled and terminated. A similar service is now delivered through a Commonwealth Program, contracted to Hammond Care called Dementia Support Australia or DSA.
19. As a NP I am able to obtain and use a Medicare Australia provider number and a PBS prescriber number. However, when working with NHW (and Albury Wodonga Health) I did not use need either a provider number or prescriber number. In the public health system I was able to order and prescribe without provider number or prescriber number.
20. In about 2011, the Deputy Director of Nursing at Illoura moved over to become the Director of Nursing (**DoN**) at St Catherines in Wangaratta. St Catherines in Wangaratta is a non-for-profit residential aged care facility but is outside the public health system. In about 2013 I was first contracted by the DoN of St Catherines to do a couple of sessions a week with some of the residents as a NP. At that time, I continued to work at NWH in the units described above on a part-time basis.

21. From 2013 I slowly built a consulting business.
22. In 2014 I was contracted to do some work as a NP at St John's Wangaratta. At that time, St John's Wangaratta was a large 120 bed facility as well as retirement village operated by from the Anglican Diocese. That work was initially for a year or so. After a tragic influenza episode in 2017 that killed about 10 residents, the Aged Care Quality and Safety Commission (**ACQSC**) investigated St John's, and after this I was contracted to come back for a couple of years to assist with care of residents. My work at St John's then revolved around the unmet standards identified by the ACQSC which included acute deterioration and host of clinical issues that were identified as non-compliant. Examples included chronic pain and BPSD. I continued my work with St Johns until 2019 when Respect, a Tasmanian NGO, took over the facility.
23. In about 2017, I started performing NP work for Omeo Hospital in small public run aged care facility of 15 beds.
24. Also in 2017, I also started doing some work at Bentley Wood, a private aged care provider, at the Myrtleford Lodge. Later in 2018 I was engaged to also perform work at the Bentley Wood facility in Woods Point, Yarrawonga. I have also worked at Yackandandah Health Service which is a community based private aged care service as well as Tallangatta Health Service in their public aged care.
25. In September 2021 I was invited to work at Yallambee Aged Care, a 120-bed community facility in Traralgon. [redacted] (Harcourt Aged care Advisers), who I work with on occasions, had been engaged by Yallambee as the nurse advisor following a serious incident at the facility. She was engaged to evaluate and investigate an incident where a 78 year-old male resident had attacked and brutally bashed 13 residents and staff. She asked me to come and assess a few of the residents involved in the incident. I did this and several had ended up in hospital with significant injuries. I had to assess one particular resident for post-traumatic stress and I was worried about whether this resident would survive. Many of the other residents were lucky in a sense because they had dementia and could not remember the trauma – you could see the battle scars however.
26. As a NP working outside the public health system, I need to enter into Collaborative Agreements (**CAs**) with GPs in order to utilise my Medicare provider number and PBS prescriber number. As a Nurse Practitioners I am an autonomous practitioner – I can diagnose, order therapeutic interventions, order diagnostics and refer patients and residents to specialists. However, under the regulations this needs to be in the context of a

CA when I work outside the public health sector. Without a CA, I could see patients but couldn't order pathology without the patient paying the full cost, or prescribe via the PBS

27. I have a group of GPs – 10 in Wangaratta – with whom I have CAs and who are happy for me to look after their residents collaboratively. I take on their residents in each facility. I manage most of the medical clinical needs of the residents. I will contact the GPs if there are particularly complex issues. I monitor the medical issues and geriatric syndromes which usually requires assessment, investigations, and pharmacological intervention. I look after about 40 residents at St Catherines. About 6 months ago I also started at Rangeview and look after about 20 residents. What I do that usual RN in aged care can't revolves around the extended scope of practice with prescribing/diagnostic and referral rights. Ultimately RN staff may identify a clinical issue and refer it to me as the NP. I would then diagnose and manage the issue.
28. From working in and with a number of residential aged care facilities, I am aware that some GPs aren't providing adequate services into aged care facilities. I have noticed that this has become worse over the years. In Wangaratta there is one GP practice which is now refusing to provide care to residents in the aged care facilities. I understand that a second practice may soon also withdraw from working in aged care facilities. The GPs who continue to provide services to residential aged care facilities have less time to service residents in those facilities. These GPs may come in for a lunch time session for an hour once or twice a week. As a result, individual resident are more heavily reliant on NPs like me and otherwise fall back on the RNs in the facility to try and monitor, observe and treat. RNs in residential aged care facilities have the added problem that they are trying to deal with every resident, deal with crises as they arise, manage other staff and they don't have the capacity to order diagnostics or prescribe medications.
29. To my knowledge, Yallambee had, and still only has, two GPs from one GP clinic who will work with the residents there. These two GPs do a total of two sessions per week at Yallambee and there is effectively no GP coverage after hours. Like a lot of regional and outer metro facilities they can call My Emergency Doctor, a national on call service.
30. I consider that residents of aged care facilities are the most complicated group of people to look after in our community. It takes time to properly assess and treat these people. Based on my observations, I consider that some GPs are not spending the necessary time to do this.
31. The reduction in GP availability, the lack of support and changes to resident acuity (as discussed below) means that the nurses on site have to be more skilled, observant and

responsible. This is all occurring in the context of recommendations from the Royal Commission about using fewer drugs and fewer restraints – both chemical and environmental.

32. In relation to chemical restraints, Recommendation 65 of the Aged Care Royal Commission Final Report included that by 1 November 2021, the Australian Government should amend the PBS Schedule so that only a psychiatrist or a geriatrician can initially prescribe antipsychotics as a pharmaceutical benefit for people receiving residential aged care.
33. The Australian Medical Association (**AMA**) recently published a submission to the Pharmaceutical Benefits Advisory Committee on the restricted prescription of antipsychotics in residential aged care. Whilst I do not agree with all aspects of this submission, I do agree that limiting prescribing to geriatricians and psychiatrists wOULD severely impact health services in rural and remote areas. I agree with the AMA that the proposal is "attempting to deal with the symptoms of a broken aged care system while ignoring the causes".
34. A copy of the AMA submission to the Pharmaceutical Benefits Advisory Committee – Restricted prescription of antipsychotics in residential aged care, dated 20 October 2021, is **Annexure SAV 2**.
35. The ACQSC has picked this up the need to limit the use of chemical and environmental restraints and has made a real focus in audits and communications on pressuring providers to cut or eliminate restraints and interventions. I support that focus and the right of residents not to be chemically or physically restrained. However, the problem is that once you go down that path a lot more resources are required to ensure harm minimisation and keep risk at an acceptable level. This is the minefield that direct care staff in most facilities face daily. There is a new philosophy, but as yet, no additional resources to implement it.
36. Unless someone like myself comes in, Dementia Support Australia (**DSA**) and the GP are the only source of external support and advice that staff and residents of facilities have in private aged care when dealing with issues related to dementia. Originally, DBMAS provided support for BPSD in the community and in aged care facilities but now this has been replaced with DSA (run by Hammond Care). GP's and facilities are able to refer behavioural problems to DSA. DSA may then send a worker in to the aged care facility and they are focussed on non-pharmacological interventions. They work out the triggers that precipitate BPSD and then develop strategies and non-pharmacological interventions. The worker can refer to their specialist, usually a psychiatrist or geriatrician, for complicated cases and pharmacological advice.

37. However, DSA are based/co-ordinated in Melbourne, they visit infrequently, and facilities really needs someone on the ground several times a week (reviewing and reassessing). So, unfortunately, DSA is not able to provide enough support. The system is pretty much busted and the nurses and carers are left to pick up the pieces. They are under pressure because of the short staffing. In my work in aged care facilities I observe that nurses and carers can't sit with people with behavioural issues when it is needed. They are under pressure to get all their other tasks and reporting done.
38. I am all in favour of non-pharmacological interventions. I never want to use psychoactive substances if this is not necessary. But when it comes to residents with psychotic symptoms which can result in moderate to severe aggression, there are simply not the resources in these facilities to manage many of these residents totally non-pharmacologically. Many of them require one on one care for a period of the day and that is what the family expect. They are a lot of work and are complex and ACFI doesn't provide the necessary funds to provide adequate care. I don't see that changing any time soon. I understand the new funding system to be introduced next year rewards immobility – the less mobile someone is the higher the funding. In my view the immobile are often actually easier to look after. Mobile residents have greater risks of falls, they present a greater risk to themselves/others and, because they are less cognitively impaired, they often have greater expectations.
39. I've witnessed a number of assaults in residential aged care facilities. I am aware of incidents where males who are sexually disinhibited have presented a threat to vulnerable female residents. On some occasions where this has arisen, I have advised of the need to intervene pharmacologically but on several occasions the families have said "no" and a sexual or physical assault has followed. It's got to the point where major providers won't take moderately to severely behaviourally disturbed patients and many end up in public facilities after being sent to emergency. I'm not sure if it is a growing problem or it has simply been hidden. Mandatory and serious incident reporting now means it is being reported more often to the ACQSC and the Department.
40. Compounding the problem for staff are several factors. I have noticed that families - and even the residents themselves – have very high expectations of the care that can be delivered. Often those expectations, which reflect the marketing and the promise of "choice", are well above what can actually be provided by the facility or sustained over a period of time.
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.

42. I have observed RNs working on their own, especially on PM shifts, nights and weekends. They have no doctors around them like a hospital and can't order diagnostics like blood tests, urine tests etc. The GPs around Wangaratta share or take turns to operate on-call service for the local aged car facilities, but this service is variable depending on the GP. As of May 2022, a further three GP practices now do not offer on-call services. The GP on call may be up in Beechworth 35 kms away and it will not be practical for them to visit the resident.
43. Another factor in adding to the stresses for staff which I've seen is reductions in overall numbers of staff and in the skill mix: steering away from RNs/ENs towards more carers. Carers do a terrific job, but they do not have the education and training of a RN or EN. They are less able to evaluate and make decisions around complex information or situations.
44. A major change in the last decade has been the new Aged Care Quality Standards introduced from July 2019. They really make the providers a lot more accountable which puts more pressure on nurses and carers because of limited funding and increasing regulation.
45. From working in residential aged care facilities, I have noticed that the ACQSC is cracking down on a few things – dementia and behaviours and the use of chemical and environmental restraint. This is a problem without adequate resources to fund non-pharmacological strategies. The management of acutely deteriorating residents is also another focus and the battle is to keep the residents at the facility and manage them there with limited resources and medical backup. The dynamic I have observed in aged care is that residents are now kept at home a lot longer and they are a lot frailer and more complex to look after when they get to the facility. Since 2010 I have observed a trend of residents being admitted from acute hospital or from the community where they have been on home care packages when they can no longer cope with that level of care. Previously, those being admitted to aged care included a mix, some reasonably well residents and some complex or dependent cases. Now all new residents are complex and there are higher levels of dementia.

46. The negative media has also raised the bar. I have noticed that residents and their families are now more aware of their rights. 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.
47. In my work in aged care facilities, I have noticed a steady increase in bariatric residents who require two and three person lifts. I notice that in facilities all the time. And there is more complex palliative care – the residents have been unwell for quite a while and there can be significant distress and pain. 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.
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.
49. I have seen that in facilities dealing with residents is much more complex than it was a decade ago. Staff have to deal with all the diseases and geriatric syndromes - falls, incontinence, polypharmacy, dementia, depression to name a few. They are often very interconnected and not easy to unravel. Changing expectations of residents and their families has also magnified this.
50. I am starting to see a lot more acute treatment in aged care – things like intramuscular anti-biotics, increasing the level of observations and vital signs, more in-dwelling catheters,

subcutaneous fluids are becoming more common (which for older people is a better alternative to intravenous). In my view, especially if nurses had access to a few more machines, there is not a lot of difference between aged care and hospital, especially the GEM wards I have been used to. That is a recent development the last five to ten years.

51. The government has funded in-reach expertise to stop transfers to hospital, but it isn't that effective – there simply aren't enough resources provided. At NHW we have one Nurse Practitioner employed on a full-time basis who works 11am-7:30pm Monday to Friday and she covers the whole of north east Victoria. I may deal with that NP if a facility in which I am working has a resident who is unwell. If I can't get to a facility I will call her and speak about specific residents. If there is a resident with chest pains, I may ask her to attend and perform an ECG. Unfortunately, this isn't an adequate resource and often isn't on hand when those RNs and carers need it most. What they need is after-hours residential in-reach.
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.
53. With ENs I have noticed that they are now expected to be quasi-RNs.
54. In my view and based on my observations and experience, RNs and ENs in aged care have to be more accountable and responsible than RNs and ENs in acute care. RNs and ENs in aged care don't have the medical and peer support. They don't have the RN down the corridor to come and have a look. They can't just escalate a difficult issue up to the medical staff – even private hospitals have resident medical officers. RNs in a hospital environment who suspect some deterioration can usually get an order for diagnostics or medications at any time of the day or night.
55. I have also noticed barriers to RNs sending residents to hospital. In my work, I have observed ageism in the acute health system. For example, there is often resistance from ambulance paramedics and hospital staff to admitting aged care residents to hospital. I have also observed that residents of aged care are often discharged back to the facility after very short periods of time and well before the cause of their admission is adequately resolved. In that case, it falls to the facility to provide that clinical care.
56. Most providers have moved over to online IT for medical records, which is a good thing, and I would expect that technology implementation will speed up in the private aged care

sector over the next few years. However, this does add to the necessary skills for those providing care in the facility.

57. There has been a lot of pressure from the ACQSC on aged care facilities to review medications. There is a lot of pressure to de-prescribe. Now, as a part of the assessments conducted by the ACQSC facilities are held accountable for polypharmacy. The ACQSC encourages facilities to intervene and manage polypharmacy with the GPs. This pressure comes in a number of ways. First there is anti-biotic (**AB**) stewardship. The ACQSC is targeting the facilities for overuse of ABs – it is now part of the standards. Second, there is now additional focus on reducing or eliminating several classes of drugs. These include psychoactive drugs and other drugs such as statins, Protein Pump Inhibitors. It is the RNs in the facility who have to now prompt the GPs about these issues.
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. Deprescribing has compounded issues to the point that on some occasions I have witnessed GP's who are reluctant to prescribe when it may be relevant to do so. Residents with clear thought disorder, perceptual disturbance and behavioural disturbance are being untreated at times. This would not happen to younger persons with similar symptoms.
59. I have also observed a focus by the ACQSC on reducing environmental restraint (no cot sides, more open doors). All of this comes back on the staff who have to manage the implementation and consequences of these initiatives. Because of the change in expectations more people are allowed to wander unrestrained now. That is a real change. The aged care facility is the resident's home and I agree with that they should get a say in their care – what they like and don't like. But with that comes a cost and you the need to have the resources to implement it properly. However positive, the focus on restraint free environments has increased demand on staff. High falls risk residents are requiring high level supervision and one-to-one attention that we just do not have resources to provide in many cases. Staff resources to minimise risk of falls have not increased in correlation with the decrease in restraint.
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.

61. With pain management there are similar issues to that above. I have observed an increasing expectation from the ACQSC that RN's will prompt and guide GPs. A massive amount of time and resources of ENs, RNs and GPs are involved in assessment, pain management and review, especially for residents with dementia. Expectations on the provider have escalated to the point that the evidence required to support effective pain management is well in excess of what would have been required 10 years ago. The resources to provide the level of evidence required is tremendous.
62. There is an increased complexity of wounds with residents coming from hospital system. The RNs and ENs lack access to wound consultants (unlike the public system) leaving aged care nurses to manage complex wounds.
63. The pandemic has resulted in a lot more isolation of residents from families and social supports. The increased need for psychological support of residents particularly during COVID pandemic has fallen onto all levels of staff within the facility.
64. Because of the difficulties in private aged care, a lot of good nurses have told me that they don't want to manage a facility as the Director of Nursing or Care Manager. I am aware that there is difficulty attracting RNs to act as Care Managers. I have been approached on a number of occasions and asked to act the Care Manager of a facility. One of the reasons I would not take on such a role is that it is just too hard to negotiate external factors (families, public health) as well as the multitude of internal management and clinical pressures. When I compare the requirements and demands of those roles today against those of aged care facilities 10 years ago, it is just chalk and cheese. The funding and wages have not kept pace with the increase in skill and responsibility.
65. I have been involved in the management of COVID outbreaks within residential aged care facilities twice now.
66. The first occasion was in August 2020 when I worked within a facility in Glenroy for a 7 week period. The second was in October 2021 at a facility in Noble Park.
67. Some aspects of these experiences have been identical, namely:
    a. the working environment is extremely stressful, being the most stressful I have experienced;
    b. there has been severe human resource depletion and availability; and
    c. the outcomes have been heart breaking for residents, family and staff.
68. Despite this I have walked away from these experiences with positives.

69. At the forefront of this is my admiration for the nursing and care staff who worked in these conditions. They endured much more than what the public are aware of, including:
    a. the stress of having to look after acutely/severely unwell residents with limited resources;
    b. continual lack of/short staffing, working 12 hours days in full PPE with minimal breaks;
    c. Some of the RNs working 5 days straight 12 hours. I am aware of staff sometimes having to work a 16 hour day and then return to work the next day at 0700 hrs for a 12 hours shift;
    d. staff have had to endure the negativity from government departments, the media and the public about COVID and criticism of residential aged care facilities;
    e. in the 2020 outbreak there were no vaccines and still little known about COVID. Staff put themselves in harm's way, risking their own health for the residents; and
    f. staff in residential aged care facilities are less well resourced than the acute public health sector.
70. From these experiences I am filled with admiration for the RNs, ENs and PCAs working in aged care. I'm not sure any other profession would endure this.

STEPHEN ANDREW VOOGT

9 May 2022

TRANSCRIPT OF RESULTS

SAV 1

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THIS IS TO CERTIFY THAT

STEPHEN ANDREW VOOGT

OBTAINED THE FOLLOWING OFFICIAL RESULTS

Postgraduate Career

TERM: 0310 PGRD Semester 1 2003
PROGRAM: GC001 Graduate Certificate In Psychiatric Nursing Practice
(27-JUN-2003) Academic requirements for the program complete.
PLAN: GC001 Graduate Certificate In Psychiatric Nursing Practice

SUBJECT AREA	CATALOGUE NUMBER	DESCRIPTION	CLASS START DT	CLASS END DT	ATTEMPTED	EARNED	MARK	GRADE	POINTS	GRADING BASIS
NURS	1042	Comm & Counselling For Health Care Professionals	24-FEB-2003	30-MAY-2003	12.00	12.00	76	DI	36.00	G00
NURS	1049	Professional Development In Health Practice	24-FEB-2003	30-MAY-2003	12.00	12.00	76	DI	36.00	G00
NURS	1066	Mental Illness And Treatment	24-FEB-2003	30-MAY-2003	12.00	12.00	77	DI	36.00	G00
NURS	1087	Assessment Analysis In Mental Health Service Deliv	24-FEB-2003	30-MAY-2003	12.00	12.00	86	HD	48.00	G00

TERM GPA : 3.25
TERM TOTALS
Total of term attempted : 48.00
Total of term earned : 48.00
Total of all term points : 156.00

1 AWARD(S) CONFERRED

30-APR-2004 Graduate Certificate In Psychiatric Nursing Practice (with Distinction)
Award Number: 0403286

Postgraduate CAREER TOTALS

CUM GPA : 3.25
CUM TOTALS
Total for Career attempted : 48.00
Total for Career earned : 48.00
Total for Career points : 156.00

4 COURSE(S) HEREBY CERTIFIED 19-AUG-2004 S.J.JELLETT
REGISTRAR

STEPHEN ANDREW VOOGT [redacted]

[redacted]

[redacted]

RMIT UNIVERSITY

IF YOU FIND ANY ERRORS OR INCONSISTENCIES PLEASE CONTACT YOUR DEPARTMENT/FACULTY IN THE FIRST INSTANCE

THIS DOCUMENT HAS THE FOLLOWING SECURITY FEATURES: HOLOGRAM, MICROPRINTING, SOLVENT BASED INK.

La Trobe University

ACADEMIC RECORD

Student No.: [redacted]
Family name: VOOGT
Other names: STEPHEN ANDREW

Details of enrolment and results

Faculty of Health Sciences
COURSE: PGDipAdvN MAJOR(S): Critical Care Nursing

2000 PART TIME

NU5CN1	CRIT CARE NURSING STUD 1	1	15.0	83	A	
NU5CN2	CRIT CARE NURSING STUD 2	1	15.0	75	B	
NU5CNC	CRIT CARE NURSING STUD 3	2	15.0	75	B	
- Complex Issues						
NU5CNS	CRIT CARE NSG STUDS 4	2	15.0	74	B	To count at year level 1
- Specialty Issues						

********** END OF TRANSCRIPT **********

LA TROBE UNIVERSITY OFFICE OF THE UNIVERSITY SECRETARY

11-FEB-2004

LA TROBE UNIVERSITY

School of Nursing
FACULTY OF HEALTH SCIENCES

20 February, 2001

TO WHOM IT MAY CONCERN

I write to confirm that Stephen Voogt has successfully completed the four critical care subjects of the Postgraduate Diploma in Advanced Nursing – critical care nursing. The four subjects are equivalent to the Graduate Certificate in Critical Care Nursing, .

Yours sincerely,

[redacted]

Postgraduate Courses Officer

HP

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DEAKIN UNIVERSITY

Academic Transcript

Student ID: [redacted]

Date: 02/12/2009

Stephen Andrew VOOGT

Year	Teaching Period	Unit Code	Unit Title	Credit Points Achieved	Unit Level	Mark	Grade
2007	**H773**	**MASTER OF NURSING PRACTICE (NURSE PRACTITIONER)**					
			CREDIT FOR PRIOR LEARNING GRANTED:				
			ON THE BASIS OF TERTIARY STUDIES UNDERTAKEN AT AN AUSTRALIAN INSTITUTION				
			UNSPECIFIED CREDIT	2.00	7		
			UNSPECIFIED CREDIT	2.00	7		
			UNSPECIFIED CREDIT	4.00	7		
	2	HNN733	ADV. PRACTICE DEVELOPMENT	1.00	7	80	HD
2008	**H773**	**MASTER OF NURSING PRACTICE (NURSE PRACTITIONER)**					
	1	HNN730	ADV. CLINICAL DECISION MAKING 1	1.00	7	67	C
	2	HNN731	CONTEMP. NURSE PRACTITIONER ROLE	1.00	7	92	HD
2009	**H773**	**MASTER OF NURSING PRACTICE (NURSE PRACTITIONER)**					
	T1	HNN732	ADV. CLINICAL DEC. MAKING 2	1.00	7	72	D

COURSE REQUIREMENTS COMPLETED ON 09/07/2009.
STUDENT ELIGIBLE FOR THE DEGREE OF MASTER OF NURSING PRACTICE (NURSE PRACTITIONER) TO BE CONFERRED AT A FORTHCOMING GRADUATION CEREMONY.

---END OF RECORD---

CERTIFIED TRUE RECORD
[redacted]
Office of the Director,
Division Of Student Administration
Date: 02/12/09

M O N A S H U N I V E R S I T Y

AUSTRALIA

ACADEMIC RECORD

ID [redacted]

This is to certify that **STEPHEN ANDREW VOOGT** has satisfied the following requirements towards the award of:

GRADUATE DIPLOMA OF BUSINESS (MANAGEMENT)

YEAR	SUBJECT NUMBER	SUBJECT NAME	GRADE	CREDIT POINTS EARNED
1993	GBU8001	MANAGEMENT THEORY AND PRACTICE	P	6.00
	GBU8003	MANAGEMENT PROCESSES AND SYSTEMS	C	6.00
	GBU8004	FINANCIAL MANAGEMENT	C	6.00
1994	GBU8002	HUMAN RESOURCE MANAGEMENT	P	6.00
1995	GBU8010	MARKETING MANAGEMENT	C	6.00
1996	GBU8042	ORGANISATIONAL BEHAVIOUR	P	6.00
	GBU8009	TRAINING AND DEVELOPMENT	C	6.00
1997	GBU8005	STRATEGIC MANAGEMENT	C	6.00

Mr Voogt completed the requirements of this award in 1997 and was awarded the Graduate Diploma of Business (Management) at the Graduation Ceremony held on the Saturday, 23rd May 1998.

COURSE DETAILS BELOW THIS LINE ARE INVALID

Certified by [redacted]

(for)

23

ADMISSIONS AND RECORDS
MONASH UNIVERSITY
Gippsland Campus

This certificate is authenticated by the University stamp and the checking officer's signature.

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AMA submission to the Pharmaceutical Benefits Advisory Committee – Restricted prescription of antipsychotics in residential aged care

pbac@health.gov.au

Introduction

The AMA does not support the restrictions proposed by the Royal Commission into Aged Care Quality and Safety (Royal Commission) in relation to restricting the prescription of antipsychotics to geriatricians and psychiatrists. This simplistic solution to the use of chemical restraints in aged care fails to acknowledge the environmental factors that have driven the use of antipsychotics and will make access to care for patients in residential aged care facilities (RACFs) unnecessarily difficult. GPs are well qualified to prescribe these medications and it is the environment in which antipsychotics are prescribed that needs to change as opposed to the imposition of ill-considered restrictions on prescribing.

The AMA has provided significant input into the work of the Royal Commission, providing seven written submissions in total. The AMA President appeared before the Royal Commission three times.

In these submissions, the AMA has extensively elaborated on what medical practitioners, AMA members, perceive as the key issues in aged care in Australia and how they can be improved. While the AMA welcomed most of the Royal Commission's recommendations, there were also areas of disagreement on the Royal Commission's proposed way forward.

The AMA supports methods to reduce inappropriate prescribing of antipsychotics. However, the AMA is concerned that restricting antipsychotic prescriptions to geriatricians and psychiatrists will create a bottleneck of care for residents in RACFs that are not appropriately set up to deal with the consequences.

This proposal lacks an understanding of Australia's health system, particularly the current climate in aged care and mental health care. The government must implement changes to aged care that support the delivery of high-quality care and that will in turn reduce the risk of inappropriate prescribing. The AMA regards this proposal as attempting to deal with the symptoms of a broken aged care system while ignoring the causes.

The AMA's report on *putting health care back into aged care* details what must be done in this space to ensure older people have their human right to healthcare recognised in RACFs[1].

Implications of specialist geriatric and psychogeriatric access in residential aged care for psychotropic prescribing

AMA position on the use of restraints in aged care

The AMA has continuously expressed concern around the inappropriate use of chemical and physical restraints in aged care settings in submissions to the Royal Commission and other Department of Health and Parliamentary inquiries[2]. AMA members have reported on aged care staff requesting chemical restraints so older people are easier to handle, effectively using antipsychotics as chemical restraint.

It is the AMA position that restrictive practices should only be used as a last resort – where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained. We maintain that the older person's GP, along with the aged care provider, the older person's family and substitute decision maker should be involved in any decision to use a restraint.

Workforce capacity is limited in aged care

The quality use of medicines can be impacted by the prescribing environment. It is internationally recognised that fatigue, poor working conditions, and workforce shortages are all factors increasing the risk of medication errors[3]. The most essential way to ensure the quality use of medicines in RACFs is to ensure that an appropriately qualified and experienced clinical workforce is available to respond to resident's needs in a timely manner.

Non-GP specialists

While the AMA supports and has called for greater involvement of geriatricians and psychiatrists in aged care, our members expressed concern that if this recommendation is implemented, specialist services, which are limited in aged care, will be overburdened and patients with a legitimate need for antipsychotics and non-GP specialist services will suffer as a result.

The AMA called on the Royal Commission to investigate the small numbers of specialist geriatricians and psychiatrists who provide services in aged care, seeking to address this issue so that they can better support GPs. The Department of Health should carry out an audit on geriatricians and psychiatrists available to visit RACFs and a regulatory impact statement should be carried out before this proposal is seriously considered. Access to geriatricians and psychiatrists can be difficult even in metropolitan areas for the general population. Access is particularly difficult for older people in aged care due to limited numbers of private specialists

[1] Australian Medical Association (2021) *Putting health care back into aged care.*
[2] Australian Medical Association (2019) *Submission to the Royal Commission into Aged Care Quality and Safety*
[3] World Health Organization (2017) *WHO Global Patient Safety Challenge: medication without harm.*

who visit RACFs and the small pool of these specialists available in the public hospital system. In Canberra for example, there are only two full time employed psychiatrists in the public system who specialise in working with older patients, who cover both residential aged care and community[4]. The population of over 65s in Canberra is around 50,000 people[5], with over 2000 older people in residential aged care[6].

Importantly, limiting prescribing to geriatricians and psychiatrists will severely impact health services in rural and remote areas, where we know there is a critical need for doctors in a range of specialities, including geriatrics[7]. Restricting prescribing in a manner that is simplistic will have detrimental effect to patients in rural and remote areas where there may be a genuine need for these medications, in order to ensure their safety and the safety of those around them.

Other medical specialists, including but not limited to geriatricians, psycho-geriatricians and psychiatrists work together with GPs to ensure continuity of care for older people. Specialist services should work in close consultation with the GP and residential aged care staff directly responsible for the older person's care and particularly if significant changes to care are recommended. Existing outreach services work on the model of care that requires the GP to be the primary and sole prescriber in aged care. For example, the AMA is aware that Queensland Health and NSW Health operate outreach geriatric services to RACFs, that provides support to GPs by facilitating geriatric reviews of the patients[8,9]. The reviews are initiated by GPs, who can also reach out to the service to ask for advice on specific issues. These are examples of good practice, that should be encouraged and expanded, as they provide collaborative and coordinated care without undermining the role of primary medical specialists in the care of older people – their GPs. The capacity of outreach services currently varies considerably across the country.

Furthermore, the AMA calls for improved funding for non-GP specialist services in aged care, through increased MBS rebates for geriatricians and psychiatrists, including through devising separate MBS items for case conferencing with GPs.

General Practitioners

GPs are suitably qualified to prescribe antipsychotics in line with clinical guidelines[10]. GPs are the primary medical specialists for the care of older people, and as such should be better supported to provide medical care in aged care. However, with its final recommendation the Royal Commission went to the extreme, diminishing the role of GPs in caring for their patients in aged care. Taking the prescribing rights from GPs risks further deterring these key medical specialists from working in aged care, when we know that the numbers of those willing to continue to care for their patients once they enter aged care have been dropping for years[11]. It will also inevitably

[4] Based on the information received from AMA members in Canberra
[5] Australian Bureau of Statistics (2016) *Population by Age and Sex, Regions of Australia, 2015 - Canberra.*
[6] Productivity Commission (2020) *Report on Government Services – Aged Care Services* Table 14.A13
[7] Rural Doctors Association Australia (2019) *Submission to the Royal Commission Into Aged Care Quality and Safety*
[8] Queensland Government (2019) *Radar Prince Charles*
[9] New South Wales Government, Agency for Clinical Innovation (2021) *Spotlight on virtual care: Geriatric Medicine Outreach Service*
[10] Royal Australian College of General Practitioners (2019) *RACGP aged care clinical guide (silver book) 5th edition.*
[11] Australian Medical Association (2017) *AMA Aged Care Survey*

lead to the deskilling of GPs in the prescribing and use of antipsychotic medication for their older patients[12].

It is internationally recognised that GPs are the cornerstone of a successful primary healthcare system, and countries with a strong general practice have better health outcomes[13]. The patient-centred medical home model (PCMHM) is a well-regarded system of integrated care that is more efficient, reduces hospital admissions and provides better support for patients[14,15]. GPs must be appropriately supported to continue to care for their patients once they enter a RACF. Continuity of care is crucial to improving health outcomes. For example, residents with dementia who had to change their GP once entering a RACF has been associated with an increase in polypharmacy and prescribing medicines such as antipsychotics, benzodiazepines, and antidepressants[16].

GPs know their patients in aged care and are best informed to decide when prescribing of certain medication is warranted. Visiting geriatricians and psychiatrists lack that connection with the patient that the GP has. This is a position universally expressed by AMA geriatrician and psychiatrist members. For situations where GP transfer is unavoidable, support for full clinical handovers and medication reviews are needed.

The AMA also calls for the establishment of a federally funded Liaison Officers coordinating primary care within RACFs. The AMA is aware that the Government accepted the Royal Commission's recommendation for improvement of access to primary care in aged care by providing "additional funding for the Primary Health Networks to expand access to palliative care services, support best practice on-site care and accessible telehealth care in residential aged care facilities, and enhanced out-of-hours support"[17]. The AMA sees the Liaison Officers linked to (or employed by) Primary Health Networks, with their tasks including those listed in the Government's response and expanded to include supporting clinical pathways, system development for care in place, education, policy development, support for GPs and registered nurses, review of clinical care issues, including support to medication auditing.

Aged care staff and allied health professionals

The most effective way to manage Behavioural and Psychological Symptoms of Dementia (BPSD) is with sufficient skilled staff. Access to well-trained and experienced aged care staff and allied health professionals are crucial to ensuring effective quality use of medicines by enabling preventative care and other non-pharmaceutical strategies for patients who would otherwise require antipsychotics. For example, AMA members report the importance of adequate measuring and documentation of BPSD before, during, and after the use of antipsychotics by a

[12] JCL Looi et al (2021) *Psychiatric care implications of the Aged Care Royal Commission: Putting the cart before the horse*, Australian and New Zealand Journal of Psychiatry 1-3

[13] The World Health Organisation (2008) *The World Health Report 2008 - primary Health Care (Now More Than Ever).*

[14] NSW Government (2021) *Navigating the health care neighbourhood – What is the patient centred medical home model?*

[15] NSW Government (2021) *Navigating the health care neighbourhood – benefits for health professionals.*

[16] Welberry et al (2021) *Psychotropic medicine prescribing and polypharmacy for people with dementia entering residential aged care: the influence of changing general practitioners.*

[17] Department of Health (2021) *Government response to the final report of the Royal Commission into Aged Care Quality and Safety*.

registered nurse as crucial to appropriate prescribing. Despite this, access is limited. RACFs need registered nurses available on-site 24/7 under minimum staff to resident ratios that reflect the needs of residents. Aged care staff, including personal care attendants and nurses, must have access to dementia management and behavioural training.

Better access to allied health services in RACFs is one strategy that could lead to reduced prescribing. Allied health professionals trained in behaviour support can help to avoid reliance on restraints for residents who are diagnosed with dementia[18]. Person-centred care provided by allied health professionals such as psychologists and occupational therapists to people living with dementia has proven to reduce use of antipsychotic drugs in aged care[19].

The AMA has continuously argued for the need for mandated staff to resident ratios in RACFs, mandated presence of registered nurses in aged care 24/7 and increased involvement of allied health professionals. These are, in the AMA view, key strategies to reduce reliance on antipsychotic medication in aged care. Limiting prescribing to a small group of specialists will not resolve this issue.

Clinical governance in aged care

Appropriate clinical governance in RACFs ensure that the older person's clinical needs are met, including adequate use of medication. RACFs are expected to have "appropriate governance structures, including committee and reporting structures to effectively monitor and improve clinical quality and safety"[20].

However, currently there is no link between clinical governance in aged care and medication management. The current Aged Care Quality Standards – Standard 8 Organisational Governance[21] does not include medication management as a requirement for RACFs to prove they implement effective clinical governance standards.

In its Final Report the Royal Commission proposed that the Aged Care Quality Standards be urgently reviewed and amended to ensure "best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention, and infection control, and providing sufficient detail on what these requirements involve and how they are achieved" and "implementing the new governance standard" (recommendation 19)[22]. The AMA is supportive of this recommendation and sees it as a crucial step forward to ensuring appropriate use of medication in aged care, including antipsychotic medication.

Clinical Governance Committees in RACFs should include representation of registered health practitioners, including medical practitioners, pharmacists, and registered nurses. The resident's

[18] Allied Health Professionals Australia (2019) *Submission to the Royal Commission into Aged Care Quality and Safety*

[19] GJ Andrews (2006) *Managing challenging behaviour in dementia - A person centred approach may reduce the use of physical and chemical restraints*

[20] Aged Care Quality and Safety Commission (2019) Clinical Governance in Aged Care *Fact Sheet 3: Core elements of clinical governance*

[21] Aged Care Quality and Safety Commission (2021) *Standard 8: organisational governance.*

[22] Department of Health (2021) *Government response to the final report of the Royal Commission into Aged Care Quality and Safety*.

usual GP is also a valuable source of advice for medication management and clinical governance.

Auditing and education for antipsychotics

Rather than introducing a 'blanket restriction' on GPs regarding prescribing antipsychotics, the AMA calls for alternative solutions to reducing prescribing, such as regular audits on prescribing/de-prescribing rates in aged care. The AMA envisages such audits to address all other strategies applied by the aged care providers to reduce the distress in the older person before prescribing of antipsychotics is required, reasons why those strategies failed, how long the older person was kept on antipsychotic medication and why. This type of auditing will require an adequate number of appropriately skilled staff available in RACFs at all times, including to document behaviours before and after the use of antipsychotic medication, specifically: the type and magnitude of the behaviour before the treatment, goal of treatment, whether the goal was achieved, etc. This type of auditing also provides an educative experience to aged care staff, clinical governance committees and prescribers on how to improve their services.

The Department of Health should also work with medical colleges to consider strategies for increasing GP education and awareness around antipsychotic prescribing as a more practical alternative to restricting their prescribing rights.

Non-pharmacological options

Non-pharmacological management plans are also crucial to preventing the need for antipsychotics and RACFs must be supported and trained to enable this. For example, reducing distressing noises or lighting and ensuring that the resident's rooms are comfortable and sensory aids are provided[23].

Medication reviews

Medication reviews are important safety mechanisms to reduce the use of unnecessary medications. They are available to older people living in residential aged care (Residential Medication Management Reviews, RMMRs) and to patients in their home (Home Medicines Reviews, HMRs). A study conducted in 2021 showed that MBS claims for RMMRs are lodged for only a small number of residents who enter residential care, even though the program has significant potential for identifying and resolving medication-related problems in aged care facilities[24].

The AMA has called for medication reviews to occur annually, and then on an as-needed basis to ensure medications are appropriate for older people. Pharmacists who work with doctors have an important role in assisting with medication adherence; improving medication management; and providing education about medication safety. The AMA welcomed the Government's

[23] Royal Australian College of General Practitioners (2019) *RACGP aged care clinical guide (silver book) 5th edition.*
[24] K Slugget et al (2021) *Residential medication management reviews in Australian residential aged care facilities, Medical Journal of Australia*

announcement following the Royal Commission's interim report[25], introducing up to two follow up reviews for both residential medication management reviews and home medicines reviews. The AMA is also aware that the 7th Community Pharmacy Agreement includes funding for Residential Medication Management Reviews[26]. The AMA supports any framework that allows for medication reviews to happen routinely for all recipients of aged care services (as above) that can be initiated by either the GP, the aged care provider or the pharmacist.

The scope of antipsychotic medicines that should be considered

The Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, Royal Australian and New Zealand College of Psychiatrists and the Australian and New Zealand Society for Geriatric Medicine are best placed to comment on the scope of antipsychotic medicines that should be considered should this proposal proceed. The AMA also encourages PBAC to consult the Aged Care Clinical Advisory Committee (Department of Health) that was working on advice around restraints in the context of the amendments to the Aged Care Act, resulting from the recommendations by the Royal Commission[27].

While non-pharmacological measures should be considered before the use of antipsychotics, which have a limited role in managing behaviour, the AMA notes that some patients still have a legitimate need for them[28]. The prescribing intent is important, as the aim of antipsychotics is not always to restrain. Antipsychotics are used for diagnosed physical or mental health conditions, most commonly for patients with behavioural and psychological symptoms of dementia such as agitation, physical aggression, paranoia, delusions and hallucinations[29]. If the RACF is not adequately set up to foster non-pharmacological strategies and patient symptoms are not managed, patients may pose a serious risk to themselves, other residents, and staff.

There is also a risk that if the patient legitimately requires antipsychotics but cannot get access to a specialist in time, private prescriptions may increase, which increases the cost for the patient. Antipsychotics are preferable to other pharmacological options that may be considered instead.

Doctors must be able to maintain clinical independence in order to make the best treatment recommendations for patients, based on current evidence, preserving their own clinical judgments regarding treatment recommendations.

Any unintended consequences should amendments to the PBS listings for antipsychotics be made according to recommendation 65

See above.

[25] Prime Minister of Australia (2019) *Response to Aged Care Royal Commission Interim Report*
[26] Department of Health (2020) *7th Community Pharmacy Agreement*
[27] Australian Government (2021) *Aged care and other legislation amendment (Royal Commission Response no 1) Bill 2021*
[28] Royal Australian College of General Practitioners (2019) *RACGP aged care clinical guide (silver book) 5th edition.*
[29] Royal Australian College of General Practitioners (2019) *RACGP aged care clinical guide (silver book) 5th edition.*

Conclusion

The AMA does not support the proposed restriction of prescribing of antipsychotics in aged care to geriatricians and psychiatrists as recommended by the Royal Commission. The AMA believes there is a whole spectrum of other strategies that should be implemented before any prescribing is restricted to a small group of specialists. Those strategies include staff to resident ratios, registered nurse presence in RACFs 24/7, improved access to allied health professionals and better integration of aged care with healthcare in general, primarily through ensuring that greater numbers of GPs work in aged care and that GPs continue to care for their patients after they enter aged care, guaranteeing continuity of care. GP education modules and RACF auditing of antipsychotic use should also be explored.

Before this proposal is considered further, the Department must carry out an audit of the available geriatricians and psychiatrists to carry out this work and regulatory impact statement should be developed.

The AMA also calls for more research in this area to ensure evidence-based policy making in aged care. AMA members note that there is minimal research and available information to describe the effects of use of antipsychotic medication in RACFs. For example, there is some research that indicates that antipsychotic medication can decrease lifespan for older people, but very little detailed research on why antipsychotic medication is used older people with broad spectrum of diagnoses.

Finally, the AMA argues that the Government relied heavily on medical information when dealing with Covid-19. It should be no different when it comes to treatment with antipsychotic medication in aged care. In this case the unanimous medical advice from AMA members, Geriatricians, Psychiatrists and GPs is that restriction of antipsychotic prescribing to small group of specialists should not go ahead. Instead of implementing this change, the Government should invest more resources into clinical research on antipsychotic prescribing to better inform evidence-based policy making.

20 October 2021

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IN THE FAIR WORK COMMISSION

Matter No.: **AM2020/99, AM2021/63 & AM2021/65**

Re Applications by: **Australian Nursing and Midwifery Federation and others**

AMENDED STATEMENT OF WENDY KNIGHTS

I, Wendy Knights of [redacted], in the State of Victoria say:

Personal Details

1. My date of birth is [redacted].

2. I live in [redacted] with my partner. I have been living in [redacted], where I grew up, for the last 12 years.

3. I am employed as a casual Enrolled Nurse (**EN**) at Princes Court Homes Ltd. I started working at Princes Court in 2009. I was a permanent or on-going employee between 2009 and 2019. In 2019, I took a ten-month break. I came back in May 2020, as a casual employee. I do at least seven shifts a fortnight. Usually I do 4 shifts as in-charge in the 18-bed dementia unit and the other three could be anywhere across the facility.

4. During my ten-month break in 2019–2020, I worked agency in Queensland private aged care around Maryborough. I was the "in-charge" of a facility on the PM shift. That was a daunting experience as you were given no induction or training about the facility systems or where things are. I have been asked to go permanent again by Princes Court but I remain casual because I intend to move to Queensland in late 2021 to live closer to family.

5. I am paid under the *Princes Court Homes Inc (t/a Princes Court Homes Hostel), ANMF & HSU Enterprise Agreement 2017* as an Enrolled Nurse Pay Point 8

6. My income barely meets my current expenses and needs now.

7. If I was on the Award rate, I would simply not be able to continue to work in residential aged care. I do the work because I love it. I certainly do not do it because the money is good. In terms of money, I could find easier and less stressful work in other industries for as much or

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even more money. But I find helping residents and their families both challenging and immensely rewarding. I like the sense of responsibility, and the camaraderie with the other carers.

Work history and qualifications

8. I have worked in residential aged care at Princes Court Homes Hostel for the last 12 years.

9. Before that I worked as a Personal Care Worker (**PCW**) or Personal Care Attendant (**PCA**) or Assistant in Nursing (**AIN**) at Tanunda Lutheran Nursing Home in the Barossa Valley in South Australia. I had done a Certificate III and Certificate IV in Community Services in 1998 to 2000. The Certificate IV had a youth focus. In about 2001, I went back and did the aged care modules at Gawler TAFE.

10. Tanunda Lutheran had about 96 residents across the spectrum of care needs – high and low. It had a 12-bed dementia ward. I worked across the facility, including a stint as the admissions officer for 12 months, which included monthly meetings with regional ACFI assessment people who visited facilities.

11. Then the State Government offered the opportunity to do Enrolled Nursing through TAFE SA in the Barossa. It was initially meant to be a six-month course but it ended up being a 12-month Diploma. I did that in 2008. A copy of my Certificate III and IV qualifications and my Diploma is **Annexure WK 1**.

12. I took up that opportunity because I could see that the people entering aged care were increasingly ill and frail. Based on my observations and speaking with incoming residents and their families at the time, 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.

13. 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.

14. I felt I needed to have more knowledge and that aged care would need increasingly skilled people. Personal Carers at Cert III are given broad training but it isn't sufficiently in depth to identify or question certain care needs like wounds, dementia, diabetes and continence. Personally I felt I needed more explanation on those matters. Even if it wasn't in my scope to

assess and action those issues, as a worker in aged care you need to be able to identify when something changes or isn't right so that you can report it in a timely way.

15. After I finished the EN course I moved home to Mildura in 2009. That is when I commenced with Princes Court as a Medication Endorsed Enrolled Nurse. Between 2000 and 2010 the role of Enrolled Nurses was changed with the inclusion of the administration of medications.

16. 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.

17. 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.

18. Princes Court is a 103-bed facility. We have 3 or 4 respite beds. The word "hostel' was in the title (including in the title of our Enterprise Agreement) until recently but has now been dropped. That reflects the reality that, as I said at paragraph 13 above, there is no longer any clear distinction between "low care" and "high care".

19. 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.

20. Apart from my EN Diploma I have done a Wikki dementia course through the University of Tasmania (which took several months on-line).

21. Back in 2010 I started my RN course, but I withdrew in 2012 because I didn't have the time to do it justice and my son was completing VCE in 2012 and that took priority.

22. I also did a palliative care course run by PEPA (Program of Experience in the Palliative Approach), which is funded by the Commonwealth to improve palliative care practice and experiences, including in residential aged care. That included understanding the goals of palliative care, new advanced care planning, documentation for assisted dying and identifying coping strategies for management of personal issues related to working in this area. A copy of the completion outcomes for these short courses is **Annexure WK 2**.

23. I am now undertaking a Diploma in Occupational Health and Safety through the ANMF Education Portal.

Staffing at Princes Court and my role

24. As a Medication Endorsed EN my role is mainly in special care or dementia care. I work mainly PM shifts. I am in charge of the dementia unit of 18 residents. I report to the single RN who in charge of the facility on the PM shift between 3pm to 11.30pm. I have two carers who report to me within the unit.

25. There are about 12 nursing and care staff in total at the facility on PM shift, comprising one RN, usually 2 or 3 ENs and 8 or 9 carers or PCAs. At 9.30 we lose three staff and then another two at 10.30. By 10.30 we only have six staff in the facility, including the RN. So that is about 1 staff to 8.6 residents through to 1 to 17 at worst. The facility has always tried to have an RN on every shift. However, one RN for 103 residents is barely enough on PM shift and the RN is often simply dealing with emergencies rather than systematically looking at the care needs of residents each evening.

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.

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 follow-up 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.

28. Occasionally when there aren't enough Enrolled Nurses a PCA will take on the in-charge role in the dementia unit on PM as well. A PCA is usually on charge of the unit overnight which is a responsibility I wouldn't take on myself. I wouldn't take it on myself because I would not feel safe. I describe below the increased risk to nurses from residents with dementia becoming aggressive. There is usually an RN on shift overnight but rarely an EN (unless we can't get an RN).

29. 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.

30. I am the only one who does an eight-hour shift in the unit (3-11.30pm including a 30-minute unpaid meal break). I have one PCA who comes on at 3pm till 9.30pm and another comes on at 4pm to 10.30 (so they both do a 6-hour shift).

31. 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.

32. We have an activities person who comes on for a sundowners shift from 4.30-6pm to keep residents engaged which means an extra pair of hands to help with behaviours. I describe below the difficult behaviours nurses encounter, especially in the later afternoon, with residents with dementia. That activities assistance was for two hours until the last few months but it was then dropped to 90 minutes (the activities person is employed for other hours each day elsewhere in the facility).

33. There is a lot of two-person care needed – especially lifting for toileting or putting to bed. I like to have all the double lifts done by 9.30pm and then I like to do a pressure area round (to turn those who are bed-bound on air mattresses or have been in princess chairs) by 10.30pm. I'm on my own doing paperwork or answering buzzers from 10.30 until 11.20, when the night duty person (usually a Personal Carer) replaces me. I then have to do handover and usually leave somewhere between 11.35-11.50pm even though my shift is scheduled to finish at 11.30.

Changes in the nature of the aged-care work

Increased acuity

34. I said at paragraph 13 above that the care needs of residents have dramatically increased over the last decade or so. That means the amount of hands-on work and monitoring has likewise increased significantly over the last decade or so.

35. The general physical capacity of incoming residents is much reduced from what it was even in the early 2000s when I started in aged care. In those days there were still some people who could still shower themselves and largely dress themselves with a little bit of assistance. Those days are long gone. Residents are older and more fragile when they enter aged care and rely on staff assistance for almost every aspect of personal care.

36. When I started in aged care, a significant proportion of residents did not need very much assistance beyond things like fastening bras, making beds, washing clothes, and things of that kind. These days, though, nearly all residents need assistance with those things and also with showering, drying themselves, moisturising, dressing, applying deodorant, toileting, wiping bottoms, inserting pads, making breakfast, making tea or coffee, making their way to the dining room (if they want to eat in the dining room), transferring to wheelchairs, and so on. In the evenings, they need assistance with changing into nighties and putting night pads on. Throughout the day they need assistance toileting as required.

37. Another change is that meals are often served in the units, not in a central dining room. So lunch/dinner could be in the unit dining area or if it is too wet or hot to go the central dining area. Residents can also choose to have meals in their room or the unit dining area. Certainly, breakfast is only available in the unit dining room and the PCAs have to prepare all breakfasts – make porridge or other cereals, drinks, toast etc. They will serve that and monitor the eating. This adds to workload on top of other personal care.

38. As a result of increased age and frailty when they enter, residents are less mobile and incontinence is increased. We use kylies, an absorbent continence aid that is put on the bed.

Medication, technology

39. Also, since I did my Diploma things have changed significantly with medications. There are a lot more cancer drugs used. Some residents can be on up to 15 medications at a time. The management of drug administration has also changed. For example, medications used to be in webster packs and then loose PRN medications. There was a drug chart which we had sign on sheets for each drug. Now it is a combination of the webster packs and we also have to

use MedSig – a computer program which details every resident and each of their medications, including the time to be given.

40. MedSig was something which we had to learn in about 2018-2019. It makes it harder because you can't complete the round on MedSig until you've given the very last medication. It also makes it harder when you have to alter the time of giving a medication (for example a tablet is due at 7pm and 8pm and because of resident confusion you need to give them together. MedSig makes that more difficult. We also have to battle with IT issues (internet connection), flat batteries and so on.

41. I am not against MedSig, or other changes intended to make residents safer. But it does (and similar changes do) create more work for aged-care workers.

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.

45. In the same way, the advent of communications technologies – smart TVs, mobiles and emails — affect our care work. This was true even before COVID-19, but is especially so now. We are often fixing equipment or connecting people. During COVID-19 when we have experienced lock downs or bans on visitors. There is now a lot more remote contact – by video call (Messenger, What's App or Zoom) or additional phone calls.

46. In terms of technology, I use lifting machines daily, computers daily including for progress notes, and MedSig daily. There are a few residents with a need for oxygen machines. Then, there is also the consumer technology — televisions, video-calling apps, WIFI, etc. There is much more technology use on the job than there used to be.

47. Again, supporting residents' emotional needs is crucial, and I support it. But, it adds to the workload. For example, we have to write each family phone call in the progress notes.

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.

Dementia

49. I mentioned above at paragraph 32 above that aged-care workers 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 over-medication. 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.

Incident reporting

55. Another big difference between aged-care work now and how it used to be is the amount work in relation to incident reporting.

56. With the introduction of the Serious Incident Response System (**SIRS**) across aged care, when you see something you have to report it. Each incident, whether it is a Priority 1 or Priority 2 incident must be documented and reported (not only internally but also the family, doctor etc). Sometimes the external liaison will be done by the RN, especially for serious matters. For less serious matters the EN would sometimes ring – it depends on the workload of the RN.

57. This can happen daily. For example, a PCA might report a bruise that looks new. I need to deal with it quickly as it may need an incident report so it can be submitted within 24 hours (under the SIRS). For example, on 28 July I had two falls, one of which needed to go to hospital. Both had to be documented and reported under SIRS.

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. 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.

Documentation

62. It is the same with medications. If you've given a PRN mediation (*i.e.*, an as-required medication), for example a Panadol for pain relief or a Coloxyl Senna for constipation, you now have to document the effect of the medication in a progress note in MedSig. So it isn't any longer just giving the medication and observing whether pain is less or whether there has been a bowel movement. You also have to document it in real time as well. And if you give strong pain relief —for example Endone — you have to notify families as well. Again, each of these small additional tasks means there is less time to do other things.

63. Other increases in documentation include where blood glucose levels are outside the parameters – a notifiable or reportable BGL – you need to notify the doctor directly. If additional PRN anti-psychotics are given – for example Respiridone – then have to notify the family, next of kin and the doctor.

64. With the ACFI there is a section that the PCAs do with basic information (weight etc). Then there is a section for an advanced PCA or EN about care needs and that is where the progress notes and medication changes are entered. This is all new in the implementation of the assessment schedules for ACFI.

65. When care plans are updated, this requires ENs to go through progress notes and document, amongst other things, changes in medication, adverse events since the previous plain, whether there are any changes to things like hearing aids, glasses, mobility aids, etc., whether care needs have increased (*e.g.*, are we showering them more than we used to), whether continence has changed, and things of this kind. It is time-consuming preparing these updates.

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.

67. Most of our care planning is on-line. The high care plans are reviewed every second month, but monthly for advanced care (high, high care) and dementia care. This has been slowly

coming in at our facilities over the last 5 or six years at our facility. We don't have very much that is still paper based. There was some training when it first started but most learning is on the job.

68. These are all good initiatives but, again, they are time consuming tasks and new skills needed to do it well.

69. Because we are now so process and activity driven, we are moving further away from a relaxed, "home" environment. Because there is so much documentation and reporting, it takes away from the time available to us for personal care to residents. It is sad and ironic, because the objective is for the facility to be residents' "homes," and for them to have choices, but we seem to have less time and resources to make that the reality. We try really hard to make resident's lives enjoyable and meaningful but I know I am frustrated that I can't give more to building the relationships with residents and making it a better experience. When I talk to other staff I know that is their major frustration as well.

<u>Changes after Royal Commission</u>

70. 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.

71. For example, there is one resident who has bolts and plates in his body. The pain caused by these bolts and plates was managed by medication. After the Royal Commission he was on reduced pain mediation, the result of which was that he was in too much pain to sit down, so he would stand and eat, or walk around and eat. That creates a choking hazard.

72. I think that this 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.

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.

74. Quite rightly there is now much more focus on infection control, hand hygiene, documentation – but ongoing training is required. This has been reinforced especially over the

18 months with COVID-19. While this might be good practice it has also added to the workload as it slows down each assessment and task. For example, there are only so many hand-sanitising stations and often you have to do a proper hand wash after handling bodily fluids.

75. There is also donning and doffing of gowns during outbreaks (or whenever a resident has a cold or temperature) and changing of masks every four hours, sometimes more often. This is now happening quite frequently as residents with flu or COVID-like symptoms are immediately isolated and full PPE and infection control is implemented. That never happened before. We have all had to learn these new processes (Monash Uni educators came in to assist us) and we have an on-line education program.

Residents and carers from culturally and linguistically diverse backgrounds

76. Being in the Mildura area, a number of our residents have Italian, Greek and other CALD backgrounds – probably about 25% to 30%. These residents enter aged care much later because of home care and more quickly revert to their first language. This makes communication harder. There are more residents from CALD backgrounds than there were when I started at Princes Court.

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% 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.

Interaction with families, visitors, allied health professionals

78. I think there is now a lot more interaction between the care staff and the family members of residents. I think several decades ago the input from families was relatively minimal and the requirement to consult families was less. Over the last decade, and especially as care standards have been under question, many families are increasingly active in requesting or advocating for their loved ones. This is great and was sorely needed. However, each interaction has to be responded to and documented. Sometimes there are conflicts between the family expectations and what we see as the care needs of the resident. Also, sometimes

family don't understand the constraints we work under in terms of resources. I think that dealing with these issues requires skills that are relatively new – for both ENs and carers.

79. There is also more interaction than there used to be with GPs and other allied health professionals. This is both because of the increased reporting and documentation requirements, and because of the increased acuity of residents, which I have described above.

COVID-19

80. COVID-19 has caused major changes – not just in terms of infection control or remote communications. We have to do daily health checks and temperature testing of each resident. It is full page for each resident and if there is any change in the resident then it has to be escalated to the EN or RN in charge. It has made the working environment harder. If I worked one night in special/dementia care last night and worked high care tonight, I'd have to wear full PPE for at least several shifts.

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.

End stage care

82. There are now a far greater number of residents who spend their end stage at the facility rather than going to hospital. That is usually specified in their Advanced Care Plan where they specify that they want to stay in the facility. I think that 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

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.

Nature of work — summary and miscellaneous observations

84. The work is draining. That is why I had to take a break in 2019-2020. All of the changes I've described above, even before the Royal Commission and the change in Aged Care Standards, meant that it is extremely difficult just to complete all the required processes and tasks in a timely and competent manner.

85. Another consequence of the increased workload is working unpaid overtime. For example, it is so busy in the dementia unit that I often do not get the chance to do my progress notes until when I am supposed to finish, at 11:30 pm. I often end up working up to an additional 30 minutes just to finish my paperwork, which is unpaid overtime. There is no other time to do it, when there is so much happening.

86. I think my skills and responsibilities have increased over the last decade. The residents have more complex needs and the expectations of the regulators, residents and families have increased. This makes the job harder than it was a decade ago.

87. Part of the role and duty of a nurse is to be an advocate for the residents. This has reared its head several times in my career. For example, earlier in my career at Princes there was only one EN on the PM shift and I argued that there should be two EN Team Leader on the PM as well as the RN in charge of the facility.

88. 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.

89. 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.

90. Supervision of other staff is now also more complex as the documentation requirements increase and I have to make sure that my reports are doing the right thing. I also have to make

sure I have reported up as required, especially where there are incidents, such as falls or choking episodes etc.

91. Training in aged care has certainly increased. However, I actually think it could go to another level as described earlier. While we have several days Professional Development leave as an entitlement in our Enterprise Agreement, the leave is often hard to organise and get approved.

Work Conditions

92. As I have described above, there is much more aggression and violence than there used to be in aged care.

93. There is also a much greater need, especially during COVID-19, for the use of PPE and infection prevention and control.

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 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.

96. For my own part, I will probably finish my career in aged care, which I think will be another four or five years.

Enterprise bargaining

97. In my time working in aged care I have noticed the following things which appear to me to be impediments to raises wages by enterprise bargaining.

98. First, very few carers are even aware of what an enterprise agreement is, or what entitlements it gives them. Second, many workers, especially those from CALD backgrounds, do not want to cause trouble by making industrial demands.

99. Third, I think it would be very difficult to organise industrial action. From my perspective, I would want to ensure that any industrial action that was organised did not affect the

residents. I am only aware of nurses in Mildura taking industrial action on one occasion. That was hospital staff. Only the staff who were not working that day turned up at the picket. Staff who were rostered that day did actually work rather than strike.

WENDY KNIGHTS

29 October 2021

WK 1

Government of South Australia

tafeSA

This is to certify that

Wendy P Knights

has fulfilled the requirements for the

Diploma

of

Nursing
(Pre-Enrolment)

39037QLD

[redacted]

Chief Executive
Department of Further Education, Employment, Science and Technology

24 April 2009

[redacted]
Parchment Number

40161
tional Training Provider Number

NATIONALLY RECOGNISED TRAINING

Issued under authority of the Training and Skills Development Act, 2008
The qualification certified herein is recognised within the Australian Qualifications Framework

Government of South Australia

TAFE SA

THIS IS TO CERTIFY THAT

Wendy Symes

HAS SATISFIED THE REQUIREMENTS FOR
THE AWARD OF

CERTIFICATE IV

IN

Community Services and Health (Youth Work)

[redacted]

PARCHMENT No.

23rd March, 1999

DATE

[redacted]

[redacted]

NATIONALLY RECOGNISED
TRAINING

DEPARTMENT OF EDUCATION
TRAINING AND EMPLOYMENT

Issued under authority of the VEET Act 1994

The qualification certified herein is recognised within the Australian Qualifications Framework.

This is to certify that

Wendy Symes

has fulfilled the requirements for the

CERTIFICATE III

in

Community Services (Aged Care Work)

[redacted]

[redacted]

Murray Institute of TAFE
National Training Provider No: 6772

[redacted]

Chief Executive,
Department of Further Education, Employment, Science and Technology

10 December 2004

0161982 AXB 2002

NATIONALLY RECOGNISED TRAINING

[redacted]

SOUTH AUSTRALIA TRAINING AND EDUCATION FURTHER

Issued under the authority of the Training and Skills Development Act 2003.
This Qualification is recognised within the Australian Qualifications Framework.

TAFE SA

THIS IS TO CERTIFY THAT

Wendy Symes

HAS SATISFIED THE REQUIREMENTS FOR
THE AWARD OF

CERTIFICATE III

IN

Community Services and Helath

[redacted]

4 April, 1997

[redacted]

NATIONALLY RECOGNISED
TRAINING

SOUTH AUSTRALIA

Issued under authority of the VEET Act 1994

This Qualification is recognised within the Australian Qualifications Framework

WK 2

PEPA Program of Experience in the Palliative Approach

Funded by the Australian Government Department of Health

Certificate of Attendance

This certifies that

Wendy Knights

has attended the following educational workshop:

A Palliative Approach to Aged Care

All day

Workshop Duration

21 May 2019

Date

[redacted]

[redacted] - PEPA Victoria Manager

Learning Objectives

- Understanding the palliative approach
- Advance care planning
- How to communicate with clients in palliative care
- Assessing common symptoms in palliative care
- Understanding the terminal phase and end of life care
- Self-Care

Aged Care Mentors

Aged Care Masterclass
November 27th, 2018
Bendigo

CERTIFICATE OF ATTENDANCE PRESENTED TO:
Wendy Knights

Topics:

- **Patient Assessment**
- **Working in a Team**
- **Dementia & Delirium**
- **The Coronial Process**
- **Coronial Case Studies**
- **When s#@t Happens**
- **Unpacking your Workplace**
- **Throw us your best & worst: Q&A debrief**

CPD POINTS: 6

agedcarementors.com.au

[redacted]

UNIVERSITY of TASMANIA | WICKING Dementia Research & Education Centre

This is to certify that

Wendy Knights

has successfully completed all units of the

Preventing Dementia

Massive open online course

[redacted]

Wicking Dementia Research
and Education Centre
College of Health and Medicine

May 2018

The identity and participation of the recipient of this certificate has not been verified
CRICOS Provider Code: 00586B